NOTICE OF INTENT

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

Behavioral Health Services
Louisiana Bayou Health and Coordinated System of Care Waiver
(LAC 50:XXXIII.Chapters 1-9)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend LAC 50:XXXIII.Chapters 1-9 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the statewide management organization (SMO) in order to include the administration of behavioral health services covered under the LaCHIP Affordable Plan (Phase 5) and to revise the provisions governing recipient coverage (*Louisiana Register*, Volume 41, Number 7).

The department now proposes to amend the provisions governing behavioral health services coordinated by the SMO to: 1) narrow the SMO's scope of service administration to coordinated system of care (CSoC) services only; 2) revise the enrollment provisions; and 3) revise the reimbursement

methodology to reflect the integration of specialized behavioral health services into Bayou Health by establishing capitation payments for recipients enrolled in managed care organizations (MCOs). For recipients enrolled with the CSoC contractor, reimbursement shall be based upon the established Medicaid fee schedule for behavioral health services.

TITLE 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXXIII. Behavioral Health Services
Subpart 1. ~~Statewide Management Organization~~Louisiana Bayou Health and Coordinated System of Care Waiver

Chapter 1. ~~General Provisions~~Managed Care Organizations and Coordinated System of Care Contractor

§101. ~~Introduction~~General Provisions

A. The Medicaid Program hereby adopts provisions to establish a comprehensive system of delivery for specialized behavioral health and physical health services ~~as part of the Louisiana Behavioral Health Partnership initiative~~. These services shall be administered through the Louisiana Bayou Health and Coordinated System of Care (CSoC) Waiver under the authority of the Department of Health and Hospitals (DHH), ~~Office of Behavioral Health,~~ in collaboration with ~~a Statewide Management Organization (SMO)~~managed care organizations (MCOs) and the coordinated system of care (CSoC) contractor, which shall be responsible for the necessary operational and

administrative functions to ensure adequate service coordination and delivery.

B. The provisions of this Rule shall apply only to the ~~behavioral health~~ services provided to Medicaid recipients/enrollees by or through ~~the SMO~~an MCO or the CSoC contractor.

C. ~~A statewide management~~Managed care organizations shall operate as such, and the CSoC contractor shall operate as a prepaid inpatient ~~healthcare~~ health plan (PIHP~~/SMO~~). The MCOs were procured through a competitive request for proposal (RFP) process. The CSoC contractor was procured through an emergency process consistent with 45 CFR part 92. The ~~PIHP/SMO~~MCOs and CSoC contractor shall assist with the state's system reform goals to support individuals with behavioral health and physical health needs in families, homes, communities, schools, and jobs.

D. Through the utilization of ~~a SMO~~MCOs and the CSoC contractor, it is the department's goal to:

1. – 4. …

E. The ~~PIHP/SMO~~CSoC contractor shall be paid on a non-risk basis for ~~children's~~ specialized behavioral health services rendered to children/youth enrolled in the Coordinated System of Care Waiver~~, for individuals with retroactive eligibility, and for individuals in the Spend-Down Medically Needy Program~~. The ~~PIHP/SMO~~MCOs shall be paid on a risk basis for ~~adult~~ specialized

behavioral health and physical health services rendered to adults and children/youth.

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:

§103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants in the coordinated specialized behavioral health and physical health system of care:

1. ~~Section 1931 Children and Related Populations. These are children eligible under §1931 of the Social Security Act, poverty-level related groups and optional groups of older~~ children who are blind or have a disability and related populations, under age 18;

2. ~~Section 1931 Adults and Related Populations. These are adults eligible under §1931 of the Social Security Act, poverty-level pregnant women and optional groups of caretaker relatives~~aged and related populations, age 65 and older who are not blind, do not have a disability, and are not members of the §1931 adult population;

3. ~~adults who are blind or have a disability and related populations, age 18 and over~~children who receive foster care or adoption assistance (title IV-E), or who are in foster care or who are otherwise in an out-of-home placement;

4. children ~~who are blind or have a disability and related populations, under age 18~~with special health care needs as defined in §1932(a);

5. ~~aged and related populations, age 65 and older who are not blind, do not have a disability, and are not members of the §1931 Adult Population~~Native Americans;

6. ~~children who receive foster care or adoption assistance (Title IV-E), or who are in foster care or who are otherwise in an out-of-home placement~~full dual eligibles (for behavioral health services only);

7. ~~Title XXI SCHIP populations, including:~~children residing in an intermediate care facility for persons with developmental disabilities (for behavioral health services only);

~~a. LaCHIP Phases 1 - 4; and~~

~~b. LaCHIP Affordable Plan (Phase 5);~~a. – b. Repealed.

