Louisiana Behavioral Health Partnership (LBHP) Service Definitions Manual

Version 2

DEPARTMENT OF HEALTH AND HOSPITALS
Behavioral Health

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NOTE: *The coding and reimbursement summary for the* ***Children's Services*** *is included in the attached excel workbook.* ***Reimbursement rates for Adult Services will be released by Magellan Health Services at a later date.***

Chapter 1:
Services for CSoC Children

HCBS CSoC SED Waiver Services & 1915(b)(3) Services for CSoC Children

Section 1.1: Parent Support and Training

Definition

Parent support and training is designed to benefit the Medicaid-eligible child/youth experiencing a serious emotional disturbance (SED) who is eligible for the Coordinated System of Care (CSoC) and is at risk of out-of-home placement. This service provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. The specialist shall attend meetings with the family and assist in helping family members to effectively contribute to planning and accessing services, including assistance with removing barriers. The specialist assists in describing the program model and providing information, as needed, to assist the family. Support and training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child/youth (e.g., parenting children with various behavior challenges).

Components

This involves:

A. Assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the eligible child/youth in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms and strategies for the child's/youth's symptom/behavior management.

B. Assisting the family in understanding various requirements of the waiver process, such as the crisis/safety plan and plan of care (POC) process.

C. Training on understanding the child's diagnoses.

D. Understanding service options offered by service providers and assisting with understanding policies, procedures and regulations that impact the child with mental illness/addictive disorder concerns while living in the community (e.g., training on system navigation and Medicaid interaction with other child-serving systems).

E. The specialist may also conduct follow-up with the families regarding services provided and continuing needs.

For the purpose of the CSoC, family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary care-giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. For the purposes of this service, "family" is defined as the persons who live with, or provide care to, a person served on the waiver and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual.

Services may be provided individually or in a group setting.

Provider Qualifications	Eligibility Criteria
• Have a high school diploma or equivalent. • Must be 21 years of age and have a minimum of two years experience living or working with a child with SED or be equivalently qualified by education in the human services field or a combination of life/work experience and education, with one year of education substituting for one year of experience (preference is given to parents or caregivers of children with SED). • Certification and completion of parent support training, according to a curriculum approved by the Office of Behavioral Health (OBH), prior to providing the service, pass criminal and professional background checks and motor vehicle screens. • A licensed mental health professional (LMHP) shall be available at all times to provide back up, support and/or consultation. • Medicaid Management Information System (MMIS) allowed provider types and specialties: Family Support Organization (FSO) – Family cultural support specialist and parent trainer/group facilitator (Provider Type (PT) AC Family Support Organization Provider Specialty (PS) 5K Family Support (Group or Individual), or PS 5L Both Youth and Family Support, Provider Sub-specialty (PSS) 8E CSoC/Behavioral Health)	For Medicaid-eligibles: Any individual found eligible, through a Child and Adolescent Needs and Strengths (CANS) comprehensive screening, for enrollment in the CSoC program (Home- and Community-Based Services (HCBS), CSoC SED Waiver eligible or CSoC Level of Need (LON) under 1915(b)(3)). For other non-Medicaid eligibles: Any individual found eligible, through a CANS comprehensive screening, for enrollment in the CSoC program, but not eligible for Medicaid (charged back to the Office of Juvenile Justice (OJJ), the Department of Child and Family Services (DCFS), OBH or the family).

Limitations/Exclusions	Allowed Mode(s) of Delivery
1. Parent support and training will not duplicate any other Medicaid State Plan service or other services otherwise available to the recipient at no cost (e.g., provided as charity care). 2. Services may be provided concurrent with development of the POC to ensure parent support and training and must be intended to address the needs identified in the assessment and to achieve the goals or objectives identified in the child's individualized POC. 3. Local Education Agencies (LEAs) may not provide this service.	Family Group On-site Off-site

Additional Service Criteria

One full-time employee (FTE) to 10 consumers/families is maximum group size.

Certified parent trainer/group facilitators (one FTE per 160 families, minimum staffing ratio)
Certified family and cultural support specialists (one FTE per 20 families, minimum staffing ratio)

The average ratios assumed are:

- 1:4 average ratio of staff to clients for group size
- 1:20 average staff to client ratio for parent support

1. Services provided to children and youth must include communication and **coordination** with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child.

Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. Time spent in coordination activities is not billable time. However, there is a cost factor for coordination built into the rates.

2. The family cultural support specialist or parent trainer/group facilitator provider must be supervised by a person meeting the qualifications for a family support supervisor (i.e., having at least a bachelor's degree and required OBH training).

3. The individuals performing the functions of the family cultural support specialist or parent trainer/group facilitator may be full-time or part-time (e.g., a family cultural support specialist may be a part-time employee, separate and distinct from a part-time parent trainer and/or group facilitator).

Section 1.2: Youth Support and Training

Definition

Youth support and training (YSAT) services are child-/youth-centered services that provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. The Youth support and training services will have a recovery focus designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the child's/youth's individualized POC. The structured, scheduled activities provided by this service emphasize the opportunity for youth to support other children and youth in the restoration and expansion of the skills and strategies necessary to move forward in recovery. YSAT is a face-to-face intervention with the child/youth present. Services can be provided individually or in a group setting. The majority of YSAT contacts must occur in community locations where the person lives, works, attends school and/or socializes.

Components

This service may include the following components:

1. Helping the child/youth to develop a network for information and support from others who have been through similar experiences.

2. Assisting the child/youth to regain the ability to make independent choices and take a proactive role in treatment, including discussing questions or concerns with their clinician about medications, diagnoses or treatment.

3. Assisting the child/youth to identify, and effectively respond to or avoid, identified precursors or triggers that maintain or increase functional impairments.

4. Assisting the child/youth with the ability to address and reduce the following behaviors, reducing reliance on YSAT over time: rebellious behavior, early initiation of antisocial behavior (e.g., early initiation of drug use, shoplifting, truancy), attitudes favorable toward drug use (including perceived risks of drug use), antisocial behaviors toward peers, contact with friends who use drugs, gang involvement and intentions to use drugs.

Provider Qualifications	Eligibility Criteria
• Must be at least 18 years old and have a high school diploma or equivalent. • Certification in the State of Louisiana to provide the service, which includes criminal and professional background checks and completion of a standardized basic training program approved by the OBH. • Self-identify as a present or former child recipient of behavioral health services. • MMIS allowed provider types and specialties: FSO – YSAT specialist PT AC Family Support Organization PS 5J Youth Support or PS 5L Both Youth and Family Support or with PSS 8E CSoC/Behavioral Health)	For Medicaid eligibles: Any individual found eligible, through a CANS comprehensive screening, for enrollment in the CSoC program (HCBS, CSoC SED Waiver eligible or CSoC LON under 1915(b)(3)). For other non-Medicaid eligibles: Any individual found eligible, through a CANS Comprehensive screening, for enrollment in the CSoC program, but not eligible for Medicaid (charged back to OJJ/DCFS/OBH or the family).

Limitations/Exclusions	Allowed Mode(s) of Delivery
Youth-certified YSAT specialists supervisor (1:80 youth) Youth-certified YSAT specialist (1:20 youth) LEAs may not provide this service. Limit of 750 hours of YSAT per calendar year. This limit can be exceeded when medically necessary through prior authorization granted by the Statewide Management Organization (SMO) in conjunction with an approved plan of care developed by the Child and Family Team.	Individual Group On-site Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. Time spent in coordination activities is not billable time. However, there is a factor for coordination built into the rates.

2. The YSAT provider must be supervised by a person meeting the qualifications for a YSAT supervisor (i.e., having at least a bachelor's degree and required OBH training) and a licensed mental health professional.

Section 1.3: Independent Living/Skills Building

Definition
Independent living/skills building services are designed to assist children who, are or will be, transitioning to adulthood with support in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to be successful in the domains of employment, housing, education and community life and to reside successfully in home and community settings. Independent living/skills building activities are provided in partnership with young children to help the child/youth arrange for the services they need to become employed, access transportation, housing and continuing education. Services are individualized according to each youth's strengths, interests, skills, goals and are included on an individualized transition plan (i.e., waiver POC). It is expected that independent living/skills building activities take place in the community. This service can be utilized to train and cue normal activities of daily living and instrumental activities of daily living. Housekeeping, homemaking (shopping, child care and laundry services) or basic services, solely for the convenience of a child receiving independent living/skills building, are not covered. An example of community settings could encompass: a grocery or clothing store, (teaching the young person how to shop for food, or what type of clothing is appropriate for interviews), unemployment office (assist in seeking jobs, assisting the youth in completing applications for jobs), apartment complexes (to seek out housing opportunities), Laundromats (how to wash their clothes), life safety skills, ability to access emergency services, basic safety practices and evacuation, physical and mental health care (maintenance, scheduling physician appointments), recognizing when to contact a physician, self administration of medication for physical and mental health conditions, understanding purpose and possible side effects of medication prescribed for conditions, other common prescription and non-prescription drugs and drug uses, use of transportation (accessing public transportation, learning to drive, obtaining insurance), etc. These services may be provided in any other community setting as identified through the POC process. This is not an all-inclusive list. Transportation provided between the child's/youth's place of residence, other services sites or places in the community, and the cost of transportation is included in the rate paid to providers of this service. Independent living/skills building services do not duplicate any other Medicaid State Plan service or service otherwise available to recipient at no cost.

Provider Qualifications	Eligibility Criteria
Transition coordinator • Have a high school diploma or equivalent. • Must be 21 years of age and have a minimum of two years experience working with children with SED or be equivalently qualified by education in the human services field or a combination of work experience and education, with one year of education substituting for one year of experience. • Pass criminal and professional background checks and motor vehicle screens. • Complete an approved training in the skills area(s) needed by the transitioning youth, according to a curriculum approved by the OBH prior to providing the service. • A LMHP shall be available at all times to provide back up, support and/or consultation.	For Medicaid eligibles: Any individual found eligible, through a CANS comprehensive screening, for enrollment in the CSoC program (HCBS, CSoC SED Waiver eligible or CSoC LON under 1915(b)(3)). For other non-Medicaid eligibles: Any individual found eligible, through a CANS comprehensive screening, enrollment in the CSoC program, but not eligible for Medicaid (charged back to OJJ/DCFS/OBH or the family).

Transition coordination agency Supervision shall be provided to the transition coordinator to provide back up, support and/or consultation. A LMHP shall be available at all times to provide back up, support and/or consultation. Employ transition coordinators who have a high school diploma or equivalent. • Must be 21 years of age and have a minimum of two years experience working with children with SED or be equivalently qualified by education in the human services field or a combination of work experience and education, with one year of education substituting for one year of experience. • Pass criminal and professional background checks and motor vehicle screens. • Completion of an approved training in the skills area(s) needed by the transitioning youth according to a curriculum approved by the OBH prior to providing the service. • MMIS allowed provider types and specialties: PT AD Transition Coordination (Skills Building) - Atypical provider, PS 5U Individual, PS 5V Agency/Business, PSS 8E – CSoC/Behavioral Health	

Limitations/Exclusions	**Allowed Mode(s) of Delivery**
Service requires prior authorization.	Individual On-site Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, <u>including any agency legally responsible for the care or custody of the child</u>. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. Time spent in coordination activities is not billable time. However, there is a factor for coordination built into the rates.

2. Independent living/skills building will not duplicate any other Medicaid State Plan service or other services otherwise available to recipient at no cost.

Section 1.4: Short Term Respite Care

Definition
Short term respite care provides temporary direct care and supervision for the child/youth in the child's home or a community setting that is not facility-based (i.e., not provided overnight in a provider-based facility). The primary purpose is relief to families/caregivers of a child with a SED or relief of the child. The service is designed to help meet the needs of the primary caregiver, as well as the identified child. Respite services help to de-escalate stressful situations and provide a therapeutic outlet for the child. Respite may be either planned or provided on an emergency basis. Normal activities of daily living are considered to be included in the content of the service when providing respite care and cannot be billed separately. These include support in the home, after school or at night, transportation to and from school/medical appointments or other community-based activities and/or any combination of the above. The cost of transportation is also included in the rate paid to providers of this service. Short term respite care can be provided in an individual's home or place of residence or provided in other community settings, such as at a relative's home or in a short visit to a community park or recreation center. Respite services provided by or in an Institution for Mental Disease (IMD) are not covered. The child must be present when providing short-term respite care. Short term respite care may not be provided simultaneously with crisis stabilization services and does not duplicate any other Medicaid State Plan service or service otherwise available to recipient at no cost. The Medicaid rate does not include costs for room and board. Other funding sources reimburse for room and board, including the family or legally responsible party (e.g., OJJ and DCFS).

Provider Qualifications	Eligibility Criteria
Direct support worker Direct service workers must enroll as providers directly with the SMO. The following individual qualifications are required for the direct care staff person: • Be at least 18 years of age. • Have a high school diploma, general equivalency diploma or trade school diploma in the area of human services, or demonstrate competency or verifiable work experience in providing support to persons with disabilities. • Criminal and professional background checks. • Be included on the Direct Service Worker Registry. • Possess a valid social security number. • Provide documentation of current cardiopulmonary resuscitation (CPR) and first aid certifications. • Completion of respite training according to the curriculum approved by the OBH prior to providing the service. • MMIS allowed provider types and specialties: Medicaid Management Information System (MMIS) Provider Type (PT) 53 and Provider Specialty (PS) 8E CSoC/Behavioral Health	For Medicaid eligibles: Any individual found eligible, through a CANS comprehensive screening, for enrollment in the CSoC program (HCBS, CSoC SED Waiver eligible or CSoC LON under 1915(b)(3)). For other non-Medicaid eligibles: Any individual found eligible, through a CANS comprehensive screening, for enrollment in the CSoC program, but not eligible for Medicaid (charged back to OJJ/DCFS/OBH or the family).

Respite care services agency • Licensed per Act 483 of 2005 Respite Care Services Agency. • The Department of Health and Hospitals (DHH) Standards of Participation; Louisiana Register (LR) Vol. 29, No.09, September 20, 2003. • The State has specific requirements and minimum criteria for provider enrollment, which can be found in the DHH Standards of Participation at the following website for the Louisiana Register: http://www.doa.state.la.us/osr/reg/register.htm. The citation for the rule is Louisiana Register, volume 29, page 1829 (September 2003). • Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. • MMIS allowed provider types and specialties: MMIS PT AE Respite Care Service Agency, PS 8E CSoC/Behavioral Health **Agency-personal care attendant** • Louisiana Revised Statutes 40.2006 (E)(2)(m)-(u) & 40.2120.1-2120.7. • Supervised Independent Living (Supported Living): Louisiana Revised Statutes 46.26 • DHH Standards of Participation; LR Vol. 29, No. 9, September 20, 2003. • Completion of State-approved training according to a curriculum approved by the OBH prior to providing the service. • MMIS allowed provider types and specialties: MMIS PT 83 and PS 83 Agency Personal Care and Provider Sub-Specialty 8E CSoC/Behavioral Health **Crisis receiving center** • Licensed per Revised Statutes (RS) 28:2180.12. • Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. • MMIS allowed provider types and specialties: MMIS PT AF Crisis Receiving Center, PS 8E CSoC/Behavioral Health **Center-based respite** • Licensed per Louisiana Administrative Code (LAC) 48:I.8101-8167. • DHH Standards of Participation (LAC	

50:XXI.Chapter 1); LR Vol.29, No. 09, September 20. 2003. • Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. • MMIS allowed provider types and specialties: MMIS PT AE Respite Care Service Agency, PS 8E CSoC/Behavioral Health	

Limitations/Exclusions	**Allowed Mode(s) of Delivery**
Short term respite care pre-approved for the duration of 72 hours per episode, with a maximum of 300 hours allowed per calendar year. These limitations can be exceeded through prior authorization by the SMO or inclusion in the SMO-approved POC. 1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the youth's medical record. 2. Short term respite care will not duplicate any other Medicaid State Plan service or other services otherwise available to the recipient at no cost. 3. Medicaid federal financial participation (FFP) will not be claimed for the cost of room and board. 4. Respite care may be provided by a licensed respite care facility, with the availability of community outings. Community outings would be included on the approved POC and would include activities, such as school attendance or other school activities or other activities the individual would receive if they were not receiving respite from a center-based respite facility. Such community outings would allow the individual's routine not to be interrupted. Respite is not provided inside a provider facility. 5. The provider must be at least three years older than an individual under the age of 18.	Individual Off-site

Additional Service Criteria
1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, <u>including any agency legally responsible for the care or custody of the child</u>. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. Time spent in coordination activities is not billable time. However, there is a factor for coordination built into the rates.

Section 1.5: Crisis Stabilization

Definition
Crisis stabilization is intended to provide short-term and intensive supportive resources for the youth and his/her family. The intent of this service is to provide an out-of-home crisis stabilization option for the family in order to avoid psychiatric inpatient and institutional treatment of the youth by responding to potential crisis situations. The goal will be to support the youth and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the crisis stabilization is supporting the youth, there is regular contact with the family to prepare for the youth's return and his/her ongoing needs as part of the family. It is expected that the youth, family and crisis stabilization provider are integral members of the youth's individual treatment team. Transportation is provided between the child's/youth's place of residence and other services sites and places in the community, and the cost of transportation is included in the rate paid to providers of these services. Medicaid is not claimed for the cost of room and board. Other funding sources reimburse for room and board, including the family or legally responsible party (e.g., OJJ and DCFS).

Provider Qualifications	Eligibility Criteria
Respite care services agency • Licensed per Act 483 of 2005 Respite Care Services Agency. • DHH Standards of Participation; LR Vol. 29, No.09, September 20, 2003. • The State has specific requirements and minimum criteria for provider enrollment, which can be found in the DHH Standards of Participation at the following website for the Louisiana Register: http://www.doa.state.la.us/osr/reg/register.htm. The citation for the rule is Louisiana Register, volume 29, page 1829 (September 2003). • Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. **Crisis receiving center** • Licensed per RS 28:2180.12. • Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. • MMIS allowed provider types and specialties: MMIS PT AF Crisis Receiving Center, PS 8E CSoC/Behavioral Health	For Medicaid eligibles: Any individual found eligible, through a CANS comprehensive screening, for enrollment in the CSoC program (HCBS, CSoC SED Waiver eligible or CSoC LON under 1915(b)(3)). For other non-Medicaid eligibles: Any individual found eligible, through a CANS comprehensive screening, to be eligible for enrollment in the CSoC program, but not eligible for Medicaid (charged back to OJJ/DCFS/OBH or the family).

Center-based respite • Licensed per LAC 48:I.8101-8167. • DHH Standards of Participation (LAC 50:XXI.Chapter 1); LR Vol.29, No. 09, September 20. 2003. • Completion of State-approved training according to a curriculum approved by OBH prior to providing the service. • MMIS allowed provider types and specialties: MMIS PT AE Respite Care Service Agency, PS 8E CSoC/Behavioral Health	
Limitations/Exclusions	**Allowed Mode(s) of Delivery**
The duration of services is pre-approved for up to seven days per episode, but the typical length of stay is often shorter than seven days. Additional days can be authorized with prior approval from SMO or in a SMO-approved POC. No more than 30 days of crisis stabilization is permitted per child, per year.	Individual On-site
Additional Service Criteria	
1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. 2. Crisis stabilization shall not be provided simultaneously with short-term respite care and does not duplicate any other Medicaid State Plan service or service otherwise available to the recipient at no cost.	

Chapter 2:
Case Conference Services for Adults & Children

1915 (b)(3) Services

Section 2.1: Case Conference

Definition
A case conference is a scheduled face-to-face meeting between two or more individuals to discuss the beneficiary's treatment. The conference may include treatment staff, collateral contact or the consumer's other agency representatives, not including court appearances and/or testimony. Case conference includes communication between a LMHP, advanced practice registered nurse (APRN) or psychiatrist for a client consultation that is medically necessary for the medical management of psychiatric conditions.

Provider Qualifications	Eligibility Criteria
LMHPs who are not physicians, APRNs or physicians. This service is coverable under the State Plan under "Physician and Other Licensed Practitioner". A LMHP is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance abuse, acting within the scope of all applicable State laws and their professional license. A LMHP includes individuals licensed to practice independently: • Medical psychologists • Licensed psychologists • Licensed clinical social workers • Licensed professional counselors (LPCs) • Licensed marriage and family therapists (LMFTs) • Licensed addiction counselors • APRNs (must be a nurse practitioner (NP) specialist in adult psychiatric and mental health, and family psychiatric and mental health or a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health, and child-adolescent mental health, and may practice to the extent that services are within the APRN's scope of practice) Service providers that offer addictive services (AD) must demonstrate competency, as defined by DHH, State law (Act 803 of the Regular Legislative Session 2004) and regulations. Anyone providing addiction or behavioral health services must be certified by DHH, in addition to their scope of practice license. LMFTs and licensed addiction counselors are not permitted to diagnose under their scope of practice under State law. "LPCs are limited to rendering or offering prevention, assessment, diagnosis and treatment of mental, emotional, behavioral, and addiction disorders requiring mental health counseling in accordance with scope of practice under state law found in La. Revised Statutes 37:1103 et seq."	Children functionally eligible for CSoC and adults eligible for the 1915(i) State Plan Amendment (SPA).

Per the State's practice act and consistent with State Medicaid regulation, medical and licensed psychologists may supervise up to two unlicensed assistants or post-doctoral individuals in supervision for licensure.
 	
