

Subpart 13. Therapeutic Group Homes

Chapter 121. General Provisions

§12101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid state plan for behavioral health services rendered to children and youth in a therapeutic group home (TGH). These services shall be administered under the authority of the Department of Health and Hospitals, in collaboration with 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. The CSOC contractor shall only manage specialized behavioral health services for children/youth enrolled in the CSOC program.

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

C. A therapeutic group home provides a community-based residential service in a home-like setting of no greater than 10 beds under the supervision and program oversight of a psychiatrist or psychologist.

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 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2371 (November 2015).

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C. Services provided to children and youth must include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody. Coordination with other child-serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the child's medical record.

1. The agency or individual who has the decision making authority for a child or adolescent in state custody must request and approve the provision of services to the recipient.

D. Children who are in need of behavioral health services shall be served within the context of the family and not as an isolated unit.

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 children and youth of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall also 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 38:428 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2371 (November 2015).

§12303. Covered Services

A. The Medicaid Program may reimburse a therapeutic group home for the following services:

1. screening and assessment services;

2. therapy services (individual, group, and family whenever possible);

3. on-going psychiatric assessment and intervention as needed; and

4. skill-building services.

B. **Service Exclusions.** The following services/components 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;

Chapter 123. Services

§12301. General Provisions

A. All behavioral health services must be medically necessary. 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. All services shall be prior authorized. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

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 institution for mental disease; and

5. room and board; and

6. supervision associated with the child's stay in the TGH.

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 38:428 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2371 (November 2015).

Chapter 125. Provider Participation

§12501. Provider Responsibilities

A. Each provider of TGH services shall enter into a contract with one or more of the MCOs and the CSoC contractor for youth enrolled in the CSoC program in order to receive reimbursement for Medicaid covered services. Providers shall meet the provisions of this Rule, the provider manual, and the appropriate statutes.

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. Any services that exceed established limitations beyond the initial authorization must be approved for re-authorization prior to service delivery.

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

E. TGH facilities shall be accredited by an approved accrediting body and maintain such accreditation. Denial, loss of or any negative change in accreditation status must be reported to their contracted MCOs and the CSoC contractor for youth enrolled in the CSoC program in writing within the time limit established by the department.

F. Providers of TGH services shall be required to perform screening and assessment services upon admission and within the timeframe established by the department thereafter to track progress and revise the treatment plan to address any lack of progress and to monitor for current medical problems and concomitant substance use issues.

G. A TGH must ensure that youth are receiving appropriate therapeutic care to address assessed needs on the child's treatment plan.

1. Therapeutic care may include treatment by TGH staff, as well as community providers.

2. Treatment provided in the TGH or in the community should incorporate research-based approaches appropriate to the child's needs, whenever possible.

H. For TGH facilities that provide care for sexually deviant behaviors, substance abuse, or dually diagnosed individuals, the facility shall submit documentation to their contracted MCOs and the CSoC contractor for youth enrolled in the CSoC program regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with ASAM level of care being provided.

I. A TGH must incorporate at least one research-based approach pertinent to the sub-populations of TGH clients to be served by the specific program. The specific research-based model to be used should be incorporated into the program description. The research-based models must be approved by OBH.

J. A TGH must provide the minimum amount of active treatment hours established by the department, and performed by qualified staff per week for each child, consistent with each child's plan of care and meeting assessed needs.

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 38:428 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2371 (November 2015).

Chapter 127. Reimbursement

§12701. General Provisions

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

1. Reimbursement for covered TGH services shall be inclusive of, but not limited to:

a. allowable cost of clinical and related services;

b. psychiatric support services;

c. allowable cost of integration with community resources; and

d. skill-building services provided by unlicensed practitioners.

2. Allowable and non-allowable costs components, as defined by the department.

B. All in-state Medicaid participating TGH providers are required to file an annual Medicaid cost report according to

the department's specifications and departmental guides and manuals.

C. Costs reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility's fiscal year end. Separate cost reports must be filed for the facilities central/home office when costs of that entity are reported on the facilities cost report. If the facility experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension must be submitted to Medicaid prior to the cost report due date.

1. Facilities filing a reasonable extension request will be granted an additional 30 days to file their cost report.

D. Services provided by psychologists and licensed mental health practitioners shall be billed to the MCO or CSoC contractor separately.

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 38:429 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2372 (November 2015).

§12705. In-State Therapeutic Group Homes

A. In-state publicly and privately owned and operated therapeutic group homes shall be reimbursed according to the MCO or CSoC contractor established rate within their contract.

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 38:429 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR:41:2372 (November 2015).

§12707. Out-of-State Therapeutic Group Homes

A. Out-of-state therapeutic group homes shall be reimbursed for their services according to the rate established by the MCO or CSoC contractor.

B. Payments to out-of-state TGH facilities that provide covered services shall not be subject to TGH cost reporting requirements.

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 38:429 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2372 (November 2015).