8. ~~recipients who receive both Medicare and Medicaid benefits; and~~all enrollees of waiver programs administered by the DHH Office for Citizens with Developmental Disabilities

(OCDD) or the DHH Office of Aging and Adult Services (OAAS) (mandatory for behavioral health services only);

9. ~~recipients enrolled in the LaMOMS program~~all Medicaid children functionally eligible for the CSoC~~.~~;

10. adults residing in a nursing facility (for behavioral health services only);

11. supplemental security income/transfer of resources/long-term care related adults and children (for behavioral health services only); and

12. transfer of resources/long-term care adults and children (for behavioral health services only).

NOTE: Recipients qualifying for retroactive eligibility are enrolled in the waiver.

B. Mandatory participants shall be automatically enrolled and ~~disenrollment~~ disenrolled from the ~~PHIP/SMO is not permitted~~MCOs or the CSoC contractor.

C. Notwithstanding the provisions of Subsection A of this Section, the following Medicaid recipients are excluded from enrollment in the ~~PIHP/SMO~~MCOs and the CSoC contractor:

1. – 3. …

4. recipients ~~enrolled in the Regular Medically Needy Program~~of refugee medical assistance;

5. recipients enrolled in the ~~Tuberculosis Infected Individual~~Spend-Down Medically Needy Program;

6. – 7. …

8. recipients enrolled in the ~~Low Income Subsidy~~Take Charge Plus Program;

9. ~~participants in the TAKE CHARGE Family Planning Waiver~~recipients enrolled in the Greater New Orleans Community Health Connection (GNOCHC) program; and

10. recipients enrolled in the ~~LaMOMS~~ Long-Term Care Medicare Co-Insurance ~~Program~~program.

D. Any Medicaid eligible person is suspended from participation during a period of incarceration.

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 38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:1286 (July 2015), LR 41:

§105. Enrollment Process

A. The ~~PIHP/SMO~~ MCOs and the CSoC contractor shall abide by all enrollment and disenrollment policies and procedures as outlined in the contract entered into by department ~~and the SMO~~.

B. The ~~PIHP/SMO~~ MCOs and the CSoC contractor shall ensure that mechanisms are implemented to assess each Medicaid enrollee identified as having special health care needs in order to

identify any ongoing conditions that require a course of treatment or regular care monitoring. The assessment mechanism shall incorporate appropriate health care professionals.

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 38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§107. Enrollee Rights and Responsibilities

A. The ~~PIHP/SMO~~ enrollee's rights shall include, but are not limited to the right to:

1. – 2. …

3. appeal an ~~PIHP/SMO~~MCO and CSoC contractor decision through the ~~PIHP/SMO's~~MCO's and CSoC contractor's internal process and/or the state fair hearing process;

4. receive a response about a grievance or appeal decision within a reasonable period of time determined by the department;

5. – 8. …

B. The Medicaid recipient/enrollee's responsibilities shall include, but are not limited to:

1. informing their ~~PIHP/SMO~~MCO or CSoC contractor of the loss or theft of their Medicaid identification card;

2. …

3. being familiar with their ~~PIHP/SMO~~MCO's or CSoC contractor's procedures to the best of his/her abilities;

4. contacting their ~~PIHP/SMO~~MCO or CSoC contractor, by telephone or in writing (formal letter or electronically, including email), to obtain information and have questions clarified;

5. – 7. …

8. accessing services only from specified providers contracted with their ~~PIHP/SMO~~MCO or CSoC contractor.

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 38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR: 41

Chapter 3. ~~Statewide Management Organization~~ Managed Care Organizations and the Coordinated System of Care Contractor Participation

§301. Participation Requirements and Responsibilities

A. In order to participate in the Medicaid Program, an ~~statewide management organization~~ MCO and the CSoC contractor shall execute a contract with the department, and shall comply with all of the terms and conditions set forth in the contract.

B. ~~A PIHP/SMO~~MCOs and the CSoC contractor shall:

1. manage ~~behavioral health~~contracted services ~~for adults with substance abuse disorders as well as adults with functional behavioral health needs~~;

2. ~~manage mental health and substance abuse care for all eligible children and youth in need of behavioral health care on a non-risk basis~~establish credentialing and re-credentialing policies consistent with federal and state regulations;

3. ~~on a non-risk basis, implement a coordinated system of care for a subset of children and youth who are in, or~~

~~at risk of, out-of-home placement~~ensure that provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

a. ~~This system will be phased in over the term of the contract;~~Repealed.