MMIS allowed provider types and specialties:
• MMIS PT 77 Mental Health Rehab PS 78 MHR
• MMIS PT 74 Mental Health Clinic PS 70 Clinic / Group
• MMIS PT 70 EPSDT (School Board) PS 44 Public Health
• MMIS PT 18 Community Mental Health Center PS 5H CMHC
• MMIS PT 31 Psychologist State Plan Services (EPSDT and 1915(i)) PS
  o 62 Cross-Over Program Only
  o 95 PBS Program Only
  ▪ Subspecialty
  ▪ 6A Psychologist - Clinical
  ▪ 6B Psychologist - Counseling
  ▪ 6C Psychologist - School
  ▪ 6D Psychologist - Developmental
  ▪ 6E Psychologist - Non-declared
  ▪ 6F Psychologist - All Other
  o 96 Both Cross-Over and PBS Programs
  ▪ Subspecialty
  ▪ 6A Psychologist - Clinical
  ▪ 6B Psychologist – Counseling
  ▪ 6C Psychologist - School
  ▪ 6D Psychologist - Developmental
  ▪ 6E Psychologist - Non-declared
  ▪ 6F Psychologist - All Other
• MMIS PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health
• MMIS PT 68 Substance Abuse and Alcohol Abuse Center PS 70 Clinic / Group
• MMIS PT 38 School Based Health Center PS 70 Clinic / Group
• MMIS PT 73 Social Worker (Licensed/Clinical) PS 73 Social Worker
• MMIS PT AK Licensed Professional Counselor (LPC) State Plan Services (EPSDT and 1915(i)) PS 56 LPC
• MMIS PT AH Licensed Marriage & Family Therapists (LMFT) State Plan Services (EPSDT and 1915(i)) PS 8A
• MMIS PT AG Behavioral Health Rehabilitation Agency (Atypical) State Plan Services (EPSDT and 1915(i)) PS 8E CSoC/ Behavioral Health
• MMIS PT 19 or 20 Physician	

Limitations/Exclusions	Allowed Mode(s) of Delivery
Services must be prior authorized and are limited to the available funding. Telephone coordination is excluded, and time spent in telephone coordination may not be billed. Service providers that offer addiction services must demonstrate competency, as defined by the DHH, State law (Act 803 of the Regular Legislative Session 2004) and regulations. Anyone providing addiction or behavioral health services must be certified by the DHH, in addition to their scope of practice license. LMFTs and LACs are not permitted to diagnose under their scope of practice under State law. LPCs are limited to rendering or offering prevention, assessment, diagnosis and treatment of mental, emotional, behavioral, and addiction disorders requiring mental health counseling in accordance with scope of practice under state law found in La. Revised Statute 37:1103 et seq. LPCs can diagnose, assess, treat, etc., as long as they comply with Act 320, which requires ongoing treatment and consultation with either an MD or medical psychologist, etc. LMFTs may provide professional marriage and family therapy services, meaning LMFTs can assess, treat, provide psychotherapy, etc. but only while rendering professional marriage and family therapy services. LMFTs and LPCs may not provide interpretation of medical tests or pharmacological monitoring. Per the State's practice act and consistent with State Medicaid regulation, medical and licensed psychologists may supervise up to two unlicensed assistants or post-doctoral individuals in supervision for licensure. LMFTs may practice and provide marriage and family therapy, etc. – Individual, group, family therapy allowed; assessment is permitted as well, but all treatment is restricted to marriage and family therapy issues. LMFTs and LACs are not permitted to render diagnosis of mental, emotional or addictive disorders but may perform assessments within their scope of practice. Commensurate with R.S. Title 37, Chapter 13, 37 and Act No 320, LPCs may render or offer prevention, assessment, diagnosis and treatment, which includes psychotherapy of mental, emotional, behavioral and addiction disorders to individuals, groups and organizations, which is consistent with their professional training. In accord with Act 320, LPCs are not authorized to assess, diagnose or provide treatment to any individual suffering from the serious mental illnesses listed below, unless that individual is under the active care of a practitioner who is licensed by the Louisiana State Board of Medical Examiners and is authorized to prescribe medications in the management of psychiatric illness, and only in the context of ongoing consultation and collaboration with that practitioner.	On-site Off-site

Serious mental illness as referenced in this section include, *but are not limited to,* the following: a. Schizophrenia or schizoaffective disorder b. Bipolar disorder c. Panic disorder d. Obsessive-compulsive disorder e. Major depressive disorder f. Anorexia/bulimia g. Intermittent explosive disorder h. Autism i. Psychosis NOS, when diagnosed in a child under seventeen years of age j. Rett's disorder k. Tourette's disorder l. Dementia LMFTs may practice and provide marriage and family therapy, including the application of psychotherapeutic and family systems theories and techniques in the assessment and treatment of individuals and families, while rendering professional marriage and family therapy services to individuals, couples and families, singly or in groups. APRN: Collaborative Practice Agreement required. APRNs have certified nurse specializations as specified in the authorities' documents (this specialization is not needed for E&M codes 99201-99215 and 99499). APRN with collaborative Practice Agreements and appropriate specialty training may provide 90201-99205, 90805, 90807 and 90809.	

Additional Service Criteria

1. Additional coordination with other medical professionals, to support the provision of the case conference, may be needed. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.

2. Case conference does not duplicate any other Medicaid State Plan service or service otherwise available to recipient at no cost.

Chapter 3:
Treatment Planning

Treatment planning under the 1915(b) Waiver (Administrative Activity per 42 CFR 438.208)

Background on Wraparound Facilitation:

Wraparound facilitation (WF) is an intensive, individualized care planning and management process. Wraparound is not a treatment, per se. Instead, WF is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. Wraparound is defined as an intensive, individualized care planning and management process. The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills and self-efficacy of the young people and their family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

The wraparound process also centers on intensive care coordination by a child and family team (CFT) coordinated by a wraparound facilitator. The family, youth and the family support network comprise the core of the CFT members, joined by parent and youth support staff from the FSO, providers involved in the care of the family, representatives of agencies with which the family is involved and natural supports chosen by the family. The CFT is the primary point of responsibility for coordinating the many services and supports involved, with the family and youth ultimately driving the process. The wraparound process involves multiple phases over which responsibility for care coordination increasingly shifts from the wraparound facilitator and the CFT, to the family (for additional information on the phases of the wraparound process, see information at http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf).

The values of wraparound, as expressed in its core principles, are fully consistent with the system of care framework. Wraparound's philosophy of care begins from the principle of "voice and choice", which stipulates that the perspectives of the family – including the child or youth – must be given primary importance during all phases and activities of wraparound. The values associated with wraparound further require that the planning process itself, as well as the services and supports provided, should be individualized, family-driven, culturally competent and community-based. Additionally, the wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, the wraparound process should be "strengths-based", including activities that purposefully help the child and family to recognize, utilize and build talents, assets and positive capacities.

Providing comprehensive care through the wraparound process, thus, requires a high degree of collaboration and coordination among the child- and family-serving agencies and organizations in a community. These agencies and organizations need to work together to provide access to flexible resources and a well-developed array of services and supports in the community. In addition, other community- or system-level supports are necessary for wraparound to be successfully implemented and sustained.

Research on wraparound implementation[1] coordinated by the National Wraparound Initiative (NWI) has defined these essential community and system supports for wraparound and grouped them into six themes:

[1] http://depts.washington.edu/wrapeval/

- **Community partnership:** Representatives of key stakeholder groups, including families, young people, agencies, providers and community representatives have joined together in a collaborative effort to plan, implement and oversee wraparound as a community process.
- **Collaborative action:** Stakeholders involved in the wraparound effort work together to take steps to translate the wraparound philosophy into concrete policies, practices and achievements that work across systems.
- **Fiscal policies and sustainability:** The community has developed fiscal strategies to support and sustain wraparound and to better meet the needs of children and youth participating in wraparound.
- **Access to needed supports and services:** The community has developed mechanisms for ensuring access to the wraparound process, as well as to the services and supports that wraparound teams need to fully implement their plans.
- **Human resource development and support:** The system supports wraparound staff and partner agency staff to fully implement the wraparound model and to provide relevant and transparent information to families and their extended networks regarding effective participation in wraparound.
- **Accountability:** The community implements mechanisms to monitor wraparound fidelity, service quality and outcomes, and to oversee the quality and development of the overall wraparound effort.

In successful systems of care, Wraparound Agencies (WAAs) serve as the locus for access, accountability, service coordination and utilization management functions. There will be one WAA in each region. The WAA is responsible for facilitating the wraparound process, developing individualized POCs that cross agencies and assigning one accountable individual to coordinate care. They act as a bridge between the SMO and families, to independently plan and coordinate care. They will work locally with children and youth, their families, providers, regional agency staff, courts, child welfare agencies, schools, community organizations and the regional FSO to coordinate care planning and access to comprehensive services and supports. Service coordination by the WAA, in collaboration with the FSO, will be guided by the wraparound process, which is defined by the ten principles established by the NWI (information on NWI is available at: http://www.nwi.pdx.edu/index.shtml; information on the ten principles is available at http://www.nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-(10-principles-of-wrap).pdf).

Section 3.1: Child and Family Team Wraparound Facilitation

Develop the POC for children in the CSoC (Using treatment planning authority in 42 CFR 438.208(c)).

Definition

WF by the WAA is performed as an administrative joint treatment planning activity under SMO requirements, in 42 CFR 438.208, to develop and facilitate implementation of individualized POCs for children and youth who meet CSoC requirements of complex behavioral healthcare needs. These children may be experiencing significant involvement in two or more child-serving systems, but such involvement will not be a condition to receive services. Under the 1915(b)/1915(c) concurrent waivers, the SMO conducts all case management functions compliant with managed care treatment planning requirements at 42 CFR 438.208(c) using WFs employed by State-certified WAAs.

The WAA will provide WF for children using CFTs to carry out specific, delegated administrative activities of the SMO. The CFT will coordinate development of a treatment plan for high-needs individuals in accordance with requirements under the new Medicaid waivers,[2] which requires the identification, assessment and development of treatment plans for high-needs individuals, as well as the referral and related activities and monitoring activities. This treatment plan is referred to as an "individualized POC", in accordance with the WF planning model used by CFTs in Louisiana. The wraparound facilitator is responsible for subsequent POC reviews and revision, as needed. At minimum, the POC is to be reviewed on a semi-annual basis, and more frequently, when changes in the consumer's circumstances warrant changes in the POC. The wraparound facilitator will emphasize building collaboration and ongoing coordination among the family, caretakers, service providers and other formal and informal community resources identified by the family and promote flexibility to ensure appropriate and effective service delivery to the child and family/caregivers.

The wraparound facilitator must be employed by a WAA and meet the following qualifications:

- Bachelor's-level degree in a human services field or bachelor's-level degree in any field, with a minimum of two years of full-time experience working in relevant family, children/youth or community service capacity. Relevant alternative experience may substitute for the bachelor's-level degree requirement in individual cases, subject to approval by OBH.
- Completion of required training and credentialing process for WF wraparound facilitators, according to a curriculum approved by OBH within timeframes required by OBH.
- Pass a Louisiana criminal history background check and motor vehicle screens.
- Demonstration of high fidelity to NWI standards through ongoing participation in wraparound fidelity monitoring, using the Wraparound Fidelity Assessment System (WFAS).

1. The wraparound facilitator works with the LMHP to ensure that the assessment is finalized and the results are incorporated in the CFT process. The independent evaluator must sign off on any recommended services in the POC to be provided by unlicensed practitioners (e.g., multi-systemic therapy).

[2] 42 CFR 438.208

2. Development of the initial POC – The wraparound facilitator formalizes the POC developed by the wraparound team. The wraparound team shall include the child/youth, parents or caregivers of the child/youth, behavioral health providers, representatives of agencies legally responsible for the care or custody of the child and other individuals invited to participate in the development of the POC. The wraparound facilitator provides adequate notice of the POC development to the wraparound team. To ensure the planning process is timely, WAAs will comply with the basic service delivery standards as outlined in the SMO and WAA contracts. The independent practitioner will complete a CANS assessment, which is forwarded to the SMO and team to identify the appropriate services provided for the POC. The wraparound facilitator is responsible for writing the POC, based upon the determinations made by the CFT. The wraparound facilitator indicates on the POC the person responsible for each task.

   As part of the initial referral process, and prior to approval of the initial POC, the WAA will conduct a "Pre-certification Home Visit". At this visit, WAA staff will review with the individuals receiving care and/or their authorized representatives, information regarding "feasible alternatives" under the waiver, including the choice of either institutional or HCBS.

3. Referral and related activities: Using the POC, the wraparound facilitator 1) convenes, coordinates and communicates with the individual and identified collateral contacts to implement the POC; 2) works directly with the child/youth and family to implement elements of the POC; 3) prepares, monitors and modifies the POC; 4) coordinates the delivery of available services, including services reimbursable under 42 USC 1396d(a) and educational, social or other services; 5) develops, in concert with the individual and collateral contacts, a transition plan when the child/youth has achieved the goals of the treatment plan; and 6) collaborates with other service providers on the child/youth and family's behalf.

4. Monitoring and follow-up activities, including intensive care coordination and reviewing the POC periodically, as needed, to update the treatment plan to reflect the changing needs of the child/youth. The wraparound facilitator performs such reviews and includes 1) whether services are being provided in accordance with the POC, 2) whether the services in the POC are adequate and 3) whether there are changes in needs or status of the individual and, if so, adjusting the POC as necessary. The wraparound process also centers on intensive care coordination by the CFT, as coordinated by the wraparound facilitator. The CFT is the primary point of responsibility for coordinating the many services and supports with which the youth and family are involved, and the family and youth ultimately drive the goals of the CFT. Over time, the wraparound process involves multiple phases over which responsibility for care coordination increasingly shifts from the wraparound facilitator and the CFT to the family (for additional information on the phases of the wraparound process, see information at http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf). Key activities of the wraparound facilitator during the implementation phase of the care coordination process from that source include:

   - Supporting the action steps of the POC by checking in and following up with CFT members, educating providers and other system and community representatives about the wraparound process, as needed, and identifying and obtaining necessary resources.
   - Monitoring progress on the actions steps of the POC by tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the POC and completion of planned interventions.
   - Guiding the CFT in evaluating whether selected strategies are helping meet the youth's and family's needs.

- Encouraging the team to acknowledge and celebrate success when progress has been made, when outcomes or indicators have been achieved or when positive events or achievements occur.
- Supporting the CFT to determine when strategies for meeting needs are not working or when new needs should be prioritized, and guiding the CFT in a process of considering new strategies and action steps using the process described above for developing the POC.
- Making use of available information to assess CFT members' satisfaction with and commitment to the CFT process and POC, sharing this information with the CFT, as appropriate, and welcoming and orienting new CFT members who may be added as the process unfolds.
- Helping to maintain CFT cohesiveness and satisfaction, supporting fidelity to wraparound principles and activities and guiding the CFT in understanding and managing any disagreements, conflicts or dissatisfactions that may arise.
- Maintaining/updating the POC and maintaining/distributing CFT meeting minutes to document results of reviews of progress, successes and changes to the CFT and POC over time.

5. Transition to natural supports. The final phase of activity centers on the transition from the CFT to natural supports. During this phase, the wraparound facilitator and CFT focus on planning for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities. However, this is the primary focus of the transition phase of the wraparound process.

Compliance with federal requirements

CFT provides an administrative joint treatment planning activity provided under Medicaid requirements[3] for developing and facilitating implementation of individualized POCs for children and youth who meet the definition of complex behavioral healthcare needs. When identifying children with complex behavioral healthcare needs, the SMO will ensure the assessment of each enrollee to determine a course of treatment or regular care monitoring. The assessment mechanism must meet the requirements outlined in this document.[4] The individualized POC should be developed in coordination with the child's physical health primary care provider (PCP). If applicable, this includes coordination with the Coordinated Care Network in which the provider participates. The CFT will take the lead in the development of the individualized POC and will coordinate with the enrollee's primary care and behavioral healthcare providers, with enrollee participation and in consultation with any other providers caring for the enrollee.

The individualized POC will be approved by the SMO in a timely manner. The individualized POC will comply with all State quality assurance and utilization standards as noted in the "Referral Process" subsection. Enrollees with special behavioral healthcare needs, determined by an assessment through the SMO to need a course of treatment or regular care monitoring, will be allowed to directly access needed behavioral healthcare providers (for example, through a standing referral or a set number of visits approved by the SMO in accord with medical necessity requirements), as appropriate for the enrollee's condition and identified needs, in compliance with the State Quality Improvement Strategy and requirements for identification, assessment and treatment planning defined in 438.208(c). An approved licensed behavioral health practitioner will sign off on the care plan to ensure that services by individuals that are not licensed to practice independently are medically necessary.

[3] More broadly in 42 CFR 438.208
[4] These are specifically found at 42 CFR 438.208(c)(2).

Process design

WF activities are carried out by wraparound facilitators. The reimbursable activities for each staff member include the following activities, when delivered to a specific enrolled child/youth or the family of that child/youth, in support of the child's/youth's overall treatment plan.

Activities center on development of an individualized POC. Using the information collected through an assessment, the wraparound facilitator convenes and facilitates the CFT and, together with the CFT, develops a person- and family-centered individual POC that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual. The wraparound facilitator works directly with the child/youth, the family (or the child's/youth's authorized health care decision maker) and others to identify the strengths, needs and goals of the child/youth and the strengths, needs and goals of the family in meeting the child's/youth's needs.

The child/youth and parents or caregivers of the child/youth have the primary role of identifying appropriate goals, strengths, needs and the development of a risk assessment and crisis/safety plan. Input of all members of the CFT is used to identify the appropriate frequency and duration of CSoC services (including relevant clinical and agency service information provided by provider and other agency members of the CFT), as well as natural supports that are built into the POC to assist the child/youth in meeting their goals. The wraparound facilitator plays a role in this process by facilitating the POC development through documentation of the decisions made by the CFT, facilitating the overall meeting and ensuring that all members of the team have the opportunity to participate. The child/youth and parents or caregivers of the child/youth have the ability to request a meeting of their CFT at any time should needs or circumstances change.

The child/youth and parents or caregivers of the child/youth are able to designate a qualified individual of their choosing as the wraparound facilitator.

Additionally, FSOs provide the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their behavioral health needs and treatment; developing and enhancing the family's specific problem-solving skills, coping mechanisms and strategies for the child's symptom/behavior management; assisting the family in understanding various requirements of the CSoC process, such as the crisis plan and POC process; understanding service options offered by service providers; and assisting with understanding policies, procedures and regulations that affect the child with behavioral health needs while living in the community. For the purposes of this service, "family" is defined as the primary care-giving unit and is inclusive of the wide diversity of primary care-giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. For the purposes of the family support and training service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual.

Components
WF staff activities The WAA (usually the wraparound facilitator) contacts the child/youth and/or the parent/caregivers of the child/youth before the initial wraparound meeting. During this contact, the wraparound facilitator (or WAA staff), in collaboration with the assigned FSO certified family and cultural support specialist (and, as appropriate, at times letting the FSO staff member take the lead), ensures the delivery of the CSoC brochure that describes the CSoC services, free choice of providers and how to report abuse and neglect. Each CSoC child/youth will be a member of the SMO and will be provided a member handbook. In the member handbook, the member's rights and responsibilities are identified. If the child/youth is eligible for the 1915(c) waiver, the wraparound facilitator will also ensure that the family is offered the choice of either institutional or HCBS waiver services, using the Bureau of Health Services Financing (BHSF) form Long Term Care/Choice of Services. The wraparound facilitator guides the development of the POC. The POC is developed based upon the CANS assessment and identified goals, as determined by the CFT. The child/youth and parents or caregivers of the child/youth have the primary role of identifying appropriate goals, strengths, needs and the development of a risk assessment and crisis plan. Other relevant information and testing may be provided by the CFT (including current and past providers of care, as appropriate, and in accord with the desires of the family) to support the development of the POC. In addition, caregivers may share additional information based on their observations and experiences with their child's presenting challenges. Input of all members of the CFT is used to identify the appropriate frequency and duration of waiver services and natural supports that are built into the POC to assist the child/youth in meeting their goals. The wraparound facilitator plays a role in this process by facilitating the POC development through documentation of the decisions made by the CFT, facilitating the overall meeting and ensuring that all members of the team have the opportunity to participate. The child/youth and parents or caregivers of the child/youth have the ability to request a meeting of their CFT, at any time, should needs or circumstances change. The wraparound facilitator ensures POCs are entered into the SMO's database and electronic health record, ensuring that compliance with the Health Insurance and Portability Act (HIPAA) and Federal Educational Right to Privacy Act (FERPA) standards is maintained. The child/youth and parents or caregivers of the child/youth are able to designate a qualified individual of their choosing as the wraparound facilitator. An individualized POC must be in place within 30 days of intake for any child/youth accessing services through the SMO. If new to the SMO provider system, the child/youth will be receiving services based upon a POC developed by the approved licensed behavioral health practitioner working with the WAA, in order to access community-based services within the first 30 days after referral to the WAA while the wraparound process is being completed. The CSoC-specific POC is developed by the CFT, led by the wraparound facilitator. The wraparound meeting is scheduled at the earliest convenience of the child/youth and parents or caregivers of the child/youth. During the wraparound meeting, a POC is developed that incorporates both formalized and natural supports to address the identified goals of the POC. An independent practitioner completes the CANS assessment. Input into the CANS is given by all members of the CFT, particularly the child/youth and parents or caregivers of the child/youth. Provider and agency staff will provide relevant information on clinical and other agency service perspectives. The CANS addresses the following domains: life domain functioning, youth strengths, acculturation, caregiver strengths and needs, youth behavioral/emotional needs and youth risk behaviors. Goal development is directly related to the CANS. Goals are established based upon the child's/youth's needs and

interventions for goals are built upon the child's/youth's identified strengths. The CFT identifies goals and interventions based upon the CANS assessment. POC goals identified by the child/youth and parents or caregivers of the child/youth as being the most pertinent or pressing are given preference.

During preliminary discussions of treatment, the child/youth and their parents or caregivers are informed by the WAA of the array of services that may be accessed through the CSoC. The array of services available to the family includes waiver-specific services and also includes services available in the system of care outside of the SED waiver. Examples of such services would be traditional behavioral health services, such as a medication management and individual therapy provided in the home. Non-traditional community-based services, such as family/YSAT, as well as psychosocial treatment group, would also be available. Natural occurring supports outside of the behavioral health system are also utilized to support the family. Formalized services are not incorporated to take the place of existing or identified natural supports.

The core values of the community-based services are strengths-based, family-centered, culturally respectful and community-based. These core values are the foundation for the training that is provided to community-based service providers throughout the state. In keeping with these core values, the wraparound process is a participant-driven process where the child/youth and the parents or caregivers of the child/youth direct the membership of their CFT. Membership is reflective of individuals the family has identified as a source of support, individuals in the community that may be able to provide support in the future through natural supports, representatives from other systems in which the child or family is involved and providers of service. All services are coordinated first through the CFT's development of the POC. It is the responsibility of the CFT to develop the POC.

The wraparound facilitator guides that process by facilitating wraparound meetings and ensuring the waiver requirements are met. The wraparound facilitator is responsible for assisting the CFT in identifying resources for the child/youth and the parents or caregivers of the child/youth. The wraparound facilitator is a part of the development process and a member of the CFT. The wraparound facilitator then takes on the responsibility of ensuring that the needed resources are implemented for the child/youth and parents or caregivers of the child/youth. Continuous monitoring of the plan occurs through 90-day and semi-annual reviews of the POC.

