DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing
and
Office of Behavioral Health

Adult Mental Health Services
Covered Services and Recipient Qualifications
(LAC 50:XXXIII.Chapters 61-67)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XXXIII.Chapters 61-67 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health amended the provisions governing adult behavioral health services in order to ensure the provider certification, assessment, and reevaluation criteria are in alignment with the approved Medicaid State Plan (*Louisiana Register*, Number 41, Volume 2).

The department now proposes to amend the provisions governing adult behavioral health services in order to: 1) provide Medicaid coverage and reimbursement for license mental health professional services and mental health rehabilitative

services to adult members enrolled in Bayou Health and terminate the behavioral health services rendered under the 1915(i) State Plan authority; 2) establish the recipient qualifications criteria; and 3) revise the assessment and plan of care requirements. This action is being taken to protect the public health and welfare of Medicaid recipients who rely on behavioral health services by ensuring continued access to these services, and to prevent imminent peril to the public health and welfare of individuals who are in dire need of adult behavioral health services. It is estimated that implementation of this Emergency Rule will increase expenditures in the Medicaid Program by approximately $2,194,795 in state fiscal year 2015-2016.

Effective December 1, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing adult mental health services.

TITLE 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXXIII. Behavioral Health Services
Subpart 7. Adult Mental Health Services

Chapter 61. General Provisions

§6101. Introduction

A. The Medicaid Program ~~hereby adopts provisions to~~ provides coverage under the Medicaid State Plan for ~~behavioral~~ mental health services rendered to adults with ~~behavioral~~ mental health disorders. These services shall be administered under the

authority of the Department of Health and Hospitals, ~~Office of Behavioral Health~~ in collaboration with ~~a~~ the ~~Statewide Management~~managed care ~~O~~organizations (~~S~~MCOs), which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. The ~~behavioral~~ mental health services rendered to adults shall be necessary to reduce the disability resulting from ~~behavioral~~ mental ~~health~~ illness and to restore the individual to his/her best possible functioning level in the community.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:358 (February 2012), LR 41:

§6103. Recipient Qualifications

A. Individuals, ~~over the age of 18~~21 years of age and older, ~~and not otherwise eligible for Medicaid,~~ who meet Medicaid eligibility and clinical criteria established in §6103.B, shall qualify to receive adult ~~behavioral~~ mental health services.

B. Qualifying individuals ~~who meet one of the following criteria~~ shall be eligible to receive the following adult ~~behavioral~~ mental health services.

1. ~~Person with Acute Stabilization Needs~~Licensed mental health professional services are available to adults enrolled in Bayou Health, provided the services are determined to be medically necessary in accordance with LAC 50:I.1101.

~~a. The person currently presents with mental health symptoms that are consistent with a diagnosable mental disorder specified within the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)*, or subsequent revisions of these documents.~~

~~b. The person is experiencing at least "moderate" levels of risk to self or others as evidenced by at least a score of 3 and no more than a score of 4 on the Level-of-Care Utilization System (LOCUS) Risk of Harm subscale and/or serious or severe levels of functional impairment as evidenced by at least a score of 4 on the LOCUS Functional Status subscale. This rating is made based on current manifestation and not past history.~~a. - b. Repealed.

2. ~~Person with Major Mental Disorder (MMD)~~Mental health rehabilitation services are available to adults enrolled in Bayou Health, provided the services are determined to be medically necessary in accordance with LAC 50:I.1101, and the enrollee meets the following conditions:

a. ~~The person has at least one diagnosable mental disorder which is commonly associated with higher levels of impairment. These diagnoses may include:~~currently presents with mental health symptoms that are consistent with a diagnosable mental disorder specified within the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* or the *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10)*, or subsequent revisions of these documents;

~~i. schizophrenia spectrum and other psychotic disorders;~~

~~ii. bipolar and related disorders; or~~

~~iii. depressive disorders.~~i. - iii. Repealed.

b. ~~The person experiences at least moderate levels of need as indicated by at least a composite LOCUS total score of 14 to 16, indicative of a low intensity community-based services level-of-care.~~has at least a score of two on the Level of Care Utilization System (LOCUS); and

c. ~~A person with a primary diagnosis of a substance use disorder without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for a major mental disorder diagnosis.~~has a condition for which services are therapeutically appropriate.

~~3. Persons with Serious Mental Illness (SMI)~~

~~a. The person currently has, or at any time during the past year, had a diagnosable qualifying mental health diagnosis of sufficient duration to meet the diagnostic criteria specified within the DSM-V or the ICD-10-CM, or subsequent revisions of these documents.~~

~~b. The person is experiencing moderate levels of need as indicated by at least a composite LOCUS total score of 17 to 19, indicative of at least a high intensity community-based services level-of-care.~~

~~c. A person with a primary diagnosis of a substance use disorder without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for a SMI diagnosis.~~

~~4. An adult who has previously met the criteria stated in §6103.B.1-3 and needs subsequent medically necessary services for stabilization and maintenance.~~3. - 4. Repealed.

C. An adult who has previously met the criteria stated in §6103.B.2.a-c, but who now meets a composite LOCUS score of one and needs subsequent medically necessary services for stabilization and maintenance, shall be eligible for adult behavioral health services.

D. An adult with a primary diagnosis of a substance use disorder without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for mental health rehabilitation services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:358 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 41:

Chapter 63. Services

§6301. General Provisions

A. All ~~behavioral~~ mental health services must be medically necessary, in accordance with the provisions of LAC 50:I.1101. The medical necessity for services shall be determined by a licensed mental health practitioner or physician who is acting within the scope of his/her professional license and applicable state law.