4. ~~establish credentialing and re-credentialing policies consistent with federal and state regulations~~maintain a written contract with subcontractors that specifies the activities and reporting responsibilities delegated to the subcontractor, and such contract shall also provide for the MCOs' or CSOC contractor's right to revoke said delegation, terminate the contract, or impose other sanctions if the subcontractor's performance is inadequate;

5. ~~ensure that provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment~~contract only with providers of services who are licensed and/or certified and meet the state of Louisiana credentialing criteria;

6. ~~maintain a written contract with subcontractors that specifies the activities and reporting responsibilities delegated to the subcontractor and such contract shall also provide for the PIHP/SMO's right to revoke said delegation,~~

~~terminate the contract, or impose other sanctions if the subcontractor's performance is inadequate~~ensure that contracted rehabilitation providers are employed by a rehabilitation agency or clinic licensed and/or certified, and authorized under state law to provide these services;

7. sub-contract ~~only~~ with ~~providers of behavioral health services who are licensed and/or certified and meet the state of Louisiana credentialing criteria~~a sufficient number of providers to render necessary services to Medicaid recipients/enrollees;

8. ~~ensure that contracted rehabilitation providers are employed by a rehabilitation agency, school or clinic licensed and/or certified, and authorized under state law to provide these services~~require each provider to implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify special conditions of the enrollee that require a course of treatment or regular care monitoring;

9. ~~sub-contract with a sufficient number of providers to render necessary services to Medicaid recipients/enrollees~~ensure that treatment plans or plans of care meet the following requirements~~;~~:

a. are developed by the enrollee’s primary care provider (PCP) with the enrollee’s participation and in

consultation with any specialists' providing care to the enrollee, with the exception of treatment plans or plans of care developed for recipients in the Home and Community Based Services (HCBS) Waiver. The wraparound agency shall develop plans of care according to wraparound best practice standards for recipients who receive behavioral health services through the HCBS Waiver;

b. are approved by the MCO or CSoC contractor in a timely manner, if required;

c. are in accordance with any applicable state quality assurance and utilization review standards; and

d. allow for direct access to any specialist for the enrollee's condition and identified needs, in accordance with the contract; and

10. ~~require each provider to implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify special conditions of the enrollee that require a course of treatment or regular care monitoring;~~ensure that Medicaid recipients/enrollees receive information:

a. in accordance with federal regulations and as described in the contract and departmental guidelines;

b. on available treatment options and alternatives in a manner appropriate to the enrollee's condition and ability to understand; and

c. about available experimental treatments and clinical trials along with information on how such research can be accessed even though the Medicaid Program will not pay for the experimental treatment.

~~11. ensure that treatment plans meet the following requirements:~~

~~a. are developed by the enrollee's primary care provider (PCP) with the enrollee's participation and in consultation with any specialists' providing care to the enrollee with the exception of treatment plans developed for recipients in the Home and Community Based Services (HCBS) Waiver. The wraparound agency shall develop treatment plans for recipients who receive behavioral health services through the HCBS Waiver;~~

~~b. are approved by the PIHP/SMO in a timely manner, if required;~~

~~c. are in accordance with any applicable state quality assurance and utilization review standards; and~~

~~d. allow for direct access to any specialist for the enrollee's condition and identified needs, in accordance with the contract; and~~

~~12. ensure that Medicaid recipients/enrollees receive information:~~

~~a. in accordance with federal regulations and as described in the contract and departmental guidelines;~~

~~b. on available treatment options and alternatives in a manner appropriate to the enrollee's condition and ability to understand;~~

~~c. about available experimental treatments and clinical trials along with information on how such research can be accessed even though the Medicaid Program will not pay for the experimental treatment.~~11 – 12 .c. 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 38:362 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§303. Benefits and Services

A. ~~The PIHP/SMO shall ensure that behavioral health benefits and services be furnished to Medicaid recipients/enrollees in an amount, duration and scope that are at least equivalent to those furnished to enrollees under the Louisiana Medicaid State Plan. The benefits~~Benefits and services

shall be ~~provided~~ rendered to Medicaid recipients/enrollees as provided under the terms of the contract and department-issued guidelines.

B. The ~~PIHP/SMO~~MCO and CSoC contractor:

1. shall ensure that medically necessary ~~behavioral health~~ services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are being furnished;

2. – 3.b. …

4. shall provide benefits and services as outlined and defined in the contract and shall provide medically necessary and appropriate care to ~~Medicaid PIHP/SMO~~ enrollees; and

C. The benefits and services provided to enrollees shall include, but are not limited to, those services specified in the contract between the ~~PIHP/SMO~~MCOs and the CSoC contractor and the department.