The POC identifies the assigned task and person responsible for implementing the identified support to attain a specific POC goal. This includes community partners identified by the CFT to provide natural supports for the family to meet the child's/youth's needs. Each POC has an identified crisis and safety plan section that identifies potential crisis scenarios, what action steps or strategies need to be implemented and the persons responsible to mitigate the risk, as discussed further below.

The POC is updated, at a minimum, on a semi-annual basis through the wraparound process. However, a CFT meeting can be convened at any time in which needs or circumstances have changed or the child/youth and parents or caregivers of the child/youth feel it is warranted, or the needs of the child/youth require the CFT to meet on a more frequent basis to best coordinate care.

The child/youth and parents or caregivers of the child/youth must be involved in the development of the POC. Participation is documented through the signatures of the child/youth and parents or caregivers of the child/youth on the POC. In addition, the SMO must operate from one integrated treatment plan. This reinforces the wraparound process and results in the POC encompassing all services that may be accessed through the SMO.

Each POC is required to contain a crisis and safety plan. Crisis plans are developed in conjunction with the POC during the CFT meeting, based upon the individualized preferences of the child/youth and parents or caregivers of the child/youth. As with the POC itself, the child/youth and parents or caregivers of the child/youth may choose to revise the crisis plan at any time they feel it is necessary. Each crisis plan is individualized to the child/youth. A potential crisis (risk) and appropriate interventions (strategies to mitigate risk) are specific to the child/youth and identified by the CFT. Training provided to wraparound facilitators highlights the need to identify different levels of intervention on a crisis plan, the different stages of crisis and how a crisis may be defined differently by each family.

The crisis plan includes action steps, as a backup plan, if the crisis cannot be averted. The action steps are developed through the wraparound process by the CFT and incorporated in the crisis plan. The action steps may involve contacting natural supports, calling a crisis phone line or contacting the wraparound facilitator. The SMO is required to provide 24 hours a day/365 days a year crisis response that is readily accessible to children/youth and their parents or caregivers. A required component of the crisis plan is the contact information for those involved at all levels of intervention during the crisis. Families are provided a copy of the crisis plan as an attachment to their POC in order to have access to the identified information should a crisis occur.

Should a crisis occur or support worker not arrive for a scheduled appointment, individual contact information is included on the crisis plan. The SMO is required to have staff on-site available by a toll-free phone number 24 hours a day/365 days a year to respond to calls.

Wraparound facilitators may conduct the following joint treatment planning activities that will vary in intensity over the course of the wraparound process:

- Completion and maintenance of an individualized POC that adheres to NWI requirements and the requirements of 42 CFR 438.208(c)(3).
- Staff facilitation of the CFT meeting, when not facilitated by the parent or caregiver.
- Planning activities, including completion of the strengths, needs and cultural discovery and gathering of information to help complete the CANS, per 42 CFR 438.208(c)(2).
- Facilitation of planning activities by the CFT, including crisis/safety planning and participation in the planning of other service systems to support the coordination of behavioral health services.
- Establishing linkages to natural supports and any service options for the youth and family that further the behavioral health goals of the individualized POC. Transportation of the client is not a reimbursable component of WF. The WAA will coordinate with local Medicaid transportation supports and also help children and families connect with natural supports to provided needed transportation as part of the CFT process. In addition, the WAA provider may develop other local funds to cover staff and travel costs to provide transportation. Any safety concerns related to transportation will be addressed as part of the CFT crisis/safety planning process.
- Monitoring the effectiveness of the individualized POC via e-mail, telephone, face-to-face interactions and other communication interactions with the youth, family and team members, ensuring compliance with HIPAA and FERPA standards for all communication.

The wraparound facilitator must work with FSO certified family and cultural support specialists, certified parent trainer/group facilitators and certified YSAT specialists as they carry out the following activities in support of the joint treatment planning:

- Activities to support the development of the individualized POC by the wraparound facilitator.
- Participation in the CFT as an additional advocate for the youth or family, if selected as such by the youth or family.

In addition, there are WAA and FSO staff that are involved in evaluation activities required to ensure that the WF activities are being done in accordance with principles and practices of the NWI. Costs for these staff are reimbursable, as a direct operating expense of the program, to the extent that the evaluation activities are specific to the assessment of WF fidelity and related factors. If the evaluation activities are broader based (for example, multi-program outcome assessment), only the pro rata share attributable to CFT oversight is reimbursable as a general administrative expense.

Children/youth and their families will have free choice of providers within the SMO and may change providers. Once enrolled in the SMO, if a child/youth is already established with a therapist who is not a member of the network, the SMO is required to make every effort to arrange for the child/youth to continue with the same provider if the child/youth so desires. The provider would be requested to meet the same qualifications as other providers in the network. In addition, if a child/youth needs a specialized service that is not available through the network, the SMO will arrange for the service to be provided outside the network if a qualified provider is available. Finally, except in certain situations, children/youth will be given the choice between at least two providers. Exceptions would involve highly specialized services that are usually available through only one agency in the geographic area. This information will be provided in the SMO's member handbook, which is given to children/youth and their families upon enrollment in the waiver. Member handbooks will also be available on the SMO website.

The CFT develops the child's/youth's POC using the CANS assessment developed through the wraparound process under the oversight of an approved licensed behavioral health practitioner. Once developed, that same information is submitted electronically for prior authorization to the SMO's care management team through the electronic health record and other applicable databases. The SMO provides reimbursable behavioral health services (including SED waiver services) under OBH oversight.

It is expected that the amount of WF will be more intensive during the initial period of engagement and individualized POC development (for example, six to ten hours weekly, subject to individualization), somewhat less intensive during the period of individualized POC implementation (for example, three to six hours weekly, subject to individualization) and less intensive during the period of transition from WF to natural supports (for example, one to three hours weekly, subject to individualization). Duration of the WF planning process is based on the child's needs and is expected to vary in length between three to eighteen months. Fidelity to NWI standards will be the primary determinant of frequency and duration, individualized to the needs and strengths of each youth and family served.

Qualifications

WF is carried out by wraparound facilitators, working as a team with certified family and cultural support specialists, certified parent trainer/group facilitators and certified YSAT specialists from the FSO. The wraparound facilitator facilitates the CFT under the oversight of a WF supervisor. The primary assessment and care planning activity guiding the CFT is WF, delivered with adherence to the standards of the NWI[5] and referred to as WF. WF is a team-based, collaborative process for helping children and youth with complex behavioral healthcare needs and their families identify and use their strengths and community resources to develop and implement individualized POCs to reduce the use of other restrictive behavioral health services. The therapeutic goals of the process are to 1) meet the behavioral health needs prioritized by the youth and family, 2) improve their ability and confidence to manage their own services and supports, 3) develop and strengthen their natural social support system over time and 4) integrate the

[5] *Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & NWI Advisory Group. (2004). Ten principles of the wraparound process. Portland, OR: NWI, Research and Training Center on Family Support and Children's Mental Health, Portland State University.*

work of all child-serving systems and natural supports into one streamlined plan to address the child's diagnosed behavioral health needs in order to restore the child to a developmentally appropriate level of functioning. The CFT will identify specific goals to enhance the functioning of the child, and recommended services will be consistent with the medical necessity criteria of the SMO.

Provider Qualifications	Eligibility Criteria
WAA provider agency certification requirements In order to develop CSoC POCs through CFT activities and access funding through the administrative portion of the SMO, each WAA must be credentialed by the SMO. Central to that credentialing will be certification by OBH of wraparound facilitators working for the WAA, as described above in Section 3. Once a region is selected for CSoC implementation, the State will provide training and establish a timeline and process through which OBH will certify the WAA. After this, the SMO will credential the WAA as compliant with required criteria in advance of WAA operations (including required criminal background checks, as appropriate). The OBH certification process primarily centers on documenting that individual WAA staff members have completed training, as described in Section 3 above. OBH will provide evidence of this certification to the SMO for the credentialing process. Once credentialed by the SMO, the use of Medicaid and other block grant reimbursement to support WF delivery through the administrative portion of a SMO's administrative rate will be allowed, subject to the limitations defined in this document. **Requirements for wraparound facilitators and supervisors** Over the course of the first 24 months of program operation, applicants will need to meet certain requirements in order to maintain certification. These requirements consist of: 1. Submission of the Advanced Wraparound Practitioner Certification Application Form. 2. Completion of core training requirements. 3. Completion of nine (9) categorized wraparound practitioner training units. 4. Participation in on-site coaching sessions from an OBH-approved trainer/coach, for a minimum of one year.	**Individuals eligible for CSoC:** WF may be delivered to children and youth whose complex behavioral health (BH) needs are identified as follows. In order to be eligible, the child or youth must also have functional needs as demonstrated by the CANS assessment. The SMO will provide the WAA results from the CANS brief in order to establish initial eligibility for WAA supports. The SMO will refer the child to an independent assessor, who conducts the CANS comprehensive in collaboration with the CFT. Staff from the WAA will ensure administration of the CANS comprehensive assessment with sign off by approved licensed BH clinicians as part of the CFT process. The licensed practitioner of the healing arts overseeing the care and the CFT will work together to determine when reassessment will be needed, individualizing that timing for each child and family, in accord with existing Medicaid regulations. Children identified as meeting the criteria for the CSoC, as determined by the CANS, may include: • Children and youth, ages 0-21 years. Under early and periodic screening, diagnosis and treatment (EPSDT) rules, services may be provided up to the time the individual turns 21. • Significant BH challenges or co-occurring disorders documented in the individualized POC. This includes youth primarily demonstrating externalizing behaviors, such as conduct disorder, delinquent, antisocial or illegal behavior or acts, substance-related disorders and attention deficit hyperactivity disorder issues that lead to costly, and oftentimes, ineffective out-of-home services or excessive use of other therapeutic supports and services. Co-occurring

5. Participation in practice observations conducted by OBH-approved trainer/coach, including at least:

   – Two (2) initial family meetings
   – Two (2) home visits
   – Two (2) CFT observations (one could be scored using the Team Observation Measure, as described below)
   – Two (2) documentation reviews of POCs (one could be scored using the Document Review Measure, as described below)

6. Completion of three (3) CFT/initial visit observations, utilizing the Team Observation Measure (TOM) (collected every four months) for wraparound facilitators. At least one observation will be conducted by OBH-approved trainer/coach. The additional two (2) TOMs are conducted by the agency supervisor. Practitioners must reach fidelity, based on their combined score. This wraparound facilitator and supervisor certification requirement is met by supervisors observing the wraparound facilitators in a CFT meeting.

7. Completion of three (3) Documentation Review Measures (DRM) (collected every four months) for wraparound facilitators with a combined score that meets fidelity. At least one DRM will be completed by OBH-approved trainer/coach, with the additional two (2) DRMs being conducted by agency supervisors. This wraparound facilitator and supervisor certification requirement is met by supervisors reviewing the care coordinators individualized POCs.

In order to maintain WAA certification, all team members must be credentialed for their specific roles on the team. Standards for certification include participation in fidelity monitoring using the WFAS and additional minimum fidelity requirements established by the SMO. Documentation of annual re-credentialing will be provided to the SMO to document continued adherence to the fidelity standards. SMO certification of the WAA will be withdrawn if current credentialing and documentation is not maintained.

The NWI fidelity standards include requirements for cultural competency.

Monitoring of compliance with NWI requirements and

disorders (COD) refer primarily to the presence of mental health and substance-related disorders. Children and youth with COD have one or more substance-related disorders, as well as one or more mental health disorders.

- For children with BH disorders and developmental disabilities, if the child has a SED and otherwise meets criteria for the CSoC, they are eligible for services within the CSoC for their SED. Services related to the developmental disability will continue to be provided by the Office for Citizens with Developmental Disabilities.
- Imminent, current or previous placement in a restrictive, intensive or intrusive level of behavioral healthcare, such as:

  – Addiction facilities
  – Alternative schools
  – Detention
  – Developmental disabilities facilities
  – Foster care
  – Homeless, as identified by the Department of Education
  – Psychiatric hospitals
  – Residential treatment facilities
  – Secure care facilities

In addition to the child or youth receiving services, parents and other family members typically participate in the CFT process. Parents, legal guardians, agencies legally responsible for the care or custody of the child, other adult caregivers, siblings and other family members may participate in the CFT process, as specified in the individualized POC, for the child or youth to be served by the WAA in addition to other natural helpers that the family or youth identifies as important to the team. Families will be encouraged to provide their own perspectives on their strengths and needs.

In addition, representatives from other agencies in which the child/family is involved, such as child welfare or juvenile services, are also typically involved to add their perspectives to the development of the POC.

outcome assessment will be carried out by the SMO, using the WFAS. Documentation of initial credentialing and subsequent re-credentialing for WF supervisors and wraparound facilitators will be monitored on an annual basis by the SMO. The SMO will also review fidelity data tracked and reported to the SMO on an annual basis. Oversight of WAA certification and re-certification will be carried out by the SMO. Certified WAAs will be reviewed annually by the SMO in order to ensure that certification requirements continue to be met. **Staffing requirements/qualifications** In order to maintain WAA certification and to ensure compliance with WF fidelity requirements, WAA staff must meet the following educational and experience requirements, as well as achieve and maintain credentialing, as specified below: **Wraparound facilitator** The wraparound facilitator must meet the following requirements: • Bachelor's-level degree in a human services field or bachelor's-level degree in any field, with a minimum of two years of full-time experience working in relevant family, children/youth or community service capacity. Relevant alternative experience may substitute for the bachelor's-level degree requirement in individual cases, subject to approval by OBH. • Completion of the required training and credentialing process for WF wraparound facilitators. • Pass a Louisiana criminal history background check and motor vehicle screens. • Demonstration of high fidelity to NWI standards through ongoing participation in wraparound fidelity monitoring using the WFAS. WAA staff will work together with FSO certified family and cultural support specialists, certified parent trainer/group facilitators and certified YSAT specialists in a team to ensure that the child and their family are at the center of planning at all times. Certified WAAs must also employ staff to supervise the wraparound facilitators. Requirements include the following:	The PCP of the child or youth must also be involved. While the CFT coordinates services and provides oversight for the implementation of the individualized POC, the CFT must document its attempts to coordinate with the child's PCP in the development of the individualized POC. If the child's PCP wishes to take part in the development of the individualized POC, then the CFT must ensure that the PCP is involved to the extent he or she desires. If the PCP chooses not to participate in the care planning process, then the CFT must initiate communication with the PCP and ensure that a copy of the individualized POC is sent to the PCP. Note: Any BH treatment must be ordered and overseen by a physician or other licensed practitioner of the healing arts to comply with other federal requirements.

- Master's-level or higher graduate degree in a human services field (as defined above).
- Minimum of three years of full-time experience working in relevant family, children/youth or community service capacity.
- Completion of the required training and credentialing process for WF supervisors.
- If the supervisor also functions, in part, as a wraparound facilitator, they must also meet the requirements for a wraparound facilitator described above.
- The WF supervisor must provide regular supervision to WF service delivery staff, including completion of all supervisor requirements for wraparound fidelity monitoring using the WFAS as required.
- The WF supervisor must have good interpersonal skills for supporting development in others. The supervisor should have a broad base of experience and possess a diverse view of what families need to live better lives. The supervisor must collaborate closely with other supervisors in other child-serving agencies in the community. A wraparound supervisor must have an outgoing personality that supports engaging people from different cultures, ages and backgrounds. A preferred supervisor characteristic is an understanding of, and experience with, different systems, including schools, behavioral health, child welfare, juvenile justice, health and others. The WF supervisor must oversee the work of the WF service delivery staff on an ongoing basis.

SMO credentialing

In order to develop Medicaid POCs through CFT activities and access funding through the administrative portion of the SMO, each WAA must be credentialed by the SMO. Central to that credentialing will be certification by OBH of wraparound facilitators working for the WAA, as described above. The State will provide training and establish a timeline and process through which OBH will certify the WAA. After this, the SMO will credential the WAA as compliant, with required criteria in advance of WAA operations (including required criminal background checks, as appropriate).

The OBH certification process primarily centers on documenting that individual WAA staff members have completed OBH-required training. OBH will provide evidence of this certification to the SMO for the

credentialing process. Once credentialed by the SMO, the use of Medicaid reimbursement to support WF delivery through the administrative portion of a SMO's capitation rate will be allowed, subject to the limitations defined in this document.

Staffing guidelines for WAAs

The recommended staffing for a WAA includes the following full-time equivalent and part-time hourly positions, as listed in the table below, that will serve 240 youth and their families. Column (1) includes the name of the position, Column (2) indicates the number of FTEs, and Column (3) describes the staffing ratio used in the guidelines. The required staffing ratio for wraparound facilitators to children/families is one FTE staff to 10.

The WAA will also employ a full-time quality improvement and data director, who will oversee the following local data tracking, utilization management and quality assurance activities:

- Tracking of individual children, services provided and costs of services, using data sets defined by the SMO.
- Utilization management (UM)/utilization review of individual children in collaboration with, and under, the oversight of the SMO.
- Quality assurance at the local level, coordinated with the broader quality oversight role of the SMO.
- Outcomes management/monitoring of individual children, using criteria defined by the SMO.
- Input of individual child data into a management information system (MIS) capable of needed tracking and monitoring functions and integrated with SMO MIS.

All WAA staff will receive training in the CANS.

The quality improvement and data director will be supported in these activities by a full-time community resource specialist, who will assist with tracking and quality improvement activities and also support the tracking of community resources (services and natural supports) for WAA staff.

In addition, the WAA will employ the following full-time administrative staff to lead and support the overall organization:

- Executive director

- Business/information technology manager
- Administrative assistant

(1) Position	(2) FTE	(3) Staffing ratio
Executive director (or program director, if part of an existing organization)	1 FTE	One per agency
Business manager/IT manager	1 FTE	One per agency – May be part-time if WAA is part of a larger organization
Administrative assistant	5 FTE	Based on 20 staff FTE (full-time and hourly)
Quality improvement/data director	1 FTE	One per agency
Community resource specialist	1 FTE	One per agency
Licensed clinical director/team supervisor	1 FTE	One per agency
Wraparound facilitators/ team supervisors	2 FTE	1 per 80 families (the clinical director also supervises a team)
Wraparound facilitators	24 FTE	1 per 10 youth
Total	**36 FTE**	

Limitations/Exclusions	Allowed Mode(s) of Delivery
All coordination of care activities must protect each enrollee's privacy in accordance with the privacy requirements at 45 CFR, parts 160 and 164, subparts A and E, to the extent that they are applicable. Costs associated with planning activities that are the responsibility of other child-serving systems are not eligible for Medicaid reimbursement and will need to be tracked and paid separately. When determining if the meeting time is reimbursable by Medicaid, as opposed to other services, the purpose of the planning meeting is the key differentiating factor. If the purpose is to coordinate medical and non-medical supports for the ultimate purpose of advancing medical treatment goals (for example, facilitating diversion from an accredited residential treatment facility), then the CFT activities are Medicaid reimbursable. However, if the primary	Individual On-site Off-site

purpose of the planning meeting is to develop a permanency plan for a child welfare placement, CFT activities are not Medicaid reimbursable and must be supported with non-Medicaid funds. As a result, close coordination is essential between the WAA wraparound facilitator and DCFS to align BH services and supports to support and inform the DCFS-developed permanency plans. In addition, consistent with Medicaid managed care rules, the Louisiana OBH will ensure that all CFTs are aware of and utilize the SMO medical necessity criteria for any BH medical services recommended as part of an individualized POC.

Conflicts of interest

Because of the inherent conflicts of interest that might arise if WAAs also directly provide the services they manage, WAAs will not act as service providers. In cases where local capacity constraints are such that a service provider may be the best possible choice to also provide care coordination, the CSoC governance entity will weigh, if by limiting the WAAs utilization management functions and delegating more authority to the SMO, thereby creating firewalls which eliminate conflicts of interest to the satisfaction of the Centers for Medicare and Medicaid Services (CMS), a waiver of this rule would be in the best interest to the taxpayer and the families to be served.

In the unlikely event that the WAA is allowed under waiver to be a provider of other direct services, the provider must describe how they will ensure that there is no conflict of interest. The provider must include a description of the process by which they will ensure that the WAA staff, and the youth and families served, will be provided information about the community's full array of providers and will not be unduly influenced to use these services, as opposed to natural supports or other services of the youth or family's choice. They must also describe the monitoring strategies they will use to oversee this process.

On behalf of the State, the SMO will ensure the independence of the licensed mental health professional administering the CANS assessment and developing POCs. The SMO's written conflict of interest standards ensure that persons performing these functions are not:

- Related by blood or marriage to the individual or any paid caregiver of the individual.
- Financially responsible for the individual.
- Empowered to make financial or health-related decisions on behalf of the individual.
- Providers of State Plan/HCBS for the individual or those who have interest in or are employed by a provider of State Plan/HCBS, except at the option of the State, when providers are given responsibility to perform assessments and POCs because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections.

Non-reimbursable activities
No direct services may be provided by the CFT team members as part of their contractually defined WAA role. The WAA staff may not provide direct services to any child for whom he or she has assisted in developing the POC. Any CFT team members providing direct services outside of their WAA role must ensure that there is no conflict of interest between their direct care activities and their WAA responsibilities. Any direct services would be reimbursed separate from WAA reimbursement, in accordance with SMO contractual relationships with the provider. Any direct service expense would be reported, along with medical service expenses, in the financial and encounter reporting processes.

The following activities by wraparound facilitators are not allowable:

- Activities that are not delivered to a specific enrolled child or youth or the family of that child/youth in support of the child's/youth's treatment.
- Activities that are the responsibility of another State agency and are excluded from Medicaid coverage (such as child welfare permanency planning). The WAA must ensure that only specifically documented coordination and delivery of BH services and supports are reimbursed by the SMO.
- Transportation of the client is not a reimbursable component of WF. The WAA will coordinate with local Medicaid transportation supports, and also help children and families connect with natural supports, to provided needed transportation as part of the CFT process. In addition, the WAA provider may develop other local funds to cover staff and travel costs to provide transportation.
- Participation by other Medicaid providers in the joint treatment planning process should be reimbursed separately, only if appropriate and in accordance with the guidelines for service delivery for that provider. A degree of non-billable case consultation is built into the rate assumptions for most providers and would not be separately covered. However, to the extent that the provider is allowed to bill for separate case consultation, with or without the enrollee present, or that a SMO has established its own protocols to fund such involvement, either on an individually approved or regular basis, some limited separate billing may be permissible. In the case of individual SMO protocols, such costs would only be allowed to be built back into subsequent capitation rate setting if they were shown to be cost-effective substitutes per the process already put in place by the SMO to oversee such determinations.

