**§2303. Covered Services**

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

1. therapeutic services delivered by licensed mental health professionals (LMHP), including diagnosis and treatment;

2. rehabilitation services, including community psychiatric support and treatment (CPST) and psychosocial rehabilitation (PSR);

3. crisis intervention services; and

4. crisis stabilization services.

B. 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 services;

4. services rendered in an institute for mental disease other than a psychiatric residential treatment facility (PRTF) or an inpatient psychiatric hospital; and

5. the cost of room and board associated with crisis stabilization.

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 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2359 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1892 (October 2018).

# Chapter 25. Provider Participation

**§2501. Provider Responsibilities**

A. Each provider of specialized behavioral health services shall enter into a contract with one or more of the MCOs and with the CSoC contractor for youth enrolled in the Coordinated System of Care program 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.

C. Anyone providing specialized behavioral health services shall be licensed in accordance with state laws and regulations, in addition to operating within their scope of practice license. 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.

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

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

2. the name of the individual;

3. the dates of service;

4. the nature, content and units of services provided;

5. the progress made toward functional improvement; and

6. the goals of the plan of care 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 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2359 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1893 (October 2018).

# Chapter 27. Reimbursement

### §2701. General Provisions

A. For recipients enrolled with one of the MCOs or CSoC contractor, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs or the CSoC contractor.

1. The capitation rates paid to MCOs or the CSoC contractor shall be actuarially sound rates.

2. The MCOs or the CSoC contractor will determine the rates paid to its contracted providers.

a. 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 38:365 (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 41:2359 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1893 (October 2018).

**§6103. Recipient Qualifications**

A. Individuals, 21 years of age and older, who meet Medicaid eligibility, shall qualify to receive adult mental health services referenced in §6307 if medically necessary in accordance with LAC 50:I.1101, if the recipient presents with mental health symptoms that are consistent with a diagnosable mental disorder, and the services are therapeutically appropriate and most beneficial to the recipient.

B. Additional Recipient Eligibility Criteria for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)

1. Members must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI). In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:

a. basic daily living (for example, eating or dressing);

b. instrumental living (for example, taking prescribed medications or getting around the community); and

c. participating in a family, school, or workplace.

2. A member must have a rating of three or greater on the functional status domain on the level of care utilization system (LOCUS).

3. Recipients receiving CPST and/or PSR shall have at least a composite score of three on the LOCUS.

4. An adult with longstanding deficits who does not experience any acute changes in their status and has previously met the criteria stated in §6103.B.2-B.3, but who now meets a composite LOCUS score of two or lower, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR, if deemed medically necessary.

C. An adult with a diagnosis of a substance use disorder or intellectual and developmental disability without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for adult 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 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018).

**§6303. Assessments**

A. For mental health rehabilitation services, each enrollee shall be assessed and have a treatment plan developed for CPST and PSR.

B. Assessments shall be performed by a licensed mental health practitioner (LMHP).

C. Assessments must be performed at least once every 365 days or any time there is a significant change to the enrollee's circumstances.

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 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018).

### §6305. Treatment Plan

A. Each enrollee who receives CPST and PSR services shall have a treatment plan developed based upon the assessment.

B. The individualized treatment plan 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 treatment plan shall be reviewed at least once every 365 days or when there is a significant change in the individual's circumstances.

C. The treatment plan shall be developed by the LMHP or physician in collaboration with direct care staff, the recipient, family and natural supports.

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 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018).

### §6307. Covered Services

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

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

2. rehabilitation services, including community psychiatric support and treatment (CPST) and psychosocial rehabilitation and crisis intervention.

B. Service Exclusions. The following 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; 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.

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 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1015 (June 2018).

## Chapter 65. Provider Participation

### §6501. Provider Responsibilities

A. Each provider of adult mental health services shall enter into a contract with 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. Anyone providing adult mental health services must operate within their scope of practice license.

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

1. the name of the individual;

2. the dates and time of service;

3. assessments;

4. a copy of the treatment plans, which include at a minimum:

a. goals and objectives, which are specific, measureable, action oriented, realistic and time-limited;

b. specific interventions;

c. the service locations for each intervention;

d. the staff providing the intervention; and

e. the dates of service;

5. progress notes that include the content of each delivered service, including the reason for the contact describing the goals/objectives addressed during the service, specific intervention(s), progress made toward functional and clinical improvement;

6. units of services provided;

7. crisis plan;

8. discharge plan; and

9. advanced directive.

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 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1015 (June 2018).

# Chapter 67. Reimbursement

## §6701. Reimbursement Methodology

A. 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 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.

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 42:61 (January 2016).