1. …

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 38:362 (February 2012), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§305. Service Delivery

A. The ~~PIHP/SMO~~MCOs and CSoC contractor shall ensure that ~~behavioral health~~ services rendered to enrollees are medically necessary, are authorized or coordinated ~~by the PIHP/SMO~~, and are provided by ~~mental health~~ professionals according to their scope of practice and licensing in the state of Louisiana.

B. …

C. MCOs shall offer a contract to all federally qualified health centers (FQHCs), rural health clinics (RHCs), and tribal clinics. Enrollees shall have a choice of available providers in the plan's network to select from. The ~~PIHP/SMO~~CSoC contractor shall be required to contract with at least one ~~federally qualified health center (~~FQHC~~)~~ in each medical practice region of the state (according to the practice patterns within the state) if there is an FQHC which can provide substance ~~abuse~~ use disorder services or specialty mental health services under state law and to the extent that the FQHC meets the required provider qualifications.

D. MCOs and the CSoC contractor shall ensure that the recipient is involved throughout the planning and delivery of services.

1. Services shall be:

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

b. respectful of the individual receiving services.

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

3. Services shall be appropriate for:

a. age;

b. development; and

c. education.

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 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 5. Reimbursement

§501. ~~Reimbursement Methodology~~General Provisions

A. ~~The department, or its fiscal intermediary, shall make actuarially sound monthly capitation payments to the PIHP/SMO on the basis of prepaid capitation payments or other payment arrangements that do not use fee-for-service payment rates~~For

recipients enrolled with the CSoC contractor, reimbursement for services shall be based upon the established Medicaid fee schedule for specialized behavioral health services.

B. ~~The PIHP/SMO is paid on a risk basis for adult behavioral health services and is paid on a non-risk basis for all children's behavioral health services and any services to individuals with retroactive eligibility in the month the enrollee meets Medically Needy Spend-Down requirements~~For recipients enrolled in one of the MCOs, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs. The capitation rates paid to the MCOs shall be actuarially sound rates and the MCOs will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid rate.

C. ~~Effective for dates of service on or after July 1, 2012, the monthly capitation payments to the PIHP/SMO for adult behavioral health services shall be reduced by 1.927 percent of the monthly capitation payments on file as of June 30, 2012~~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 38:363

(February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 39:317 (February 2013), LR 41:

§503. Reimbursement Methodology (Reserved)

Chapter 7. Grievance and Appeals Process

§701. General Provisions

A. The ~~PIHP/SMO~~ MCOs and the CSoC contractor shall be required to have an internal grievance system and internal appeal process ~~which~~. The appeal process allows a Medicaid recipient/enrollee to challenge a decision made, a denial of coverage, or a denial of payment for services.

B. – C. …

D. An enrollee must exhaust the ~~PIHP/SMO~~ MCO or the CSoC contractor grievance and appeal process before requesting a state fair hearing.

E. The ~~PIHP/SMO~~MCO and CSoC contractor shall provide Medicaid enrollees with information about the state fair hearing process within the timeframes established by the department and in accordance with the state fair hearing policies.

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 38:363 (February 2012), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 9. Monitoring Activities

§901. General Provisions

A. The contracted ~~PIHP/SMO~~MCOs and the CSoC contractor shall be accredited by an accrediting body that is designated in the contract, or agrees to submit an application for accreditation at the earliest possible date as allowed by the accrediting body. Once accreditation is achieved, it shall be maintained through the life of this agreement.

B. The ~~PIHP/SMO~~MCOs and CSoC contractor shall be required to track grievances and appeals, network adequacy, access to services, service utilization, quality measure and other monitoring and reporting requirements in accordance with the contract with the department. ~~Grievance and appeal data shall be included in quarterly QI reporting and are reviewed at least annually by the department or its designee.~~

~~C. The PIHP/SMO shall report demographic data, outcomes measures, utilization and special needs population (target population) data to the department through the required OBH database.~~

~~D. The PIHP/SMO shall submit documentation to the department to substantiate that it offers an appropriate range of services that is adequate for the anticipated number of~~

~~enrollees and maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of enrollees.~~

~~E. The PIHP/SMO shall conduct Performance Improvement Projects (PIPs) that are designed to achieve, through on-going measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.~~

~~F. The PIHP/SMO shall annually report the number and types of Title XIX practitioners (by service type not facility or license type) relative to the number and types of Medicaid providers at the start date of the contract.~~

~~G. The PIHP/SMO shall be required to conduct statistically valid sample reviews.~~C. – G. 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 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, 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.

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider’s ability to provide the same level of service as described in HCR 170.

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 proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, September 24, 2015 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Kathy H. Kliebert

Secretary