Additional Service Criteria

The SMO will develop and implement a data-driven approach to identifying members who meet the criteria for a WAA referral based on the CANS. The SMO will determine appropriateness for WAA enrollment, based on the assessment information submitted by the WAA, including results of the CANS tool.

The SMO will send referrals and initial 30-day authorization to the appropriate WAA electronically upon

completion of the telephonic interview for those applicants determined to be eligible for the CSoC.

- The SMO will authorize the WAA to arrange for community services necessary to support the child and family for up to 30 days while establishing the CFT and beginning the wraparound planning process. Inpatient or other out-of-home placements must be pre-authorized by the SMO during the initial 30 day and subsequent authorization periods. An approved licensed BH practitioner will sign off on any treatment to ensure that services by unlicensed individuals are medically necessary.
- The WAA will work with the family to gain access to federal funding when available (i.e., help them complete a Medicaid application).
  The WAA shall initiate the CFT process immediately upon receipt of the referral by the SMO. Upon referral to the WAA, the SMO will also authorize an assessment to be conducted by a licensed mental health professional using the CANS. The assessment findings will be sent to the WAA wraparound facilitator to assist the CFT with the wraparound planning process.
- The WAA wraparound facilitator assembles the CFT, which conducts the wraparound planning process, identifies the individual needs and strengths of the child and family and develops a customized wraparound approach and POC.
- The child/youth and family support network comprise the majority of the CFT. The CFT, with the assistance of the WAA wraparound facilitator, develops a sustainable and individualized POC consistent with the CANS results, individual needs, SMO UM guidelines, evidence-based practices (EBPs) and use of natural and informal supports whenever possible. The SMO and WAA shall expect providers to participate on the CFT. The SMO shall align incentives to support provider participation.
- The WAA shall work closely with the FSO to integrate the provision of supports from certified family and cultural support specialists, certified parent trainer/group facilitators and certified YSAT specialists, in support of the CFT. To the fullest extent possible, the WAA and FSO will collaborate to initiate contact with the team. In some cases, staff from both agencies will initiate contact together; in other cases, it may be preferable for the FSO to lead. It is expected that personnel from the FSO will have ongoing active involvement on the CFT, unless the family chooses not to have them involved or the CFT in consultation, as needed, with the physician overseeing the care determines FSO involvement to be clinically contra-indicated. It is expected that family and YSAT will be a key component of the array of services and supports included in the POC.
- The WAA shall work closely with the child welfare, juvenile justice and LEAs to integrate care management responsibilities. It is expected that personnel from all the child-serving State agencies, the juvenile justice system and LEAs will have active involvement on the CFT unless clinically contra-indicated.
- The WAA wraparound facilitator works with the child/youth and family/caregiver to determine membership of the CFT. The CFT, with the assistance of the WAA wraparound facilitator, develops a sustainable POC that is consistent with the wraparound planning goals.
- An approved licensed BH practitioner will sign off on any treatment on the POC to ensure that services by unlicensed individuals are medically necessary.
- The WAA wraparound facilitator submits the POC to the SMO for review prior to the end of the initial 30-day authorization period.
- The SMO reviews the POC for consistency with the child/youth and family's strengths and needs (as identified by the CANS, broader assessment and the POC) and utilization guidelines. If the POC meets these criteria, the SMO provides authorization for a period of up to 90 days. Ongoing authorizations provided by the SMO will be for up to 90-day periods for most children/youth. (Authorizations may exceed 90 days for some children/youth, as determined by medical and social necessity for the service).
- If the POC appears to be inconsistent with assessed strengths and needs and the utilization guidelines for the desired services or if it exceeds the cost of care limitations, the SMO and the WAA wraparound facilitator discuss the child/youth/family strengths and needs to determine a recommendation for further discussion with the CFT. The WAA wraparound facilitator will work with the CFT to develop a sustainable plan. The expectation is that the SMO will have clear, transparent utilization guidelines that are developed with and approved by the State CSoC governance and widely

shared throughout the CSoC.

The following must be completed within 30 days of the start of WAA involvement (and the SMO may require proof that these requirements have been met through periodic audits of select cases or providers):

- Individualized POC – A copy of the initial assessment and individualized POC developed by the CFT must be completed within 30 days of the start of WAA involvement. The individualized POC must be developed with adherence to NWI standards and treatment planning requirements consistent with 42 CFR 438.208(c)(3).
- CFT meeting documentation – The initial CFT meeting must be held within 30 days of the start of WAA involvement. A sign-in form from each CFT meeting will be completed and kept in the child's record.

Section 3.2: Treatment Plan Development

for:

- **Any individual with intravenous (IV) drug use, pregnant substance abuse users, substance-using women with dependent children or co-occurring disorders**
- **Children with BH needs in contact with other child-serving systems not eligible for CSoC**
- **Children eligible for CSoC in regions not yet implemented**
- **1915(i) adults**

Definition

The SMO treatment planner assesses special needs children and adults identified under the waiver and develops an individualized, person-centered, strengths-based treatment plan. All adults are assessed annually. Children are reassessed semi-annually.

The current populations eligible for treatment planning under the 1915(b) waiver (in addition to the CSoC children eligible for WF above) include:

- Any individual with IV drug use, pregnant substance abuse users, substance-using women with dependent children or co-occurring disorders.
- Children with BH needs in contact with other child-serving systems not eligible for CSoC.
- Children eligible for CSoC in regions not yet implemented.
- Adults eligible for the 1915(i) HCBS services. Adults eligible to receive 1915(i) State Plan services include: An adult over the age of 21, who meets one of the following criteria is eligible to receive State Plan HCBS services:

  – Persons with acute stabilization needs
  – Persons with the federal definition of serious mental illness (SMI)
  – Persons with major mental disorder (MMD)
  – An adult who has previously met the above criteria and needs subsequent medically necessary services for stabilization and maintenance

The function of the treatment planner is to produce a community-based, individualized treatment plan. This includes working with the individual and/or family to identify who should be involved in the treatment planning process. The treatment planner guides the treatment plan development process. The treatment planner also is responsible for subsequent treatment plan review and revision, as needed, at minimum, on a yearly basis for adults and a semi-annual basis for children to review the treatment plan and, more frequently, when changes in the consumer's circumstances warrant changes in the treatment plan. Note: it is recommended that children's treatment plans be revisited on a semi-annual basis. The treatment planner will emphasize building collaboration and ongoing coordination among the family, caretakers, service providers and other formal and informal community resources identified by the family and promote flexibility to ensure that appropriate and effective service delivery to the child or adult and family/caregivers. Treatment planners will be certified after completion of specialized training in the Treatment Planning Philosophy, 1915(b) waiver and 1915(i) State Plan HCBS rules and processes, service eligibility and associated paperwork and meeting facilitation. Medical necessity of any State Plan rehabilitation services must be determined by a LMHP or physician conducting an assessment consistent with State law, regulation and policy

1. Assessment

Adults eligible for the 1915(i): Per 42 CFR 438.208(c), the treatment planner will determine if the adult individual meets functional need for the 1915(i) using the 1915(i) criteria outlined in the SPA. OBH will contract with the SMO for the conduct of the assessments and evaluations. The individual performing assessment, eligibility and POC cannot be a provider on the POC. The SMO will utilize

authority under treatment planning, per 42 CFR 438.208(c), to identify, assess and develop treatment plans for individuals with special health care needs, as defined under this 1915(i) authority.

The evaluation and re-evaluation must be finalized through the SMO using the universal needs assessment criteria and qualified SMO personnel or contractors. This is the same process used to both evaluate and reevaluate whether an individual is eligible for the 1915(i) services.

An adult, over the age of 21, who meets one of the following criteria, is eligible to receive State Plan HCBS services:

- Persons with acute stabilization needs
- Persons with SMI
- Persons with MMD
- An adult who has previously met the above criteria and needs subsequent medically necessary services for stabilization and maintenance

A. Persons with acute stabilization needs – 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-IV-TR) or the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or subsequent revisions of these documents.

  – Exclusion: Primary diagnosis of a substance use disorder without an additional co-occurring Axis I disorder. 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 Scale (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.

B. Persons with MMD – The person has at least one diagnosable mental disorder, which is commonly associated with higher levels of impairment. These diagnoses, per the DSM-IV-TR or the ICD-9-CM or subsequent revisions of these documents, include:

  – Psychotic disorders:
    - 295.10 - Schizophrenia, Disorganized type 295.20 - Schizophrenia, Catatonic type 295.30 - Schizophrenia, Paranoid type 295.60 - Schizophrenia, Residual type 295.70 - Schizoaffective Disorder 295.90 - Schizophrenia, Undifferentiated type
    - 297.1 - Delusional Disorder
    - 298.9 - Psychotic Disorder, not otherwise specified (NOS)

  – Bipolar disorders:
    - 296.00-Bipolar Disorder, Single Manic Episode 296.40-Bipolar I Disorder, Most Recent Episode Manic 296.50-Bipolar I Disorder, Most Recent Episode Depressed 296.60-Bipolar I Disorder, Most Recent Episode Mixed 296.7-Bipolar I Disorder, Most Recent Episode Unspecified 296.80-Bipolar Disorder NOS 296.89-Bipolar II Disorder

  – Depression:
    - 296.2x - Major Depressive Disorder, Single Episode
    - 296.3x - Major Depressive Disorder, Recurrent 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 Level of Care of 2 (also known as low intensity community-based services)

C. Persons with SMI – The person currently has or, at any time during the past year, had a diagnosable Axis I mental disorder of sufficient duration to meet the diagnostic criteria specified within the DSM-IV-TR or the ICD-9-CM or subsequent revisions of these documents.

   – Exclusion: Primary diagnosis of a substance use disorder without an additional co-occurring Axis I disorder. 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 Level of Care of 3 (also known as high intensity community-based service)

D. An adult who has previously met the above criteria and needs subsequent medically necessary services for stabilization and maintenance.

For children with BH needs in contact with other child-serving systems not eligible for CSoC, as well as for adults eligible for treatment planning under the 1915(b), including adults in the 1915(i), IV drug user, pregnant substance abuse user, substance-abusing women with dependent children or co-occurring disorders:

The SMO will perform the CANS brief screening on all children. The treatment planner may also use multiple tools, including a strengths-based standardized assessment instrument approved by OBH, in conjunction with a comprehensive psychosocial assessment and other clinical information to organize and guide the development of an individualized treatment plan. Assessment activities include, without limitation, the treatment planner 1) assisting the adult, child and family to identify appropriate collateral contacts; 2) identifying strengths and needs of the child or adult and strengths and needs of the family in meeting the child or adult's needs and 3) collecting the needs of the child or adult for any medical, educational, social or other services. Further assessments will be provided as medically necessary. Collateral contacts: reimbursable activities that may be included in the time billed for the assessment include phone and written correspondence, as well as face-to-face contacts with non-medical social service agencies, schools, housing and employment resources and medical services, including the PCP and BH providers.

2. Development of an individualized treatment plan

Using the information collected through an assessment, the treatment planner, together with the individual and others identified through the assessment, develops a person- and family-centered, individual treatment plan that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual. The treatment planner works directly with the child/adult, the family (or the authorized health care decision maker) and others to identify the strengths, needs and goals of the child and the strengths, needs and goals of the family in meeting the child/adult's needs. The treatment plan meets the following requirements: It is developed by enrollees' PCP with enrollee participation and in consultation with any specialists' care for the enrollee. If the PCP is not the primary developer of the plan, then the primary BH treatment planner consults with the PCP and informs him or her of all treatment planning decisions, including sharing a copy of the treatment plan with the PCP. The treatment plan is developed in accord with any applicable State quality assurance and utilization review standards. The treatment plan outlines how the individual is allowed to directly access specialists, as appropriate, for enrollee's condition and identified needs.

3. Referral and related activities

Using the individual treatment plan, the treatment planner 1) convenes, coordinates and communicates with the individual and identified collateral contacts to implement the individual treatment plan; 2) works directly with the child/adult and family to implement elements of the individual treatment plan; 3) prepares, monitors and modifies the individual treatment plan; 4)

coordinates the delivery of available services, including services reimbursable under 42 USC 1396d(a) and educational, social or other services; 5) develops, in concert with the individual and collateral contacts, a transition plan when the child/adult has achieved the goals of the treatment plan; and 6) collaborates with other service providers on the child/adult and family's behalf.

4. Monitoring and follow-up activities

Includes reviewing the individual treatment plan periodically, as needed, to update the treatment plan to reflect the changing needs of the child/adult. The treatment planner performs such reviews and includes 1) whether services are being provided in accordance with the individual treatment plan, 2) whether the services in the individual treatment plan are adequate and 3) whether there are changes in needs or status of the individual and, if so, adjusting the treatment plan as necessary.

Provider Qualifications	Eligibility Criteria
• Have at least a BA/BS degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education, with one year of experience substituting for one year of education. • Certification in the State of Louisiana to plan treatment, which includes criminal and professional background checks and completion of a standardized basic training program approved by the OBH.	• Children with BH needs in contact with other child-serving systems but not eligible for CSoC (e.g., OJJ and DCFS). • Adults eligible to receive 1915(i) State Plan services, IV drug user, pregnant substance abuse user, substance-abusing women with dependent children or co-occurring disorder. • Children eligible for CSoC in regions not yet implemented Adults eligible to receive 1915(i) State Plan services include: An adult over the age of 21, who meets one of the following criteria, is eligible to receive State Plan HCBS services: • Persons with acute stabilization needs • Persons with a MMD • Persons that meet the federal definition of SMI • An adult who has previously met the above criteria and needs subsequent medically necessary services for stabilization and maintenance

Limitations/Exclusions	Allowed Mode(s) of Delivery
Treatment planning is an administrative treatment planning activity provided under Medicaid requirements at 42 CFR 438.208(c) for entities, such as the SMO, for developing and facilitating implementation of individualized POCs.	Individual On-site Off-site

Additional Service Criteria

1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian, including any agency legally responsible for the care or custody of the child. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record.

2. Treatment planning is provided to address the unique needs of clients living in the community and does not duplicate any other Medicaid State Plan service or services otherwise available to the

recipient at no cost.

3. Receive ongoing and regular clinical supervision by a person meeting the qualifications of a LMHP with experience regarding specialized mental health service and such, shall be available at all times to provide back up, support and/or consultation.

Chapter 4:
Behavioral Health Services by Unlicensed Individuals

Behavioral Health Services Provided by Unlicensed Individuals

Section 4.1: Psychosocial Rehabilitation (PSR)

Definition

Psychosocial rehabilitation (PSR) services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan. The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the individual present. Services may be provided individually or in a group setting. A minimum of 51% of a PSR's contacts must occur in community locations where the person lives, works, attends school and/or socializes.

Components

A. Restoration, rehabilitation and support to develop social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual's social environment, including home, work and school.

B. Restoration, rehabilitation and support to develop daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Supporting the individual with development and implementation of daily living skills and daily routines necessary to remain in home, school, work and community.

C. Implementing learned skills so the person can remain in a natural community location and achieve developmentally appropriate functioning.

D. Assisting the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Provider Qualifications	Eligibility Criteria
• Provider qualifications: Must be at least 18 years old and have a high school diploma or equivalent. Additionally, the provider must be at least three years older than any individual they serve under the age of 18. • Certification in the State of Louisiana to provide the service, which includes criminal, professional background checks and completion of a State-approved, standardized basic training program. • MMIS allowed provider types and specialties: o PT 77 Mental Health Rehab PS 78 MHR o PT 74 Mental Health Clinic PS 70 Clinic / Group o PT 18 Community Mental Health Center PS 5H CMHC o PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health o PT 38 School Based Health Center PS	Meets functional assessment criteria for target population under the 1915(i) State Plan for individuals over the age of 21. Meets medical necessity criteria for rehabilitation services for children under the age of 21.

70 Clinic / Group o PT AG Behavioral Health Rehabilitation Agency (Atypical) State Plan Services (EPSDT and 1915(i) PS 8E CSoC/ Behavioral Health)	

Service Utilization	Allowed Mode(s) of Delivery
Initial authorization of 750 hours of group PSR per calendar year. This authorization can be exceeded when medically necessary through prior authorization for children under EPSDT. The PSR provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP or a prepaid inpatient health plan (PIHP)-designated LMHP, with experience regarding this specialized mental health service. **Ratio:** • One FTE to 15 consumers is maximum group size for adults • One FTE to eight consumers is maximum group size for youth	Individual Group On-site Off-site

Additional Service Criteria
1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. Time spent in face-to-face communication and coordination with the child's family/legal guardian is billable. 2. The PSR provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service.

Section 4.2: Crisis Intervention

Definition

Crisis intervention (CI) services are provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience, via a preliminary assessment, immediate crisis resolution and de-escalation and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of CIs are symptom reduction, stabilization and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school and/or socializes.

Components

A. A preliminary assessment of risk, mental status and medical stability and the need for further evaluation or other mental health services. Includes contact with the client, family members or other collateral sources (e.g., caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level.

B. Short-term CIs, including crisis resolution and debriefing with the identified Medicaid-eligible individual.

C. Follow up with the individual and, as necessary, with the individuals' caretaker and/or family members.

D. Consultation with a physician or with other qualified providers to assist with the individuals' specific crisis.

Provider Qualifications	Eligibility Criteria
• Must be at least 20 years old and have an associate's degree in social work, counseling, psychology or a related human services field or two years of equivalent education and/or experience working in the human services field. Additionally, the provider must be at least three years older than an individual under the age of 18. • Certification in the State of Louisiana to provide the service, which includes criminal, professional background checks and completion of a State-approved, standardized basic training program. • Employed by a mental rehabilitation agency or licensed clinic or otherwise credentialed by the SMO, because of accessibility issues. • The assessment of risk, mental status and medical stability must be completed by a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service, practicing within the scope of their professional license. • This assessment is billed separately by the LMHP under EPSDT Other Licensed Practitioner current procedural terminology (CPT) codes. • MMIS allowed provider types and specialties: o PT 77 Mental Health Rehab PS 78 MHR o PT 74 Mental Health Clinic PS 70 Clinic / Group o PT 18 Community Mental Health Center PS 5H CMHC o PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health	Meets functional assessment criteria for target population under the 1915(i) State Plan for individuals over the age of 21. Meets medical necessity criteria (MNC) for rehabilitation services for children under the age of 21. All individuals who self-identify as experiencing a seriously acute psychological/emotional change, which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved to effectively resolve it, are eligible.

o PT 38 School–based Health Center PS 70 Clinic or Other Group Practice o PT AG Behavioral Health Rehabilitation Agency (Atypical) State Plan Services (EPSDT and 1915(i) PS 8E CSoC/ Behavioral Health)	

Service Utilization	Allowed Mode(s) of Delivery
• An individual in crisis may be represented by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning. Individuals in crisis who require this service may be using substances during the crisis, and this will not, in and of itself, disqualify them for eligibility for the service**.** • Substance use should be recognized and addressed in an integrated fashion, as it may add to the risk, increasing the need for engagement in care. • The crisis plan developed by the unlicensed professional from this assessment and all services delivered during a crisis must be provided under the supervision of a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service and must be available at all times to provide back up, support and/or consultation. • The CI provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service. • Employed by a mental rehabilitation agency or licensed clinic or otherwise credentialed by the SMO because of accessibility issues.	Individual On-site Off-site

Additional Service Criteria

- CI – Emergent is authorized up to six hours per episode. Additional hours may be approved with prior authorization for children under EPSDT.
- CI – Ongoing is authorized up to 66 hours per episode. An episode is defined as the initial face-to-face contact with the individual until the current crisis is resolved, not to exceed 14 days. The individual's chart must reflect resolution of the crisis which marks the end of the current episode. If the individual has another crisis within seven calendar days of a previous episode, it shall be considered part of the previous episode, and a new episode will not be allowed. For children under EPSDT, the initial authorization can be exceeded when medically necessary through prior authorization or through the provision of other medically necessary on-going services such as PSR, community psychiatric support and treatment (CPST), etc.
- LEA staff cannot bill the CI codes. Licensed LEA staff should bill for any crisis services, in the school setting, under the CPT codes available under their license, if such care is recognized on an individualized education plan (IEP). Unlicensed LEA staff should only bill under CPST or addiction disorder treatment codes, if such care is recognized on an IEP.

The time spent by the LMHP during face-to-face time with the client is billed separately. This would include the assessment of risk; mental status and medical stability must be completed by the licensed practitioner. Licensed professionals should choose the code that best describes the care provided. If a psychiatrist completes a psychiatric evaluation of the patient, then 90801 is the appropriate code. If 45 to 50 minutes of psychotherapy, with evaluation and management to determine appropriate medications for the patient, use code 90807. If therapy is provided to the patient with the family present, then code 90847 would be used, or if the practitioner meets with the family in the patient's absence, use code 90846. CPT codes 90808 and 90809 should be used for a crisis visit and not for an extended office visit.

Section 4.3: Community Psychiatric Support and Treatment

Definition

Community Psychiatric Support and Treatment (CPST) are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's individualized treatment plan. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. A minimum of 51% of CPST contacts must occur in community locations where the person lives, works, attends school and/or socializes.

Components

This service may include the following components:

Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships and community integration.

Individual supportive counseling, solution-focused interventions, emotional and behavioral management and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains and to adapt to community living.

Participation in, and utilization of, strengths-based planning and treatments, which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources and natural supports to address functional deficits associated with their mental illness.

Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or, as appropriate, seeking other supports to restore stability and functioning.

Restoration, rehabilitation and support to develop skills to locate, rent and keep a home, landlord/tenant negotiations, selecting a roommate and renter's rights and responsibilities.

Assisting the individual to develop daily living skills specific to managing their own home, including managing their money, medications and using community resources and other self care requirements.