B. …

C. There shall be recipient involvement throughout the planning and delivery of services. ~~Services shall be appropriate for:~~

1. ~~age;~~Services shall be:

a. delivered in a culturally and linguistically competent manner; and

b. respectful of the individual receiving services.

2. ~~development;~~Services shall be appropriate to individuals of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. ~~education; and~~Services shall be appropriate for:

a. age;

b. development; and

c. education.

4. ~~culture~~Repealed.

D. Anyone providing ~~behavioral~~mental health services must ~~be certified by the department, or its designee, in addition to operating~~operate within their scope of practice license.

E. …

F. Services may be provided at a ~~site-based~~ facility, in the community, or in the individual's place of residence as outlined in the plan of care. Services may be furnished in a

nursing facility only in accordance with policies and procedures issued by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 41:

§6303. Assessments

A. For mental health rehabilitation services, ~~E~~each ~~recipient~~ enrollee shall ~~undergo an independent assessment prior to receiving behavioral health services~~be assessed and have a plan of care (POC) developed. ~~The individual performing the assessment, eligibility, and plan of care shall meet the independent assessment conflict free criteria established by the department.~~

B. ~~All assessments shall be based upon department designated assessment criteria and in accordance with the provisions of this Rule, the provider manual and other notices or directives issued by the department~~Assessments shall be performed by a licensed mental health practitioner (LMHP).

C. ~~The assessments shall be conducted by a case manager who is a physician or licensed mental health practitioner (LMHP) (in consultation with a psychiatrist who must complete portions of the assessment) who is trained to administer the evaluation and operating within their scope of license, and who is annually recertified~~Assessments must be performed at least every 365 days or as needed any time there is a significant change to the enrollee's circumstances.

D. ~~The evaluation and re-evaluation must be finalized through the SMO using the universal needs assessment criteria and qualified SMO personnel. Needs-based eligibility evaluations are conducted at least every 12 months~~Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 41:

§6305. Plan of Care

A. Each ~~individual~~ enrollee who receives adult ~~behavioral~~ mental health rehabilitation services shall have a ~~plan of care (~~POC~~)~~ developed based upon the ~~independent~~ assessment.

B. The individualized ~~plan of care~~ POC shall be developed according to the criteria established by the department and in accordance with the provisions of this Rule, the provider manual and other notices or directives issued by the department.

1. The POC is reviewed at least every ~~12 months~~365 days and as needed when there is significant change in the individual's circumstances.

C. The plan of care shall be developed by a case manager who acts as an advocate for the individual and is a source of information for the individual and the team. ~~The case manager shall be a physician or an LMHP.~~

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:359 (February 2012), LR 41:

§6307. Covered Services

A. The following ~~behavioral~~ mental health services shall be reimbursed under the Medicaid Program:

1. therapeutic services, including diagnosis and treatment delivered by LMHPs;

2. – 3. …

B. Service ~~Limitations~~Exclusions. The following shall be excluded from Medicaid reimbursement:

1. ~~Psychosocial rehabilitation is limited to 750 hours of group services per calendar year. Hours in excess of 750 may be authorized when deemed medically necessary.~~components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual;

2. ~~Emergent crisis intervention services are limited to six hours per episode. Ongoing crisis intervention services are limited to 66 hours per episode.~~services provided at a work site which are job tasks oriented and not directly related to the treatment of the recipient's needs; and

3. any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.

~~C. Service Exclusions. The following services shall be excluded from Medicaid reimbursement:~~

~~1. components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual;~~

~~2. services provided at a work site which are job tasks oriented and not directly related to the treatment of the recipient's needs;~~

~~3. any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or~~

~~basic services for the convenience of an individual receiving substance abuse services; and~~

~~4. services rendered in an institute for mental disease.~~C. - C.4. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:359 (February 2012), LR 41:

Chapter 65. Provider Participation

§6501. Provider Responsibilities

A. Each provider of adult ~~behavioral~~ mental health services shall enter into a contract with ~~the Statewide Management Organization~~one or more of the managed care organizations in order to receive reimbursement for Medicaid covered services.

B. All services shall be delivered in accordance with federal and state laws and regulations, the provisions of this Rule, the provider manual, and other notices or directives issued by the department. The provider shall create and maintain documents to substantiate that all requirements are met.

C. Providers of adult ~~behavioral~~ mental health services shall ensure that all services are authorized and any services that exceed established limitations beyond the initial

authorization are approved for re-authorization prior to service delivery.

D. Anyone providing adult ~~behavioral~~ mental health services must be certified by the department, or its designee, in addition to operating within their scope of practice license. ~~To be certified or recertified, providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.~~

E. Providers shall maintain case records that include, at a minimum:

1. a copy of the plan of care and treatment plan;

2. – 5. …

6. the goals of the plan of care and/or treatment plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:360 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 41:

Chapter 67. Reimbursement

§6701. Reimbursement Methodology

A. ~~The department, or its fiscal intermediary, shall make monthly capitation payments to the SMO. Payments shall be developed and based upon the fee-for-service reimbursement methodology currently established for the covered services~~Effective for dates of service on or after December 1, 2015, the department, or its fiscal intermediary, shall make monthly capitation payments to the MCOs.

B. The capitation rates paid to the ~~SMO~~ MCOs shall be actuarially sound rates and the ~~SMO~~ MCOs will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid rate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:360 (February 2012), LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth

Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert

Secretary