Provider Qualifications	Eligibility Criteria
• Practitioners with a master's degree in social work, counseling, psychology or a related human services field may provide all aspects of CPST, including counseling. Other aspects of CPST, except for counseling, may otherwise be performed by an individual with a bachelor's degree in social work, counseling, psychology or a related human services field or four years of equivalent education and/or experience working in the human services field. • Certification in the State of Louisiana to provide the	Meets functional assessment criteria for target population under the 1915(i) State Plan for individuals over the age of 21. Meets MNC for rehabilitation services for children under the age of 21.

service, which includes criminal, professional background checks and completion of a State-approved, standardized basic training program. • Employed by a mental rehabilitation agency, LEA or licensed clinic or otherwise credentialed by the SMO because of accessibility issues.	
Service Utilization	**Allowed Mode(s) of Delivery**
Ratio: Caseload size must be based on the needs of the clients/families, with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan. The CPST provider must receive regularly scheduled clinical supervision from a person meeting the qualifications of a LMHP or PIHP-designated LMHP with experience regarding this specialized mental health service. All analysis of problem behaviors must be performed under the supervision of a licensed psychologist/medical psychologist. Certified school psychologists must be supervised consistent with RS 17:7.1. The following general ratio (full-time equivalent to Medicaid-eligible) should serve as a guide: • One FTE to 15 youth consumers • One FTE to 25 adult consumers No other limitations apply. MMIS allowed provider types and specialties: • PT 77 Mental Health Rehab PS 78 MHR • PT 74 Mental Health Clinic PS 70 Clinic / Group • PT 70 EPSDT (School Board) PS 44 Public Health • PT 18 Community Mental Health Center PS 5H CMHC • PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health • PT 38 School Based Health Center PS 70 Clinic / Group • PT AG Behavioral Health Rehabilitation Agency (Atypical) State Plan Services (EPSDT and 1915(i) PS 8E CSoC/ Behavioral Health	Individual On-site Off-site In residential setting
Additional Service Criteria	
1. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. 2. Research- based and evidence-based practices may be billed using a combination of codes for licensed	

practitioners, PSR and CPST, subject to prior authorization. The EBPs must be consistent with the CPST State Plan definition. Specific codes for designated EBP are listed below in the coding and reimbursement summary. Intensive case management (ICM) may be billed using a combination of codes for licensed practitioners, PSR and CPST, subject to prior authorization. Use of research-based and evidence-based practices is preferred over the use of ICM.

3. Face-to-face for CPST includes a therapist in a different room/location from the client/family**,** but in the same building, with real-time visual and audio transmission from the therapy room and two-way audio transmission between client and/or family member and therapist. If the therapist is working with a single client/family, then family or individual therapy requirements and reimbursement would apply. If the therapist is working with more than one client/family, group therapy requirements and reimbursement would apply. Must be provided by licensed or qualified MA-level staff. MA-level staff must have appropriate oversight when providing treatment through real-time visual and audio transmission. The practice must be in accord with documented EBPs or promising practices approved by OBH (or the SMO). If not in the same building, then telemedicine requirements and reimbursement would apply.

4. School-based health services include covered BH services, treatment and other measures to correct or ameliorate an identified mental health or substance abuse diagnosis. Services are provided by or through a LEA to children with, or suspected of having, disabilities who attend public school in Louisiana.

5. Assessment, diagnosis and evaluation services, including testing, are services used to determine Individuals with Disabilities Education Act (IDEA) eligibility or to obtain information on the individual for purposes of identifying or modifying the health-related services on the IEP. These services are not covered if they are performed for educational purposes (e.g., academic testing or are provided to an individual who, as the result of the assessment and evaluation, is determined not to be eligible under IDEA). Services must be performed by qualified providers, as set forth in this SPA and who provide these services as part of their respective area of practice (e.g., psychologist providing a BH evaluation).

6. Services provided in a school setting will only be reimbursed for recipients who are at least three years of age and under 21 years of age, who have been determined eligible for Title XIX and IDEA, Part B services, with a written service plan (an IEP) which contains medically necessary services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law. Medicaid covers §1905(a) medical services addressed in the IEP that are medically necessary that correct or ameliorate a child's health condition. Medicaid does not reimburse for social or educational needs or habilitative services. Medicaid-covered services are provided in accordance with the established service limitations.

7. A LEA may employ unlicensed BH practitioners if requirements under the IDEA are met. Individual practitioner requirements for the Medicaid qualifications and Department of Education Bulletin 746, Louisiana Standards for State Certification of School Personnel, must be met prior to a LEA billing for any services of a clinician under Medicaid. Louisiana certified school psychologists and counselors in a school setting must meet the provider qualifications and providing services consistent with CPST.

Section 4.4: Therapeutic Group Home

Definition

Therapeutic Group Homes (TGHs) provide a community-based residential service in a home-like setting of no greater than eight beds, under the supervision and program oversight of a psychiatrist or psychologist. The treatment should be targeted to support the development of adaptive and functional behaviors that will enable the child or adolescent to remain successfully in his/her home and community and to regularly attend and participate in work, school or training. TGHs deliver an array of clinical and related services within the home, including psychiatric supports, integration with community resources and skill-building taught within the context of the home-like setting. TGH treatment must target reducing the severity of the BH issue that was identified as the reason for admission. Most often, targeted behaviors will relate directly to the child's or adolescent's ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations, safe behavior and appropriate responses to social cues and conflicts). Treatment must:

- Focus on reducing the behavior and symptoms of the psychiatric disorder that necessitated the removal of the child or adolescent from his/her usual living situation.
- Decrease problem behavior and increase developmentally appropriate, normative and pro-social behavior in children and adolescents who are in need of out-of-home placement.
- Transition child or adolescent from TGH to home- or community-based living, with outpatient treatment (e.g., individual and family therapy).

The State Medicaid agency or its designee must have determined that less intensive levels of treatment are unsafe, unsuccessful or unavailable. The child must require active treatment that would not be able to be provided at a less restrictive level of care being provided on a 24-hour basis with direct supervision/oversight by professional behavioral health staff. The setting must be geographically situated to allow ongoing participation of the child's family. The child or adolescent must attend a school in the community (e.g., a school integrated with children not from the group home and not on the group home's campus). In this setting, the child or adolescent remains involved in community-based activities and may attend a community educational, vocational program or other treatment setting.

TGHs provide a 24 hours/day, seven days/week, structured and supportive living environment. Care coordination is provided to plan and arrange access to a range of educational and therapeutic services. Psychotropic medications should be used with specific target symptoms identification, with medical monitoring and 24-hour medical availability when appropriate and relevant. Screening and assessment is required upon admission, and every 14 days 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. The individualized, strengths-based services and supports:

- Are identified in partnership with the child or adolescent and the family and support system, to the extent possible, and if developmentally appropriate.
- Are based on both clinical and functional assessments.
- Are clinically monitored and coordinated, with 24-hour availability.
- Are implemented with oversight from a licensed mental health professional.
- Assist with the development of skills for daily living, and support success in community settings, including home and school.

The TGH is required to coordinate with the child's or adolescent's community resources, including schools,

with the goal of transitioning the youth out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate. Discharge planning begins upon admission, with concrete plans for the child to transition back into the community beginning within the first week of admission, with clear action steps and target dates outlined in the treatment plan. The treatment plan must include behaviorally measurable discharge goals.

Limitations/Exclusions	Allowed Mode(s) of Delivery
Limitations: Licensed psychologists/medical psychologists and LMHP bill for their services separately under the approved State Plan for "Other Licensed Practitioners", Item 4b, Page 8a. The psychiatrist or psychologist/medical psychologist must provide twenty-four (24) hour, on-call coverage seven (7) days a week. The psychologist/medical psychologist or psychiatrist must see the client at least once, prescribe the type of care provided and, if the services are not time-limited by the prescription, review the need for continued care every 14 days. Although the psychologist/medical psychologist or psychiatrist does not have to be on the premises when his/her client is receiving covered services, the supervising practitioner must assume professional responsibility for the services provided and ensure that the services are medically appropriate. Therapy (individual, group and family, whenever possible) and ongoing psychiatric assessment and intervention, as needed, (by a psychiatrist) are required of TGH, but provided and billed separately by licensed practitioners for direct time spent. TGHs are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections. The facility is expected to provide recreational activities for all enrolled children but not use Medicaid funding for payment of such non-Medicaid activities.	On-site

Components

For treatment planning, the program must use a standardized assessment and treatment planning tool (the CANS). The assessment protocol must differentiate across life domains, as well as risk and protective factors sufficiently, so that a treatment plan can be tailored to the areas related to the presenting problems of each youth and their family in order to ensure targeted treatment. The tool should also allow tracking of progress over time. The specific tools and approaches used by each program must be specified in the program description and are subject to approval by the State. In addition, the program must ensure that requirements for pretreatment assessment are met prior to treatment commencing. Annually, facilities must submit documentation demonstrating compliance with fidelity monitoring for at least two EBPS and/or one level of the American Society of Addiction Medicine (ASAM) criteria. The State must approve the auditing body providing the EBP/ASAM fidelity monitoring. TGH facilities may specialize and provide care for sexually deviant behaviors, substance abuse or dually diagnosed individuals, subject to state approval, if treatment for these populations is provided. If a program provides care to any of these categories of youth, the program must submit documentation regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with the ASAM level of care being provided (if applicable).

For service delivery, the program must incorporate at least two research-based approaches pertinent to the sub-populations of TGH clients to be served by the specific program. The specific research-based models to be used should be incorporated into the program description and submitted to the State for approval. All research-based programming in TGH settings must be approved by the State. For milieu management, all programs should also incorporate some form of research-based, trauma-informed programming and training, if the primary research-based treatment model used by the program does not (e.g., LAMod).

Staffing for the facility must be consistent with State licensure regulations on an FTE basis. For example, if State licensure requires a staff to client ratio of 1:25 and the facility has 16 child residents, then the facility

must have at least .64 FTE for the 16 children. If the facility has 8 beds, then the facility must have at least .32 FTE for the 8 children.	
Provider Qualifications	**Eligibility Criteria**
Provider qualifications: A TGH must be licensed by the Louisiana DHH and may not exceed eight beds. TGH staff must be supervised by a licensed mental health professional (supervising practitioner) with experience in evidence-based treatments. Staff includes paraprofessional, master's and bachelor's level staff with degrees in social work, counseling, psychology or a related human services field, with oversight by a psychologist or psychiatrist. At least 21 hours of active treatment per week for each child is required to be provided by qualified staff (e.g., having a certification in the EBPs selected by the facility and/or licensed practitioners operating under their scope of practice in Louisiana), consistent with each child's treatment plan and meeting assessed needs. • A minimum of two (2) staff on duty per shift in each living unit, with the ability to call in as many staff as necessary to maintain safety and control in the facility, depending upon the needs of the current population at any given time. • A ratio of not less than one (1) staff to four (4) youth is maintained at all times; however, two (2) staff must be on duty at all times. • At least one (1) staff member per shift is required to have a current CPR and first aid certification. • Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of youth treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix and the consistent presence and availability of professional staff. In addition, staffing schedules should ensure the presence and availability of professional staff on nights and weekends, when parents are available to participate in family therapy and to provide input on the treatment of their child. • Individual, group and family therapists are master's level staff, available at least three (3) hours per week (individual and group) or two (2) hours per month (family). • A licensed registered nurse (RN) is on staff to establish the system of operation for administering or supervising residents' medications and medical needs or requirements; monitoring the residents' response to medications; tracking and attending	For children only, less intensive levels of treatment must have been determined to be unsafe, unsuccessful or unavailable. The child must require active treatment provided on a 24-hour basis with direct supervision/oversight by professional BH staff that would not be able to be provided at a less restrictive level of care.

to dental and medical needs and training staff to administer medications and proper protocols.
• MMIS allowed provider types and specialties:
  o PT 96 Psychiatric Residential Treatment Facility PS 5X Therapeutic Group Home
  o PS 5Z Therapeutic Group Home Disorder
  o PS 8P Other Specialization (other than Addiction Disorder)	

Service Utilization	Allowed Mode(s) of Delivery
Licensed psychologists and LMHP bill for their direct services separately under the approved State Plan for Other Licensed Practitioners, Item 6d. Supervision of unlicensed practitioners by licensed practitioners is built into the TGH rate. The psychiatrist or psychologist must provide twenty-four (24) hour, on-call coverage seven (7) days a week. The psychologist or psychiatrist must see the client at least once, prescribe the type of care provided, and, if the services are not time-limited by the prescription, review the need for continued care every 14 days. Although the psychologist or psychiatrist does not have to be on the premises when his/her client is receiving covered services, the supervising practitioner must assume professional responsibility for the services provided and ensure that the services are medically appropriate. Therapy (individual, group and family, whenever possible) and ongoing psychiatric assessment and intervention, as needed, (by a psychiatrist) are required of TGH but provided and billed separately by licensed practitioners for direct time spent. TGHs are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections. The facility is expected to provide recreational activities for all enrolled children but not use Medicaid funding for payment of such non-Medicaid activities.	On-site

Additional Service Criteria

Unit of service: Reimbursement for the TGH is based on a daily rate for the services provided by unlicensed practitioners only.

TGHs may not be Institutions for Mental Disease (IMD). Each organization owning TGHs must ensure that in no instance, does the operation of multiple TGH facilities constitute operation of an IMD. All new construction, newly acquired property or facilities or new provider organizations must comply with facility bed limitations not to exceed eight beds. Existing facilities may not add beds if the bed total would exceed eight beds in the facility. A waiver, up to a maximum of 16 beds, may be granted for existing facilities of greater than eight beds at the existing capacity, not to exceed 16 beds in the institution until alterations of the existing facility are made. Any physical plant alterations of existing facilities must be completed in a manner to comply with the eight bed per facility limit (i.e., renovations of existing facilities exceeding eight beds must include a reduction in the bed capacity to eight beds).

Average length of stay ranges from 14 days to six months. TGH programs focusing on transition or short-term crisis are typically in the 14 to 30 day range. Discharge may be determined based on the child no longer making adequate improvement in this facility (and another facility being recommended) or the child no longer having medical necessity at this level of care. Continued TGH stay should be based on a clinical expectation

that continued treatment in the TGH can reasonably be expected to achieve treatment goals and improve or stabilize the child's or adolescent's behavior, such that this level of care will no longer be needed and the child or adolescent can return to the community. Transition should occur to a more appropriate level of care (either more or less restrictive) if the child or adolescent is not making progress toward treatment goals, and there is no reasonable expectation of progress at this level of care (e.g., child's or adolescent's behavior and/or safety needs require a more restrictive level of care or, alternatively, child's or adolescent's behavior is linked to family functioning and can be better addressed through a family-/home-based treatment).

Reimbursement Methodology

Reimbursement for the TGH is based on an interim Medicaid per diem reimbursement rate. The interim Medicaid per diem reimbursement rate, will be inclusive of, but not limited to, the allowable cost of clinical and related services, psychiatric supports, integration with community resources and the skill-building provided by unlicensed practitioners. Licensed psychologists and LMHPs, as defined in 3.1A item 4.b, Page 8a, bill for their services separately. Definitions of allowable and non-allowable costs are contained in the Provider Reimbursement Manual, CMS Publication 15-1. The TGH provider types and associated reimbursement are as follows:

In-State Publicly Owned and Operated TGH Reimbursement Rates:

A. Publicly owned and operated TGH will be reimbursed for all reasonable and necessary costs of operation. The in-state publicly owned and operated TGHs will receive the interim Medicaid per diem reimbursement rate detailed in the In-State Privately Owned or Operated TGH section below. The interim rate will be subject to retroactive cost settlement in accordance with Medicare allowable cost principles contained in the Provider Reimbursement Manual CMS Publication 15-1.

In-State Privately Owned or Operated TGH Reimbursement Rates:

A. Medicaid certified providers will be reimbursed for covered TGH services through an interim modeled Medicaid per diem reimbursement rate. The interim Medicaid reimbursement per diem is a modeled rate using estimated allowable cost for the TGH-covered services and staffing requirements.

B. Retroactive Adjustments to Interim Rates (cost sharing): In-state privately owned and operated TGH providing covered services will also be subject to the retrospective rate adjustments. This process is part of a transitional plan to include these TGH services within the Medicaid program. The retrospective payments adjustments will be determined as follows:

1. The facilities' allowable per diem cost will be determined from the Medicaid cost report submitted in accordance with the Therapeutic Group Home Cost Reporting Requirements section of the Medicaid State Plan. The provider will receive a retrospective rate adjustment equal to 50% of the difference between the actual Medicaid allowable per diem cost and the interim Medicaid per diem reimbursement rate for each covered TGH patient day.

2. The payment adjustment will not recognize provider allowable cost beyond the threshold of 125% of the initial Medicaid per diem reimbursement rate paid during each fiscal year. For example: If the initial Medicaid reimbursement rate is $200, the maximum allowable cost recognized for rate adjustment purposes would be a $250 per diem.

3. Providers who have disclaimed cost reports or are non-filers will be subject to the modification of the payment adjustment as described in the Therapeutic Group Home Providers with Disclaimed Cost Reports or Non-Filer Status section of the State Plan.

Out-of-State Therapeutic Group Home Reimbursement Rates:

A. Out of state therapeutic group homes will be reimbursed the lesser of their specific in-state TGH Medicaid per diem reimbursement rate or 95% of the Louisiana interim Medicaid per diem reimbursement rate as detailed in the In-State Privately Owned or Operated Section above. The

out-of-state TGH will not be subject to retroactive cost adjustments, or the TGH cost reporting requirement listed below.

TGH Cost Reporting Requirements:

A. All in-state Medicaid-participating TGH providers are required to file an annual Medicaid cost report. The required cost reporting period must correspond to a calendar year basis of January 1 through December 31 for all TGH providers.

   1. All providers shall submit the uniform cost report form prescribed by the Department on an annual basis. Financial information shall be based on the provider's financial records. When records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting.

   2. Cost reports shall be submitted on or before the last day of the fifth month after the end of the provider's fiscal year end.

   3. Separate cost reports must be submitted by central/home offices when costs of the central/home office are reported in the TGH provider's cost report.

   4. Failure to maintain records to support the cost report or failure to file a timely cost report may result in penalties determined solely by DHH as described below. Only those cost that are reported, documented and allowable per the Medicare and Medicaid provider reimbursement manual will be recognized as cost by DHH.

   5. All cost reports may be subject to an audit or desk review by the DHH audit contractor.

   6. If the TGH provider experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension request must be submitted to DHH prior to the cost report due date. A facility filing a reasonable extension request will be granted an additional 30 days to file their cost reports.

New Therapeutic Group Homes and Change of Ownership of Existing Facilities:

A. Changes of ownership (CHOW) exist if the beds of a new owner have previously been certified to participate in the Medicaid program under the previous owner's provider agreement. The acceptance of a CHOW will be determined solely by DHH. Reimbursement will continue to be based on the interim Medicaid reimbursement rate. The rate adjustment process will be determined using the previous owners cost report information for the applicable time periods.

B. New providers are those entities whose beds have not previously been certified to participate in the Medicaid program. New providers will be reimbursed, depending on provider type, in accordance with the Therapeutic Group Home Unit of Service section of the State Plan.

Therapeutic Group Home Providers with Disclaimed Cost Reports or Non-Filer Status:

A. Providers with disclaimed cost reports are those providers that receive a disclaimer of opinion from the DHH audit contractor after conclusion of the audit process.

B. Providers with non-filer status are those providers that fail to file a complete cost report in accordance with the Therapeutic Group Home Cost Reporting Requirements section of the State Plan.

C. Providers with disclaimed cost reports or providers with non-filer status will not receive any additional reimbursement through the rate adjustment process. These providers will however be subject to the recoupment of Medicaid payments equal to the provider with the greatest recoupment of Medicaid payments in the State of Louisiana for the applicable fiscal year.

Section 4.5: Addiction Services

Definition
Addiction services include an array of individual-centered outpatient, intensive outpatient and residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors. Services for adolescents must be separate from adult services, be developmentally appropriate, involve the family or caregiver and coordinate with other systems (such as child welfare, juvenile justice and the schools). These services are designed to help individuals achieve changes in their substance abuse behaviors. Services should address an individual's major lifestyle, attitudinal and behavioral problems that have the potential to be barriers to the goals of treatment. Outpatient services may be indicated as an initial modality of service for an individual whose severity of illness warrants this level of treatment or when an individual's progress warrants a less intensive modality of service than they are currently receiving. Intensive outpatient treatment is provided any time during the day or week and provides essential skill restoration and counseling services for individuals needing more intensive treatment. Outpatient, intensive outpatient and residential services are delivered on an individual or group basis in a wide variety of settings, including treatment in residential settings of 16 beds or less, designed to help individuals achieve changes in their substance abuse behaviors.

Provider Qualifications	Eligibility Criteria
• Services are provided by licensed and unlicensed professional staff at least 18 years of age, with a high school or equivalent diploma according to their areas of competence as determined by degree, required levels of experience as defined by State law and regulations and departmentally approved guidelines and certifications. • The provider must be at least three years older than an individual under the age of 18. • Anyone who is unlicensed providing addiction services must be registered with the Addictive Disorders Regulatory Authority and demonstrate competency as defined by the Department of Health and Hospitals, state law (ACT 803 of the Regular Legislative Session 2004) and regulations. State regulations require supervision of unlicensed professionals by a Qualified Professional Supervisor (QPS). A QPS includes the following professionals who are currently registered with their respective Louisiana board: licensed psychologist; licensed clinical social worker; licensed professional counselor; licensed addiction counselor; licensed physician and advanced practice registered nurse. The following professionals may obtain Qualified Professional Supervisor credentials; masters-prepared individual who is registered with the appropriate State Board and under the supervision of a licensed psychologist, licensed professional counselor (LPC), or licensed clinical social worker (LCSW). The QPS can	Any Medicaid-eligible person needing medically necessary substance abuse services. Adolescents are defined as children and youth, ages 0-21 years. Services may be provided up to the time the individual turns 21. An adult is defined as anyone over the age of 21 years.

provide clinical/administrative oversight and supervision of staff. • MMIS allowed provider types and specialties: o Outpatient Services ▪ PT 18 Community Mental Health Center PS 5H CMHC ▪ PT 38 School Based Health Center PS 70 Clinic / Group ▪ PT 68 Substance Abuse and Alcohol Abuse Center PS 70 Clinic / Group ▪ PT 70 EPSDT (School Board) PS 44 Public Health ▪ PT 74 Mental Health Clinic PS 70 Clinic / Group ▪ PT 77 Mental Health Rehab PS 78 MHR ▪ PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health ▪ PT AJ Licensed Addiction Counselor (LAC) State Plan Services (EPSDT and 1915(i) PS A9 o Residential Services ▪ PT 96 Residential Care PS 5Y PRCS Addiction Disorder ▪ PT AJ Licensed Addiction Counselor (LAC) State Plan Services (EPSDT and 1915(i) PS A9	

Limitations/Exclusions	Allowed Mode(s) of Delivery
• These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid-eligible individuals with significant functional impairments resulting from an identified addiction diagnosis. Services are subject to prior approval, must be medically necessary and must be recommended by a LMHP or physician who is acting within the scope of his/her professional licensed and applicable State law to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level according to an individualized treatment plan. • The activities included in the service must be intended to achieve identified treatment plan goals or objectives. The treatment plan should be developed in a person-centered manner, with the active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of rehabilitative services. The treatment plan should identify the medical or remedial services intended to reduce the identified condition, as well as the anticipated outcomes of the individual. The treatment plan must specify the frequency, amount and duration of services. The treatment plan must be signed by the LMHP or physician responsible for developing the plan. The plan will specify a timeline for re-evaluation of the plan that is, at least, an annual redetermination. The re-evaluation should	Individual Group, as noted Off-site On-site

involve the individual, family and providers and include a re-evaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategy with revised goals and services. If the services are being provided to a youth enrolled in a wrap around agency (WAA), the substance abuse provider must either be on the CFT or will work closely with the CFT. • Providers must maintain medical records that include a copy of the treatment plan, the name of the individual, dates of services provided, nature, content and units of rehabilitation services provided and progress made toward functional improvement and goals in the treatment plan. • Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid-eligible individual are not eligible for Medicaid reimbursement. • Services provided at a work site must not be job tasks-oriented and must be directly related to treatment of an individual's mental health needs. Any services or components of services, the basic nature of which are to supplant housekeeping, homemaking or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care and laundry services) are non-covered. • In addition, if the youth receiving substance abuse services is enrolled in a WAA, the substance abuse provider must either be a member of the CFT or work closely with the CFT. Substance abuse service provision will be part of the youth's POC developed by the team. • All substance abuse involving adolescents should emphasize the family component within adolescent substance abuse programs and include family involvement, parent education and family therapy. • Services cannot be provided in an IMD. • Room and board is excluded from any rates provided in a residential setting. • ASAM levels of care require prior approval and reviews on an ongoing basis, as determined necessary by DHH to document compliance with the national standards.	

Additional Service Criteria

A unit of service is defined according to the Health Care Financing Industry common procedure coding system (HCPCS) approved code set, unless otherwise specified. One session = one visit

1. School-based health services include covered BH services, treatment and other measures to correct or ameliorate an identified mental health or substance abuse diagnosis. Services are provided by or through a LEA to children with or suspected of having disabilities who attend public school in Louisiana.

2. Assessment, diagnosis and evaluation services, including testing, are services used to determine IDEA eligibility or to obtain information on the individual for purposes of identifying or modifying the health-related services on the IEP. These services are not covered if they are performed for

educational purposes (e.g., academic testing or are provided to an individual who, as the result of the assessment and evaluation, is determined not to be eligible under IDEA). Services must be performed by qualified providers as set forth in this SPA and who provide these services as part of their respective area of practice (e.g., psychologist providing a BH evaluation).

3. Services provided in a school setting will only be reimbursed for recipients who are at least three years of age and under 21 years, who have been determined eligible for Title XIX and IDEA, Part B services with a written service plan (an IEP) which contains medically necessary services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law. Medicaid covers §1905(a) medical services addressed in the IEP that are medically necessary and that correct or ameliorate a child's health condition. Medicaid does not reimburse for social or educational needs or habilitative services. Medicaid covered services are provided in accordance with the established service limitations.

4. A LEA may employ unlicensed BH practitioners if requirements under the IDEA are met. Individual practitioner requirements for the Medicaid qualifications and Department of Education Bulletin 746, Louisiana Standards for State Certification of School Personnel must be met prior to a LEA billing for any services of a clinician under Medicaid. Louisiana certified school psychologists and counselors in a school setting must meet the provider qualifications and providing services consistent with AD.

5. Staffing for the facility must be consistent with State licensure regulations on an FTE basis. For example, if State licensure requires a staff-to-client ratio of 1:25 and the facility has 16 child residents, then the facility must have at least .64 FTE for the 16 children. If the facility has eight beds, then the facility must have at least .32 FTE for the eight children.

6. Adolescent facilities with greater than 16 beds must be a psychiatric residential treatment facility (PRTF) providing an inpatient level of care. Only facilities providing ASAM Level III.7 will be permitted to become PRTFs.

7. LACs may also bill 90804 HF, 90806 HF, 90853 HF, 90847 HF, 90846 HF and 90847 HF. Licensed practitioners acting under their scope of license may bill 90862 for pharmacological management. See Other Licensed Practitioner Codes for details on these CPT codes and billing guidance.

8. For adults, independent lab work is not part of the capitated rate. However, routine drug screens that are part of residential, outpatient and inpatient services are covered under the rate paid to the provider.

9. "Motivational enhancement program" refers to the systematic approach for encouraging change in clients by using principles/techniques like those found in Motivational Interviewing (client-centered, works with intrinsic motivation, focuses on resolving ambivalence about change, emphasis on clinician empathy, utilizes Prochaska/DiClemente's stages of change model, etc.).See Appendix C regarding the Motivation phase. Motivation phase: The goals of this phase include creating a positive motivational context, minimizing hopelessness and low self-efficacy and changing the meaning of family relationships to emphasize possible hopeful experience. Required phase skills consist of relationship and interpersonal skills, a nonjudgmental approach, plus acceptance and sensitivity to diversity. Therapist focus is on the relationship process, separating blaming from responsibility while remaining strength-based. Activities include the interruption of highly negative interaction patterns and blaming (e.g., divert and interrupt), changing meaning through a strength-based relational focus, pointing process, sequencing and reframing of the themes by validating negative impact of behavior, while introducing possible benign/noble (but misguided) motives for behavior. Finally, the introduction of themes and sequences that imply a positive future are important activities of this phase.

Alcohol and drug assessment and referral
Alcohol and drug assessment and referral programs provide ongoing assessment and referral services for individuals presenting a current or past abuse pattern of alcohol or other drug use. The assessment is designed to gather and analyze information regarding a client's current substance use behavior and social, medical and treatment history. The purpose of the assessment is to provide sufficient information for problem identification and, if appropriate, substance abuse-related treatment or referral. A licensee shall develop, implement and comply with policies and procedures that establish processes for referrals for a client. A licensee may conduct an initial screen of an individual's presenting substance abuse problem before conducting an assessment of the individual. A licensee shall comply with licensing standards in regard to assessment practices. Once an individual receives an assessment, a staff member shall provide the individual with a recommendation for further assessment or treatment and an explanation of that recommendation.

ASAM Level I: Outpatient
Outpatient level 1 services are professionally directed assessment, diagnosis, treatment and recovery services provided in an organized non-residential treatment setting. Outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure.

These services include, but are not limited to, individual, group, family counseling and psycho-education on recovery and wellness. These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but are fewer than nine contact hours or less per week.

Admission guidelines for ASAM Level I

1. Acute intoxication and/or withdrawal potential – No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in an outpatient setting.

2. Biomedical conditions and complications – None, or sufficiently stable to permit participation in outpatient treatment.

3. Emotional, behavioral or cognitive conditions and complications – None or minimal. If present, symptoms are mild, stable and do not interfere with the patient's ability to participate in treatment.

4. Readiness to change – Participant should be open to recovery but require monitoring and motivating strategies to engage in treatment and to progress through the stages of change but not be in need of a structured milieu program.

5. Relapse, continued use or continued problem potential – Participant is able to achieve abstinence and related recovery goals, with support and scheduled therapeutic contact to assist with issues that include, but not limited to, ambivalence about preoccupation of alcohol use or other drug use, cravings, peer pressure and lifestyle and attitude changes.

6. Recovery environment – Environment is sufficiently supportive that outpatient treatment is feasible, or the individual does not have an adequate, primary or social support system but has demonstrated motivation and willingness to obtain such a support system.

Additional admission guidelines for outpatient treatment:

1. Initial point of entry/reentry. Activities related to assessment, evaluation, diagnosis and assignment of level of care are provided, including transfer between facilities and/or treatment levels, relapse assessment and assignment to level of care.

2. Early intervention for those who have been identified as individuals suffering from addictive

disorders and referred for education, activities or support services designed to prevent progression of disease.

3. Continuing care for those who require a step-down, following a more intensive level of care and require minimal support to avoid relapse.

4. Any combination of the above.

Assessment/treatment plan review

1. Comprehensive bio-psychosocial assessment completed within 72 hours of admission which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional.

2. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

3. The treatment plan is reviewed/updated in collaboration with the client, as needed, or at a minimum of every 90 days.

4. Discharge/transfer planning must begin at admission.

5. Referral arrangements made, as needed.

Staffing

Facility license is not required for individual or group practice of licensed counselors/therapists providing the above services under the auspices of their individual license(s).

1. Qualified professional supervisor: must be available on site for supervision, as needed, and available by phone for CI.

2. Qualified professional: must be available (defined as on site or available by phone) at all times for CI and on site when clinical services are being provided.

3. Caseload size is based on needs of the active individuals to ensure effective, individualized treatment and rehabilitation. Approval by the Health Standards Section (HSS) is required in writing when caseload exceeds 50 active individuals. For this standard, *active* is defined as being treated at least every 90 days.

4. Counseling groups should not exceed 12 individuals – educational group size is not restricted.

Level II.1 Intensive Outpatient Treatment

Intensive outpatient treatment is professionally directed assessment, diagnosis, treatment and recovery services provided in an organized non-residential treatment setting. Intensive outpatient services are organized activities which may be delivered in any appropriate community setting that meets State licensure.

These services include, but are not limited to, individual, group, family counseling and psycho-education on recovery, as well as monitoring of drug use, medication management, medical and psychiatric examinations, CI coverage and orientation to community-based support groups. Intensive outpatient program services should include evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing and multidimensional family therapy. These programs offer comprehensive, coordinated and defined services that may vary in level of intensity but must be a minimum of nine contact hours per week for adults, age 21 years and older, (six hours per

week for adolescents, age 0-21 years) at a minimum of three (3) days per week. This level consists of a scheduled series of face-to-face sessions appropriate to the individual's POC. This level provides:

Admission guidelines ASAM Level II.1

1. Acute intoxication and/or withdrawal potential – No signs or symptoms of withdrawal, or individual's withdrawal can be safely managed in an intensive outpatient setting.

2. Biomedical conditions and complications – None, or sufficiently stable to permit participation in outpatient treatment.

3. Emotional, behavioral or cognitive conditions and complications – None to moderate. If present, client must be admitted to either a co-occurring disorder capable or co-occurring disorder enhanced program, depending on the client's level of function, stability and degree of impairment.

4. Readiness to change – Participant requires structured therapy and a programmatic milieu to promote treatment progress and recovery. The participant's perspective inhibits their ability to make behavioral changes without repeated, structured and clinically directed motivational interventions.

5. Relapse, continued use or continued problem potential – Participant is experiencing an intensification of symptoms related to substance use, and their level of functioning is deteriorating despite modification of the treatment plan.

6. Recovery environment – Insufficiently supportive environment and participant lacks the resources or skills necessary to maintain an adequate level of functioning without services in intensive outpatient treatment.

Additional admission guidelines for intensive outpatient treatment:

1. Initial point of entry/re-entry – Activities related to assessment, evaluation, diagnosis and assignment of level of care are provided, including transfer between facilities and/or treatment modalities, relapse assessment and assignment to level of care.

2. May be provided for persons at risk of being admitted to more intensive levels of care, such as residential, inpatient or detoxification.

3. Continuing care for those who require a step-down following a more intensive level of care and require support to avoid relapse.

4. Any combination of the above.

Assessment/treatment plan review:

1. Comprehensive bio-psychosocial assessment completed within 72 hours of admission which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional.

2. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

3. The treatment plan is reviewed/updated in collaboration with the client, as needed, or at minimum of every 30 days.

4. Discharge/transfer planning must begin at admission.

5. Referral arrangements, made as needed.

Staffing

1. Qualified professional supervisor: 10 hours weekly on site during hours of operation.

2. Qualified professional: Must be available (defined as on site or available by phone) at all times for CI and on site when clinical services are being provided.

3. Caseload size is based on needs of the active individuals to ensure effective, individualized treatment and rehabilitation. For this standard, *active* is defined as being treated at least every 90 days.

4. Counseling groups should not exceed 12 individuals. Educational group size is not restricted.

Level II-D Ambulatory detoxification with extended on-site monitoring

This level of care is an organized outpatient service, which may be delivered in an office setting, health care or addiction treatment facility by trained clinicians, who provide medically supervised evaluation, detoxification and referral services. The care is delivered in an office/health care setting or BH treatment facility.

Appointments for services are regularly scheduled. These services are designed to treat the individual's level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate the individual's entry into ongoing treatment and recovery. Detoxification is conducted on an outpatient basis. It is important for medical and nursing personnel to be readily available to evaluate and confirm that detoxification in the less supervised setting is relatively safe. Counseling services may be available through the detoxification program or may be accessed through affiliation with entities providing outpatient services. Ambulatory detoxification is provided in conjunction with intensive outpatient treatment services (Level II.1).

Admission guidelines

Provides care to patients whose withdrawal signs and symptoms are of moderate intensity but are sufficiently stable enough physically and mentally to permit participation in outpatient treatment. Medical and nursing services must be available on-site during hours of clinic operations and on-call after hours. The focus is on medical stabilization and preparation for transfer to a less intensive level of care.

Assessment/treatment plan review

1. Comprehensive bio-psychosocial assessment completed within 72 hours of admission which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional.

2. An individualized, interdisciplinary treatment plan which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

3. The treatment plan is reviewed/updated in collaboration with the client, as needed, or at minimum of every 30 days.

4. Discharge/transfer planning must begin at admission.

5. Referral arrangements made as needed.

Staffing

1. Facility shall have qualified professional medical, nursing counseling and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

    a. Physician, medical director –10 hours per week, on site during hours of operation and on call availability 24 hours
    b. PCP – Optional, if medical director is not a PCP – 24-hour availability
    c. Psychologist – NA
    d. Nurse (NP/RN or licensed practical nurse (LPN)) – Optional (NP/APRN/physician assistant (PA) in the absence of an MD is acceptable)
    e. Licensed or certified clinician or counselor with direct supervision – one clinician per 25 clients and available 40 hours per week
    f. Clerical support staff – one to two FTE per day shift
    g. Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
    h. Physicians, who are available 24 hours a day by telephone. (Or a PA, NP or APRN, licensed as physician extenders, may perform duties designated by physician)

2. A physician is available to assess the individual within 24 hours of admission (or earlier, if medically necessary) and is available to provide on-site monitoring of care and further evaluation on a daily basis.

3. A RN or other licensed and credentialed nurse is available on call 24 hours per day and on site no less than 40 hours per week and will conduct a nursing assessment on individuals at admission. A nurse is responsible for overseeing the monitoring of the individual's progress and medication. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders.

4. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

5. A counselor is available on site 40 hours per week to provide direct client care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license. Caseloads not to exceed 10 clients.

6. Qualified professional supervisor: Available for clinical supervision and by telephone for consultation.

Toxicology/drug screening
Urine drug screens are required upon admission and as directed by the treatment plan and are considered covered under the rate paid to the provider.

Stabilization plan
Qualified professional shall identify the individual's short-term needs, based on the detoxification history, the medical history and the physical examination and prepare a plan of action.

Detoxification/treatment plan
The detoxification/treatment plan shall be reviewed and signed by the physician and the individual and shall be filed in the individual's record within 24 hours of admission with updates, as needed.

Detoxification progress notes
The program shall implement the detoxification/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:

- The individual's physical condition, including vital signs
- The individual's mood and behavior
- Statements about the individual's condition and needs
- Information about the individual's progress or lack of progress in relation to detoxification/treatment goals
- Additional notes shall be documented, as needed.

Physician orders
Required for medical and psychiatric management.

Clinician will bill the appropriate CPT codes in conjunction with intensive outpatient program (IOP) codes (e.g., billing a minimum of 9 hours of IOP).

Level III.1 Clinically Managed Low Intensity Residential Treatment – Adolescent

Residential programs offer at least five hours per week of a combination of low-intensity clinical and recovery-focused services. All facilities are licensed by DHH.

Treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the worlds of work, education and family life. Services provided may include individual, group and family therapy, medication management and medication education. Mutual/self-help meetings usually are available on site. Does not include sober houses, boarding houses or group homes where treatment services are not provided.

Admission guidelines:
1. Acute intoxication and/or withdrawal potential – No or minimal/stable withdrawal risk.

2. Biomedical conditions and complications – None or stable. If present, the participant must be receiving medical monitoring.

3. Emotional, behavioral or cognitive conditions and complications – None or minimal. If present, conditions must be stable and not too distracting to the participant's recovery.

4. Readiness to change – Participant should be open to recovery, but in need of a structured, therapeutic environment.

5. Relapse, continued use or continued problem potential – Participant understands the risk of relapse, but lacks relapse prevention skills or requires a structured environment.

6. Recovery environment – Environment is dangerous, but recovery is achievable within a 24-hour structure.

Assessment/treatment plan review
1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The SMO ensures that pre-certification requirements are met.

2. Comprehensive bio-psychosocial assessment completed within seven days, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol

d. Drug

3. A physical examination performed within a reasonable time, as determined by the client's medical condition.

4. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

5. The treatment plan is reviewed in collaboration with the client every 90 days and documented accordingly.

6. Discharge/transfer planning must begin at admission.

7. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional staff and support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program. **In addition to the staffing required by TGH, Adolescent TGH ASAM III.1 must have at least the following staffing:**

   – Licensed or certified clinician or counselor with direct supervision – one FTE per 25 clients
   – Psychiatric aide – 1:5 ratio day and evening shift, 1:10 ratio night shift
   – Clerical support staff – one FTE recommended
   – Care coordinator – one FTE per 50 clients, and/or duties may be assumed by clinical staff
   – Outreach worker/peer mentor – Strongly recommended

2. Qualified professional supervisor: available for clinical supervision and by telephone for consultation.

3. Qualified professional**:** counselor must be on duty when majority of individuals are awake and on site. Caseload shall not exceed 1:25 unless prior approved by OBH and HSS.

4. House manager: person who supervises activities of the facility when the professional staff is on call, but not on duty. This person is required to have adequate orientation and skills to assess situations related to relapse and to provide access to appropriate medical care when needed.

5. Clerical/support staff recommended.

Level III.1 Clinically Managed Low-Intensity Residential Treatment - Adult

Residential programs offer at least five hours per week of a combination of low-intensity clinical and recovery-focused services. All facilities are licensed by DHH.

Treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the worlds of work, education and family life. Services provided may include individual, group and family therapy, medication management and medication education. Mutual/self-help meetings usually are available on site. Does not include sober houses, boarding houses or group homes where treatment services are not provided. (Example: halfway house).

Admission guidelines

1. Acute intoxication and/or withdrawal potential – None, or minimal/stable withdrawal risk.

2. Biomedical conditions and complications – None or stable. If present, the participant must be

receiving medical monitoring.

3. Emotional, behavioral or cognitive conditions and complications – None or minimal. If present, conditions must be stable and not too distracting to the participant's recovery.

4. Readiness to change – Participant should be open to recovery but in need of a structured, therapeutic environment.

5. Relapse, continued use or continued problem potential – Participant understands the risk of relapse but lacks relapse prevention skills or requires a structured environment.

6. Recovery environment – Environment is dangerous, but recovery is achievable within a 24-hour structure.

Assessment/treatment plan review

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The SMO ensures that pre-certification requirements are met.

2. Comprehensive bio-psychosocial assessment completed within seven days which substantiate appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol
   d. Drug

3. A physical examination performed within a reasonable time, as determined by the client's medical condition.

4. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

5. The treatment plan is reviewed in collaboration with the client every 90 days and documented accordingly.

6. Discharge/transfer planning must begin at admission.

7. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional staff and support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

   Adult staffing patterns:
   - Physician (MD), medical director – NA
   - PCP – NA
   - Psychologist – NA
   - Nurse (NP/RN or LPN) – NA
   - Licensed or certified clinician or counselor with direct supervision – one FTE per 25 clients
   - Psychiatric aid – Two PAs on first, second and third shifts
   - Clerical support staff – one FTE recommended
   - Activity/occupational therapist – NA

- Care coordinator – one FTE per 50 clients, and/or duties may be assumed by clinical staff
- Outreach worker/peer mentor – Strongly recommended

2. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

3. Qualified professional counselor – Must be on duty when majority of individuals are awake and on site. Caseload shall not exceed 1:25,.

4. House manager – Person who supervises activities of the facility when the professional staff is on call but not on duty. This person is required to have adequate orientation and skills to assess situations related to relapse and to provide access to appropriate medical care when needed.

5. Clerical/support staff – Recommended.

Level III.2D Clinically Managed Residential Social Detoxification – Adolescent

Residential programs provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring, observation and support in a supervised environment for a person served, to achieve initial recovery from the effects of alcohol and/or other drugs. All facilities are licensed by DHH.

Social detoxification is appropriate for individuals who are able to participate in the daily residential activities and is often used as a less restrictive, non-medical alternative to inpatient detoxification.

Admission guidelines
Provides care to patients whose withdrawal signs and symptoms are non-severe but require 24-hour inpatient care to address biomedical and recovery environment conditions/complications. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically supported program are not necessary.

Screening/assessment/treatment plan review
1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The SMO ensures that pre-certification requirements are met.

2. Comprehensive bio-psychosocial assessment completed within seven days of admission, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional (exclusions: detoxification programs are not required to complete a psychosocial assessment but must screen for proper patient placement and referral).
3. An individualized stabilization/treatment plan. This plan should be developed in collaboration with the client.

4. Daily assessment of progress through detoxification, documented in a manner consistent from individual to individual.

5. Discharge/transfer planning must begin at admission.

6. Referral arrangement made, as needed.

Staffing
1. Facility shall have qualified professional and other support staff necessary to provide services appropriate to the needs of individuals being admitted to the program. **In addition to the staffing required by TGH, Adolescent TGH ASAM III.2D must have at least the following staffing:**

- Physician (MD), medical director – 24 hours on-call availability
- Nurse (NP/RN or LPN) – Optional (NP/APRN/ PA) in the absence of an MD is acceptable)
- Licensed or certified clinician or counselor with direct supervision – One clinician per 25 clients
- Psychiatric aid – One FTE per shift
- Clerical support staff – One to two FTE per day shift
- Care coordinator – One FTE per day shift, and/or duties may be assumed by clinical staff
- Outreach worker/peer mentor – Optional

2. Physicians or a PA, NP or APRN, licensed as physician extenders, may perform duties designated by physician. Their duties would include:
   - Review and sign off on medical treatment
   - Triage medical needs at admission and through course of stay for all clients

3. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals.

4. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists, is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

5. A qualified professional is available on site 40 hours per week to provide direct individual care utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license.

6. Clinically managed detoxification personnel shall consist of professional and other support staff that are adequate to meet the needs of the individuals admitted to the facility:
   - Qualified professional supervisor: available for clinical supervision and by telephone for consultation
   - Qualified professional: 40 hours per week, per 25 individuals (may be combination of two or more professional disciplines)

7. Designated medical director may be consultative only.

Emergency admissions
The admission process may be delayed only until the individual can be interviewed, but no longer than 24 hours, unless seen by a physician. Facilities are required to orient direct care employees to monitor, observe and recognize early symptoms of serious illness and to access emergency services promptly.

Minimum standards of practice
1. **History**
   The program shall obtain enough medical and psychosocial information about the individual to provide a clear understanding of the individual's present status. Exceptions shall be documented in individual's record.

2. **Medical clearance/screening**
   Medical screening, upon arrival, by staff with current CPR and first aid training, with telephone access to RN or MD for instructions for the care of the individual. Individuals who require medication management shall be transferred to medically monitored or medical detoxification program until stabilized.

3. **Toxicology/drug screening**
(Not required in this level of care).

4. **Stabilization/treatment plan**
   a. The stabilization/treatment plan shall be reviewed and signed by the qualified professional and the individual and shall be filed in the individual's record within 24 hours of admission with updates, as needed.
   b. Detoxification/progress notes. The program shall implement the stabilization/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:
      i. The individual's physical condition, including vital signs
      ii. The individual's mood and behavior
      iii. Individual statements about the individual's condition and needs
      iv. Information about the individual's progress or lack of progress in relation to stabilization goals
      v. Additional notes shall be documented, as needed

5. **Physicians' orders**
Required for medical and psychiatric management

Level III.2D Clinically Managed Residential Social Detoxification – Adult
Residential programs provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring observation and support in a supervised environment for a person served to achieve initial recovery from the effects of alcohol and/or other drugs. All facilities are licensed by DHH.

Social detoxification is appropriate for individuals who are able to participate in the daily residential activities and is often used as a less restrictive, non-medical alternative to inpatient detoxification.

The clinician will bill the CPT code in conjunction with the relevant Level II.1 codes.

Admission guidelines
Provides care to patients whose withdrawal signs and symptoms are non-severe but require 24-hour inpatient care to address biomedical and recovery environment conditions/complications. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically supported program are not necessary.

Screening/assessment/treatment plan review
1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The SMO ensures that pre-certification requirements are met.

2. Comprehensive bio-psychosocial assessment completed within seven days of admission which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional (exclusions: detoxification programs are not required to complete a psychosocial assessment but must screen for proper patient placement and referral).

3. An individualized stabilization/treatment plan. This plan should be developed in collaboration with the client.

4. Daily assessment of progress, through detoxification, documented in a manner consistent from individual to individual.

5. Discharge/transfer planning must begin at admission.

6. Referral arrangements made, as needed.

Staffing

1. Facility shall have qualified professional and other support staff necessary to provide services appropriate to the needs of individuals being admitted to the program.
   a. Physician (MD), medical director – 24 hours on-call availability
   b. PCP – NA
   c. Psychologist – NA
   d. Nurse (NP/RN or LPN) – Optional (NP/APRN/PA in the absence of an MD is acceptable)
   e. Licensed or certified clinician or counselor with direct supervision – one clinician per 25 clients
   f. Psychiatric aide– one FTE per shift
   g. Clerical support staff – one to two FTE per day shift
   h. Activity/occupational therapist – NA
   i. Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
   j. Outreach worker/peer mentor – Optional

2. Physicians or a PA, NP or APRN, licensed as physician extenders, may perform duties designated by physician. Their duties would include:
   a. Review and sign off on medical treatment
   b. Triage medical needs at admission and through course of stay for all clients

3. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals.

4. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists, is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

5. A qualified professional is available on site 40 hours per week to provide direct individual care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license.

6. Clinically managed detoxification personnel shall consist of professional and other support staff that are adequate to meet the needs of the individuals admitted to the facility:
   a. Qualified professional supervisor: Available for clinical supervision and by telephone for consultation
   b. Qualified professional: 40 hours per week per 25 individuals (may be combination of two or more professional disciplines)

7. Designated medical director may be consultative only.

Emergency admissions

The admission process may be delayed only until the individual can be interviewed but no longer than 24 hours, unless seen by a physician. Facilities are required to orient direct care employees to monitor, observe and recognize early symptoms of serious illness and to access emergency services promptly.

Minimum standards of practice

1. **History**

   The program shall obtain enough medical and psychosocial information about the individual to provide a clear understanding of the individual's present status. Exceptions shall be documented in the individual's record.

2. **Medical clearance/screening**
Medical screening upon arrival by staff with current CPR and first aid training, with telephone access to RN or MD for instructions for the care of the individual. Individuals who require medication management shall be transferred to medically monitored or medical detoxification program until stabilized.

3. **Toxicology/drug screening**
(Not required in this level of care).

4. **Stabilization/treatment plan**
   a. The stabilization/treatment plan shall be reviewed and signed by the qualified professional and the individual and shall be filed in the individual's record within 24 hours of admission with updates, as needed.
   b. Detoxification/progress notes. The program shall implement the stabilization/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:
      i. The individual's physical condition, including vital signs
      ii. The individual's mood and behavior
      iii. Individual statements about the individual's condition and needs
      iv. Information about the individual's progress or lack of progress in relation to stabilization goals
      v. Additional notes shall be documented, as needed

5. **Physicians' orders**
Required for medical and psychiatric management.

Level III.3 Clinically Managed Medium Intensity Residential Treatment - Adult
Residential programs offer at least 20 hours per week of a combination of medium-intensity clinical and recovery-focused services. All facilities are licensed by DHH.

Frequently referred to as extended or long-term care, Level III.3 programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery from substance-related disorders.

Admission guidelines
1. Acute intoxication and/or withdrawal potential – None, or minimal risk of withdrawal.

2. Biomedical conditions and complications – None or stable. If present, the participant must be receiving medical monitoring.

3. Emotional, behavioral or cognitive conditions and complications – Mild to moderate severity; need structure to focus on recovery; if stable, a co-occurring disorder capable program is appropriate. If not, a co-occurring disorder enhanced program is required. Treatment should be designed to respond to the client's cognitive deficits.

4. Readiness to change – Has little awareness and needs intervention to engage and stay in treatment, or there is high severity in this dimension.

5. Relapse, continued use or continued problem potential – Has little awareness and needs intervention available to prevent continued use, with imminent dangerous consequences because of cognitive deficits.

6. Recovery environment – Environment is dangerous, but recovery is achievable within a 24-hour structure.

Screening/Assessment/Treatment Plan Review

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The SMO ensures that pre-certification requirements are met.

2. Comprehensive bio-psychosocial assessment completed within seven days, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol
   d. Drug

3. A physical examination performed within a reasonable time, as determined by the client's medical condition.

4. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

5. The treatment plan is reviewed in collaboration with the client, as needed, or at a minimum of every 90 days and documented accordingly.

6. Discharge/transfer planning, beginning at admission.

7. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

   Adult staffing patterns
   - Physician (MD), medical director – 24 hours on-call availability
   - PCP – NA
   - Psychologist – NA
   - Nurse (NP/RN or LPN) – one FTE; 24-hour on-call availability
   - Licensed or certified clinician or counselor with direct supervision – one FTE per 25 clients
   - Psychiatric aid – Two PAs on first, second and third shifts
   - Clerical support staff – one FTE recommended
   - Activity/occupational therapist – NA
   - Care coordinator – one FTE per 50 clients, and/or duties may be assumed by clinical staff
   - Outreach worker/peer mentor – Strongly recommended

Level III.5 Clinically Managed High Intensity Residential Treatment – Adolescent

Designed to treat persons who have significant social and psychological problems. All facilities are licensed by DHH.

Programs are characterized by their reliance on the treatment community as a therapeutic agent. Treatment goals are to promote abstinence from substance use and antisocial behavior and to effect a global change in participants' lifestyles, attitudes and values. Individuals typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values. (Example: therapeutic community or residential treatment center.) The program must include an in-house education/vocational component if serving

adolescents.

Admission guidelines

1. Acute intoxication and/or withdrawal potential: None or minimal risk of withdrawal.

2. Biomedical conditions and complications: None or stable or receiving concurrent medical monitoring.

3. Emotional, behavioral or cognitive conditions and complications: Demonstrates repeated inability to control impulses or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A co-occurring disorder-enhanced setting is required for severely and persistently mentally ill (SPMI) patients.

4. Readiness to change: Has marked difficulty with or opposition to treatment, with dangerous consequences, or there is high severity in this dimension but not in others. The client, therefore, needs ASAM Level I placement with inclusion of Motivational Enhancement Therapy (MET). MET is a therapeutic intervention and a component part of the program.

5. Relapse, continued use or continued problem potential: Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences.

6. Recovery environment: Environment is dangerous, and client lacks skills to cope outside of a highly structured 24-hour setting.

Screening/assessment/treatment plan review

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The SMO ensures that pre-certification requirements are met.

2. Comprehensive bio-psychosocial assessment completed within seven days, which substantiate appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol
   d. Drug

3. A physical examination performed within a reasonable time, as determined by the client's medical condition.

4. An individualized, interdisciplinary treatment plan which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

5. The treatment plan is reviewed in collaboration with the client, as needed, or at a minimum of every 30 days and documented accordingly.

6. Discharge/transfer planning must begin at admission.

7. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

Adolescent staffing patterns

- Physician (MD), medical director – 10 hour per week
- PCP – 10 hours per week for histories and physicals at admission and medication management
- Psychologist – 20 hours per week
- Nurse (NP/RN or LPN) – one FTE NP/RN, with LPN required for first shift, with one backup LPN, two LPNs on second shift, and one RN/LPN required for third shift; RN supervisor or NP on call
- Licensed or certified clinician or counselor with direct supervision – one clinician per eight clients
- Psychiatric aid – 1:5 ratio day and evening shifts, 1:10 ratio night shift
- Clerical support staff – one to two FTE per day shift
- Activity/occupational therapist – one FTE
- Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
- Outreach worker/peer mentor - Optional

2. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

3. Qualified professional – 40 hours per week.

4. Caseload not to exceed 1:12 for adults and 1:8 for adolescents, unless prior approval granted by OBH and HSS.

5. Senior individuals may be utilized as volunteers to assist in the recovery process, provided that facility staff is on site and immediately available, if needed.

Level III.5 Clinically Managed High Intensity Residential Treatment – Adult

Designed to treat persons who have significant social and psychological problems. All facilities are licensed by DHH.

Programs are characterized by their reliance on the treatment community as a therapeutic agent. Treatment goals are to promote abstinence from substance use and antisocial behavior and to effect a global change in participants' lifestyles, attitudes and values. Individuals typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values. Example: therapeutic community or residential treatment center.

Admission guidelines

1. Acute intoxication and/or withdrawal potential: None, or minimal risk of withdrawal.

2. Biomedical conditions and complications: None or stable or receiving concurrent medical monitoring.

3. Emotional, behavioral or cognitive conditions and complications: Demonstrates repeated inability to control impulses, or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A Co-Occurring Disorder Enhanced setting is required for SPMI patients.

4. Readiness to change: Has marked difficulty with or opposition to treatment, with dangerous consequences, or there is high severity in this dimension but not in others. The client, therefore, needs ASAM Level I placement with inclusion of Motivational Enhancement Therapy (MET). MET is a therapeutic intervention and a component part of the program.

5. Relapse, continued use or continued problem potential: Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences.

6. Recovery environment: Environment is dangerous, and client lacks skills to cope outside of a highly structured 24-hour setting.

Screening/assessment/treatment plan review

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The SMO ensures that pre-certification requirements are met.

2. Comprehensive bio-psychosocial assessment completed within seven days, which substantiate appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol
   d. Drug

3. A physical examination performed within a reasonable time, as determined by the client's medical condition.

4. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

5. The treatment plan is reviewed in collaboration with the client, as needed, or at a minimum of every 30 days and documented accordingly

6. Discharge/transfer planning must begin at admission.

7. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

   Adult staffing patterns
   - Physician (MD), medical director – 10 hours per week
   - PCP – 10 hours per week for histories and physicals, at admission and medication management
   - Psychologist – Optional
   - Nurse (NP/RN or LPN) – one FTE NP/RN, with LPN required for first shift, with one backup LPN, two LPNs on second shift, and one RN/LPN required for third shift; RN supervisor or NP on call
   - Licensed or certified clinician or counselor with direct supervision – one clinician per 12 clients
   - Psychiatric aid – Two PAs on first, second and third shifts
   - Clerical support staff – one to two FTE per day shift
   - Activity/occupational therapist – Optional (0.5 FTE)
   - Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
   - Outreach worker/peer mentor – Optional

Level III.7 Medically Monitored Intensive Residential Treatment – Adult
This COD residential treatment facility provides 24 hours of structured treatment activities per week including, but not limited to, psychiatric and substance use assessments, diagnosis treatment, habilitative and rehabilitation services to individuals with co-occurring psychiatric and substance disorders (ICOPSD), whose disorders are of sufficient severity to require a residential level of care. All facilities are licensed by DHH.

It also provides a planned regiment of 24-hour professionally directed evaluation, observation and medical monitoring of addiction and mental health treatment in a residential setting. They feature permanent facilities, including residential beds, and function under a defined set of policies, procedures and clinical protocols. Appropriate for patients whose subacute biomedical and emotional, behavior or cognitive problems are so severe that they require co-occurring capable or enhanced residential treatment, but who do not need the full resources of an acute care general hospital. In addition to meeting integrated service criteria, COD treatment providers must have experience and preferably licensure and/or certification in both addictive disorders and mental health.

Admission guidelines
Individuals in this level of care may have co-occurring addiction and mental health disorders that meet the eligibility criteria for placement in a co-occurring disorder-capable program or difficulties with mood, behavior or cognition related to a substance use or mental disorder or emotional behavioral or cognitive symptoms that are troublesome, but do not meet the DSM criteria for mental disorder.

1. Acute intoxication and/or withdrawal potential – None or minimal/stable withdrawal risk.

2. Biomedical conditions and complications – Moderate to severe conditions (which require 24-hour nursing and medical monitoring or active treatment but not the full resources of an acute care hospital).

3. Emotional, behavioral or cognitive conditions and complications – Moderate to severe conditions and complications (such as diagnosable co-morbid Axis I disorders or symptoms). These symptoms may not be severe enough to meet diagnostic criteria but interfere or distract from recovery efforts (for example, anxiety/hypomanic or depression and/or cognitive symptoms (which may include compulsive behaviors, suicidal or homicidal ideation with a recent history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others) are interfering with abstinence, recovery and stability to such a degree that the individual needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts.

4. Readiness to change – Participant is in need of intensive motivating strategies, activities and processes available only in a 24-hour structured medically monitored setting (but not medically managed.)

5. Relapse, continued use or continued problem potential – Participant is experiencing an escalation of relapse behaviors and/or acute psychiatric crisis and/or re-emergence of acute symptoms and is in need of 24-hour monitoring and structured support.

6. Recovery environment – Environment or current living arrangement is characterized by a high risk of initiation or repetition of physical, sexual or emotional abuse or substance use so endemic that the patient is assessed as unable to achieve or maintain recovery at a less intensive level or care.

Screening/assessment/treatment plan review:
1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The SMO ensures that pre-certification requirements are met.

2. Comprehensive bio-psychosocial assessment completed within seven days, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol
   d. Drug

3. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

4. The treatment plan is reviewed/updated in collaboration with the client, as needed, or at a minimum of every 30 days.

5. Discharge/transfer planning must begin at admission.

6. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

   Adult staffing patterns
   - Physician (MD), medical director – 0.5 FTE or 20 hours per week; 24 hours on-call availability
   - PCP – 15 hours per week, 24 hours on-call availability
   - Psychologist – Optional
   - Nurse (NP/RN or LPN) – one FTE NP/RN, with LPN required for first shift, with one backup LPN, two LPNs on second shift and one RN/LPN required for third shift; RN supervisor or NP on call
   - Licensed or certified clinician or counselor with direct supervision – one clinician per six clients
   - Psychiatric aid – Two PAs on first, second and third shifts, one FTE must be a psychiatric aid supervisor. Nursing staff may be included.
   - Clerical support staff – one to two FTE per day shift
   - Activity/occupational therapist – 0.5 FTE
   - Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
   - Outreach worker/peer mentor – Optional

Level III.7D Medically Monitored Residential Detoxification – Adult

Medically monitored residential detoxification is an organized service delivered by medical and nursing professionals, which provide for 24-hour medically supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. All facilities are licensed by DHH.

This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. It sometimes is provided by overlapping with Level IV-D services (as a “step-down” service) in a specialty unit of an acute care general or psychiatric hospital. Twenty-four hour observation, monitoring and treatment are available.

Admission guidelines

Provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-

hour inpatient care. It sometimes is provided as a “step-down” service from a specialty unit of an acute care general or psychiatric hospital. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary.

Screening/assessments/treatment plan review

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The SMO ensures that pre-certification requirements are met.

2. Approval of admission by a physician. A physical examination by a physician, PA or NP within 24 hours of admission and appropriate laboratory and toxicology tests. A physical examination conducted within 24 hours prior to admission may be used, if reviewed and approved by the admitting physician.

3. Comprehensive bio-psychosocial assessment completed within seven days of admission, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional (exclusions: detoxification programs are not required to complete a psychosocial assessment but must screen for proper patient placement and referral). An individualized, interdisciplinary stabilization/treatment plan should be developed in collaboration with the client, including problem identification in ASAM Dimensions 2-6.

4. Discharge/transfer planning must begin at admission.

5. Referral arrangements made, as needed.

6. Daily assessment of client’s progress, which should be documented accordingly.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.
   a. Physician (MD), medical director – 0.5 hour per resident per week, and available 24 hours on call
   b. PCP – NA
   c. Psychologist – NA
   d. Nurse (NP/RN or LPN) – one FTE NP/RN, with LPN required for first shift, with one backup LPN, two LPNs on second shift, one required for the third shift, RN supervisor or NP on call
   e. Licensed or certified clinician or counselor with direct supervision – one clinician per 10 clients; and available 40 hours per week. A counselor is available 40 hours per week
   f. Psychiatric aid – Two PAs on first and second shifts, and three on third shift
   g. Clerical support staff – one to two FTE per day shift
   h. Activity/occupational therapist – NA
   i. Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
   j. Outreach worker/peer mentor – Optional

2. Physicians, who are available 24 hours a day by telephone. (Or a PA, NP or APRN licensed as physician extenders may perform duties designated by physician).

3. A physician is available to assess the individual within 24 hours of admission (or earlier, if medically necessary) and is available to provide on-site monitoring of care and further evaluation on a daily basis.

4. A RN or other licensed and credential nurse is available on-call 24 hours per day and on-site no less than 40 hours per week and will conduct a nursing assessment on individuals at admission.

5. A nurse is responsible for overseeing the monitoring of the individual's progress and medication administration on an hourly basis, if needed.

6. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders. The level of nursing care is at a ratio of one nurse per every 15 individuals.

7. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

8. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

9. A counselor is available on site 40 hours per week to provide direct client care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license. Caseloads not to exceed 10 clients.

10. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

Toxicology/drug screening
Medically monitored. Physician may waive drug screening if and when individual signs list of drugs being abused and understands that his/her dishonesty could result in severe medical reactions during detoxification process.

Stabilization plan
Qualified professional shall identify the individual's short-term needs based on the detoxification history, the medical history and the physical examination, if available, and prepare a plan of action until individual becomes physically stable.

Detoxification/treatment plan
Medically monitored. The detoxification/treatment plan shall be reviewed and signed by the physician and the individual and shall be filed in the individual's record within 24 hours of admission with updates, as needed.

Detoxification progress notes
The program shall implement the detoxification/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:

- The individual's physical condition, including vital signs
- The individual's mood and behavior
- Statements about the individual's condition and needs
- Information about the individual's progress or lack of progress in relation to detoxification/treatment goals
- Additional notes shall be documented, as needed

Physicians' orders
Required for medical and psychiatric management.

Chapter 5:
Outpatient & Inpatient Hospital & PRTF

Outpatient and Inpatient Hospital and Psychiatric Residential Treatment Facility Services

Section 5.1: Outpatient and Inpatient Hospital

Definition

All costs for inpatient hospital admissions for Medicaid enrollees with a primary diagnosis of BH are included in the BH program, except that the following services for Medicaid managed care enrollees in managed care organizations (MCOs), such as a prepaid coordinated care network (CCN-P), will be excluded from the BH program and included in the MCO prepaid rates:

- Acute detoxification (Revenue codes of 116, 126, 136, 146, 156, as well as 202 and 204 with delirium tremens (DT) diagnoses to accommodate for DT)
- Mental health services provided in a medical (physical health) Medicaid MCO member's PCP or medical office (i.e., MD, doctor of osteopathic medicine or rural health clinic (RHC), other than services provided by a psychiatrist)
- Mental health services provided in a federally qualified health center
- Emergency room services, except services provided to members with primary codes of 290 through 319

For non-MCO enrollees, all mental health and substance abuse inpatient services (with a primary BH diagnosis) and outpatient services (with a primary BH diagnosis) are included in this program for members of the PIHP.

The SMO will call the State Medicaid manager for hospitals to obtain the facility-specific rates for inpatient hospital care for adults and children. For all care for children under age 21, the SMO must pay the FFS rates including hospital facility-specific rates.

Level IV D: Medically Managed Intensive Inpatient Addiction Disorder Treatment:

This hospital level of care is appropriate for those individuals whose acute biomedical, emotional, behavioral and cognitive problems are so severe they require primary medical and nursing care. This program encompasses a planned regimen of 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting. Although treatment is specific to substance use problems, the skills of the interdisciplinary team and the availability of support services allow the conjoint treatment of any co-occurring biomedical conditions and mental disorders that need to be addressed. A licensee providing inpatient treatment shall assign one qualified staff for every four clients in residence. The licensee shall maintain sufficient employees on duty 24 hours a day to meet the needs and protect the safety of clients. Employees on duty shall be awake on all shifts. The program must include an in-house education/vocation component if serving adolescents.

A licensee providing inpatient treatment shall provide a licensed physician or nurse on site or on call, and licensed medical or nursing staff to monitor and administer medications on a 24-hour per day basis.

Admission guidelines

Provides care to patients whose withdrawal signs and symptoms are sufficiently severe enough to require primary medical and nursing services on a 24-hour basis. This program offers intensive physical health and/or psychiatric care in a hospital setting. The focus is on stabilization and preparation for transfer to a less intensive level of care.

Screening/assessments/treatment plan review

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The SMO ensures that pre-certification requirements are met.

2. Approval of admission by a physician. A physical examination by a physician, PA or NP within 24 hours of admission and appropriate laboratory and toxicology tests. A physical examination conducted within 24 hours prior to admission may be used if reviewed and approved by the admitting physician.

3. Comprehensive bio-psychosocial assessments are not required for this level of care:

   – An individualized, interdisciplinary stabilization/treatment plan should be developed in collaboration with the client, including problem identification in ASAM Dimensions 2-6.
   – Daily assessments of client's progress should be documented.
   – Discharge/transfer planning must begin at admission.
   – Referral arrangements prior to discharge.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.
   a. Physician (MD), medical director – one hour per resident per week and available 24 hours on call
   b. PCP – NA
   c. Psychologist – NA
   d. Nurse (NP/RN or LPN) – one FTE NP/RN, with LPN required for first shift, with one backup LPN, two LPNs on second shift, one required for the third shift, RN supervisor or NP on call
   e. Licensed or certified clinician or counselor with direct supervision – one clinician per four clients; and available 40 hours per week. A counselor is available 40 hours per week.
   f. Psychiatric aid – Two PAs on first and second shifts, and three on third shift
   g. Clerical support staff – one to two FTE per day shift
   h. Activity/occupational therapist – NA
   i. Care coordinator – one FTE per day shift, and/or duties may be assumed by clinical staff
   j. Outreach worker/peer mentor – Optional.

2. Physicians, who are available 24 hours a day by telephone. (Or a PA, NP or APRN, licensed as physician extenders, may perform duties designated by physician).

3. A physician is available to assess the individual within 24 hours of admission (or earlier, if medically necessary) and is available to provide on-site monitoring of care and further evaluation on a daily basis.

4. A RN or other licensed and credentialed nurse is available on call 24 hours per day and on site no less than 40 hours per week and will conduct a nursing assessment on individuals at admission.

5. A nurse is responsible for overseeing the monitoring of the individual's progress and medication administration on an hourly basis, if needed.

6. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders. The level of nursing care is at a ratio of one nurse per every 15 individuals.

7. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

8. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

9. A counselor is available on site 40 hours per week to provide direct client care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license. Caseloads not to exceed 10 clients.

10. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

Toxicology/drug screening
Urine drug screens are required upon admission and as directed by the treatment plan.

Stabilization plan
Qualified professional shall identify the individual's short-term needs, based on the detoxification history, the medical history and the physical examination and prepare a plan of action.

Detoxification/treatment plan
The detoxification/treatment plan shall be reviewed and signed by the physician and the individual and shall be filed in the individual's record within 24 hours of admission with updates, as needed.

Detoxification progress notes
The program shall implement the detoxification/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:

- The individual's physical condition, including vital signs
- The individual's mood and behavior
- Statements about the individual's condition and needs
- Information about the individual's progress or lack of progress in relation to detoxification/treatment goals
- Additional notes shall be documented, as needed

Physicians' orders
Required for medical and psychiatric management.

Provider Qualifications	Eligibility Criteria
General hospital outpatient and inpatient settings for adults and children. Psychiatric hospital inpatient settings for children under age 21.	All Medicaid-eligible adults All Medicaid-eligible children

Limitations/Exclusions and Fee Schedules	Allowed Mode(s) of Delivery
As outlined in the Medicaid provider manuals and fee schedules. The SMO will pay the provider at the billed amount up to the fee schedule amount noted. Note: CCN-P must pay for all costs associated with an inpatient hospital stay that does not have a primary BH diagnosis.	Inpatient

Section 5.2: Psychiatric Residential Treatment Facility (PRTF)

Definition

Psychiatric Residential Treatment Facilities are required to ensure that all medical, psychological, social, behavioral and developmental aspects of the recipient's situation are assessed and that treatment for those needs are reflected in the POC per 42 CFR 441.155. In addition, the PRTF must ensure that the resident receives all treatment needed for those identified needs. In addition to services provided by and in the facility, when they can be reasonably anticipated on the active treatment plan, the PRTF must ensure that the resident receives all treatment identified on the active treatment plan and any other medically necessary care required for all medical, psychological, social, behavioral and developmental aspects of the recipient's situation. The facility must provide treatment meeting State regulations per LAC 48:I. Chapter 90.
Services must meet active treatment requirements, which mean implementation of a professionally developed and supervised individual POC that is developed and implemented no later than 72 hours after admission and designed to achieve the recipient's discharge from inpatient status at the earliest possible time. “Individual POC” means a written plan developed for each recipient to improve his condition to the extent that inpatient care is no longer necessary. The POC must:

- Be based on a diagnostic evaluation conducted within the first 24 hours of admission in consultation with the child and the parents/legal guardian that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.
- Be developed by a team of professionals specified under §441.156 in consultation with the child and the parents, legal guardians or others in whose care the child will be released after discharge.
- State treatment objectives.
- Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives.
- Include, at an appropriate time, post-discharge plans and coordination of inpatient services, with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

The plan must be reviewed as needed or at a minimum of every thirty days by the facility treatment team to:
- Determine that services being provided are or were required on an inpatient basis.
- Recommend changes in the plan, as indicated by the recipient's overall adjustment as an inpatient.

The facility treatment team develops and reviews the individual POC. The individual POC must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to, patients in the facility. The individual POC must be based on education and experience, preferably including competence in child psychiatry. The team must be capable of:

- Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities and personal strengths and liabilities in accord with the POC development requirements above.
- Assessing the potential resources of the recipient's family.
- Setting treatment objectives in accord with the requirements above.
- Prescribing therapeutic modalities to achieve the plan's objectives.

Per federal regulations at 42 CFR 441.156 and state regulations at LAC 48:I.Chapter 90.9083.C. The team must include, as a minimum, either:
- A board-eligible or board-certified psychiatrist.
- A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy.
- A physician licensed to practice medicine or osteopathy, with specialized training and experience in the

diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association. Note: Louisiana does not consider individuals with a master's degree in clinical psychology to practice and be considered "psychologists". Facilities wishing to utilize this option under federal and state regulations must ensure that State psychology scope of practice is followed. In this case it would mean that the psychologist must be a licensed or medical psychologist.

The team must also include one of the following:

- A psychiatric social worker.
- A RN with specialized training or one year's experience in treating mentally ill individuals.
- An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals.
- A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association. Note: Louisiana does not consider individuals with a master's degree in clinical psychology to practice and be considered "psychologists". Facilities wishing to utilize this option under federal and state regulations must ensure that State psychology scope of practice is followed. In this case it would mean that the psychologist must be a licensed or medical psychologist.

In all cases, it is preferred that team members also have experience treating children and adolescents.

Because the PRTF is not in itself a specific research-based model, it must instead incorporate research-based models developed for a broader array of settings that respond to the specific presenting problems of the clients served. Each PRTF program should incorporate appropriate research-based programming for both treatment planning and service delivery.

For milieu management, all programs should also incorporate some form of research-based, trauma-informed programming and training, if the primary research-based treatment model used by the program does not (e.g., LAMod). Annually, facilities must submit documentation demonstrating compliance with at least two EBP fidelity monitoring or ASAM criteria. The State must approve the auditing body providing the EBP/ASAM fidelity monitoring. PRTF may specialize and provide care for sex offenders, substance abuse or individuals with co-occurring disorders. If a program provides care to any of these categories of youth, the program must submit documentation regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with the ASAM level of care being provided.

In addition, programs may propose other models, citing the research base that supports use of that model with the target population (e.g., gender-specific approaches). They may also work with the purveyors of research-based models to develop more tailored approaches, incorporating other models.

The specific research-based models to be used should be incorporated into the program description and submitted to the State for approval by the SMO, subject to OBH review. All research-based programming in PRTF settings must be approved by the State.

Staffing for the facility must be consistent with State licensure regulations on an FTE basis. For example, if State licensure requires a staff to client ratio of 1:25 and the facility has 16 child residents, then the facility must have at least .64 FTE for the 16 children. If the facility has eight beds, then the facility must have at least .32 FTE for the eight children.

Prior to admission, the SMO team, including a physician with competence in diagnosis and treatment of mental illness, preferably in child psychiatry and has knowledge of the individual's situation, must certify need that:

- Ambulatory care resources available in the community do not meet the treatment needs of the recipient
- Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the

direction of a physician

- The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed

Children/adolescents receiving services in a PRTF program must have access to education services, including supports to attend public school if possible, or in-house educational/vocational components if serving adolescents. Educational/vocational expenses are not Medicaid expenses. In addition, supports to attend public school outside of the PRTF are not considered activities provided by and in the PRTF and on the active treatment plan, and may not be reimbursed by Medicaid. However, supports to attend in-house education/vocational components may be reimbursed by the PRTF utilizing Medicaid funding to the extent that it is therapy to support education in a PRTF (e.g., OT, PT, ST. etc.). Medicaid funding for the education itself is not permitted. Medicaid will pay for the therapies associated with the education provided in-house while the child is in a PRTF.

Level III.7 Medically Monitored Intensive Residential Treatment – Adolescent

This COD residential treatment facility provides 24 hours of structured treatment activities per week including, but not limited to, psychiatric and substance use assessments, diagnosis treatment, habilitative and rehabilitation services to individuals with ICOPSD, whose disorders are of sufficient severity to require a residential level of care. All facilities are licensed by DHH.

It also provides a planned regiment of 24-hour professionally directed evaluation, observation and medical monitoring of addiction and mental health treatment in a residential setting. They feature permanent facilities, including residential beds, and function under a defined set of policies, procedures and clinical protocols. Appropriate for patients whose subacute biomedical and emotional, behavior or cognitive problems are so severe that they require co-occurring capable or enhanced residential treatment, but who do not need the full resources of an acute care general hospital. In addition to meeting integrated service criteria, COD treatment providers must have experience and preferably licensure and/or certification in both addictive disorders and mental health. Children/adolescents receiving services in a PRTF program must have access to education services, including supports to attend public school if possible, or in-house educational/vocational components if serving adolescents. Educational/vocational expenses are not Medicaid expenses. In addition, supports to attend public school outside of the PRTF are not considered activities provided by and in the PRTF and on the active treatment plan, and may not be reimbursed by Medicaid. However, supports to attend in-house education/vocational components may be reimbursed by the PRTF utilizing Medicaid funding to the extent that it is therapy to support education in a PRTF (e.g., OT, PT, ST. etc.). Medicaid funding for the education itself is not permitted. Medicaid will pay for the therapies associated with the education provided in-house while the child is in a PRTF.

Admission guidelines

Individuals in this level of care may have co-occurring addiction and mental health disorders that meet the eligibility criteria for placement in a co-occurring-capable program or difficulties with mood, behavior or cognition related to a substance use or mental disorder, or emotional behavioral or cognitive symptoms that are troublesome, but do not meet the DSM criteria for mental disorder.

1. Acute intoxication and/or withdrawal potential – None or minimal/stable withdrawal risk.

2. Biomedical conditions and complications – Moderate to severe conditions (which require 24-hour nursing and medical monitoring or active treatment but not the full resource of an acute care hospital).

3. Emotional, behavioral or cognitive conditions and complications – Moderate to severe conditions and complications (such as diagnosable co-morbid Axis I disorders or symptoms). These symptoms may not be severe enough to meet diagnostic criteria but interfere or distract from recovery efforts (for example, anxiety/hypomanic or depression and/or cognitive symptoms, which may include compulsive behaviors, suicidal or homicidal ideation, with a recent history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others) are interfering with abstinence, recovery and stability to such a degree that the individual needs a structured 24-hour, medically monitored (but not medically

managed) environment to address recovery efforts.

4. Readiness to change – Participant is in need of intensive motivating strategies, activities and processes available only in a 24-hour structured medically monitored setting (but not medically managed.)

5. Relapse, continued use or continued problem potential – Participant is experiencing an escalation of relapse behaviors and/or acute psychiatric crisis and/or reemergence of acute symptoms and is in need of 24-hour monitoring and structured support.

6. Recovery environment – Environment or current living arrangement is characterized by a high risk of initiation or repetition of physical, sexual or emotional abuse or substance use so endemic that the patient is assessed as unable to achieve or maintain recovery at a less intensive level or care.

Screening/assessment/treatment plan review:

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The SMO ensures that pre-certification requirements are met.

2. Comprehensive bio-psychosocial assessment completed within seven days, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional. The following sections must be completed prior to seven days of admission:
   a. Medical
   b. Psychological
   c. Alcohol
   d. Drug

3. An individualized, interdisciplinary treatment plan, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed in collaboration with the client.

4. The treatment plan is reviewed/updated in collaboration with the client, as needed, or at a minimum of every 30 days.

5. Discharge/transfer planning must begin at admission.

6. Referral arrangements made prior to discharge.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.

   Adolescent staffing patterns
   - MD, medical director – 0.5 FTE or 20 hours per week; 24-hour on-call availability
   - PCP – 15 hours per week; 24 hour on-call availability
   - Psychologist – 20 hours per week
   - Nurse (NP/RN or LPN) – one FTE NP/RN, with LPN required for first shift, with one backup LPN, two LPNs on second shift, and one RN/LPN required for third shift; RN supervisor or NP on call
   - Licensed or certified clinician or counselor with direct supervision – one clinician per eight clients
   - Psychiatric aid – ration 1:5 PAs/therapeutic guards on first and second shift, and 1:10 ratio on third shift
   - Clerical support staff – two FTE per day shift
   - Activity/occupational therapist – one FTE
   - Care coordinator – one FTE
   - Outreach worker/peer mentor – Optional

2. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

3. Qualified professional – Available 40 hours per week.

Level III.7D Medically Monitored Residential Detoxification - Adolescent

Medically monitored residential detoxification is an organized service delivered by medical and nursing professionals, which is provided for 24-hour medically supervised evaluation under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. All facilities are licensed by DHH. Children/adolescents receiving services in a PRTF program must have access to education services, including supports to attend public school if possible, or in-house educational/vocational components if serving adolescents. Educational/vocational expenses are not Medicaid expenses. In addition, supports to attend public school outside of the PRTF are not considered activities provided by and in the PRTF and on the active treatment plan, and may not be reimbursed by Medicaid. However, supports to attend in-house education/vocational components may be reimbursed by the PRTF utilizing Medicaid funding to the extent that it is therapy to support education in a PRTF (e.g., OT, PT, ST. etc.). Medicaid funding for the education itself is not permitted. Medicaid will pay for the therapies associated with the education provided in-house while the child is in a PRTF.

This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. It sometimes is provided by overlapping with Level IV-D services (as a “step-down” service) in a specialty unit of an acute care general or psychiatric hospital. Twenty-four hour observation, monitoring and treatment are available.

Admission guidelines

Provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. It sometimes is provided as a “step-down” service from a specialty unit of an acute care general or psychiatric hospital. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary.

Screening/assessments/treatment plan review

1. Triage screening to determine eligibility and appropriateness (proper patient placement) for admission and referral. The SMO ensures that pre-certification requirements are met.

2. Approval of admission by a physician. A physical examination by a physician, PA or NP within 24 hours of admission, and appropriate laboratory and toxicology tests. A physical examination conducted within 24 hours prior to admission may be used if reviewed and approved by the admitting physician.

3. Comprehensive bio-psychosocial assessment completed within seven days of admission, which substantiates appropriate patient placement. The assessment must be reviewed and signed by a qualified professional (exclusions: detoxification programs are not required to complete a psychosocial assessment but must screen for proper patient placement and referral). An individualized, interdisciplinary stabilization/treatment plan should be developed in collaboration with the client, including problem identification in ASAM Dimensions 2-6.

4. Discharge/transfer planning must begin at admission.

5. Referral arrangements made, as needed.

6. Daily assessment of client’s progress, which should be documented accordingly.

Staffing

1. Facility shall have qualified professional medical, nursing and other support staff necessary to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program.
   a. Physician (MD), medical director – 0.5 hour per resident per week, and available 24 hours on call

b. PCP – NA
c. Psychologist – NA
d. Nurse (NP/RN or LPN) – one FTE NP/RN, with LPN required for first shift, with one backup LPN, two LPNs on second shift, one required for the third shift, RN supervisor or NP on call
e. Licensed or certified clinician or counselor with direct supervision – one clinician per 10 clients and available 40 hours per week. A counselor is available 40 hours per week
f. Psychiatric aid – Two PAs on first and second shifts, and three on third shift
g. Clerical support staff – One to two FTE per day shift
h. Activity/occupational therapist – NA
i. Care coordinator – One FTE per day shift, and/or duties may be assumed by clinical staff
j. Outreach worker/peer mentor – Optional

2. Physicians, who are available 24 hours a day by telephone. (Or a PA NP or APRN, licensed as physician extenders, may perform duties designated by physician).

3. A physician is available to assess the individual within 24 hours of admission (or earlier, if medically necessary) and is available to provide on-site monitoring of care and further evaluation on a daily basis.

4. A RN or other licensed and credentialed nurse is available on-call 24 hours per day and on site no less than 40 hours per week and will conduct a nursing assessment on individuals at admission.

5. A nurse is responsible for overseeing the monitoring of the individual's progress and medication administration on an hourly basis, if needed.

6. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders. The level of nursing care is at a ratio of one nurse per every 15 individuals.

7. Licensed, certified or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care and treatment services for individuals and their families.

8. An interdisciplinary team of appropriately trained clinicians, such as physicians, nurses, counselors, social workers and psychologists is available to assess and treat the individual and to obtain and interpret information regarding the patient's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

9. A counselor is available on site 40 hours per week to provide direct client care, utilizing the 12 core functions of substance use counseling and/or specific functions related to professional license. Caseloads not to exceed 10 clients.

10. Qualified professional supervisor – Available for clinical supervision and by telephone for consultation.

Toxicology/drug screening
Medically monitored. Physician may waive drug screening if and when individual signs a list of drugs being abused and understands that his/her dishonesty could result in severe medical reactions during detoxification process.

Stabilization plan
Qualified professional shall identify the individual's short-term needs based on the detoxification history, the medical history and the physical examination, if available, and prepare a plan of action until individual becomes physically stable.

Detoxification/treatment plan
Medically monitored. The detoxification/treatment plan shall be reviewed and signed by the physician and the

individual and shall be filed in the individual's record within 24 hours of admission with updates, as needed.

Detoxification progress notes
The program shall implement the detoxification/treatment plan and document the individual's response to and/or participation in scheduled activities. Notes shall include:

- The individual's physical condition, including vital signs
- The individual's mood and behavior
- Statements about the individual's condition and needs
- Information about the individual's progress or lack of progress in relation to detoxification/treatment goals
- Additional notes shall be documented, as needed

Physicians' orders
Required for medical and psychiatric management.

I. Psychiatric Residential Treatment Facility Reimbursement

A. Covered inpatient PRTF activities for individuals under twenty-one years of age shall be reimbursed by Medicaid.

1. Free-standing PRTF services will be reimbursed using an interim Medicaid per diem reimbursement rate, which includes the following activities when provided by and in the PRTF when included on the patient's inpatient psychiatric active treatment plan of care:
   a. Occupational therapy/Physical therapy/Speech therapy
   b. Laboratory
   c. Transportation

2. For hospital-based Medicaid PRTF, the per diem rate will also include the following activities provided by and in the PRTF when included in the inpatient psychiatric active treatment plan of care:
   a. Dental
   b. Vision
   c. Diagnostics/radiology (x-ray)

B. Pharmaceuticals and physician activities provided to the youth in a PRTF, when provided by and in the PRTF and on the active treatment plan of care, are components of the Medicaid covered PRTF service. These activities will be paid directly to the treating pharmacy or physician, using Medicaid pharmacy and physician fee schedule rates excluded from the PRTF State of Louisiana interim Medicaid per diem reimbursement rates.

1. The interim Medicaid PRTF per diem reimbursement rates shall exclude such costs other than pharmaceutical and physician activities on the inpatient psychiatric active treatment plan unrelated to providing inpatient psychiatric care for individuals less than twenty-one years of age including, but not limited to, the following:
   a. Group education, including elementary and secondary education
   b. Medical services provided outside the PRTF
   c. Activities not on the inpatient psychiatric active treatment plan

II. In-State Publicly Owned and Operated Psychiatric Residential Treatment Facility Reimbursement Rates

A. Publicly owned and operated PRTFs will be reimbursed for all reasonable and necessary costs of operation. These PRTFs will receive a State of Louisiana interim Medicaid per diem reimbursement rate for activities provided in and by the facility on the active treatment plan. The interim rate will be subject to retroactive cost settlement in accordance with Medicare allowable cost principles contained in the Provider Reimbursement Manual CMS Publication 15-1.

III. In-State Privately Owned or Operated Psychiatric Residential Treatment Facility Reimbursement Rates

A. Medicaid certified providers will be reimbursed for covered PRTF services using an interim Medicaid per diem reimbursement rate consistent with the principles in section I above. The interim Medicaid per diem reimbursement rate paid to the provider will be determined by the following ownership and service criteria:

1. Free-standing privately owned and operated PRTF specializing in sexually-based treatment programs.

2. Free-standing privately owned and operated PRTF specializing in substance abuse treatment programs.

3. Hospital-based privately owned or operated PRTF specializing in sexually-based treatment programs.

4. Hospital-based privately owned or operated PRTF specializing in substance abuse treatment programs.

B. Retroactive Adjustment to Interim Rates (cost sharing): In-state privately owned and operated PRTFs providing covered services will be subject to retrospective rate adjustments. This process is part of a transitional plan to include these PRTF services within the Medicaid program. The retrospective rate adjustments will be determined as follows:

1. The facilities allowable per diem cost will be determined from the Medicaid cost report submitted in accordance with subsection V cost reporting requirements. The provider will receive a retrospective rate adjustment equal to 50% of the difference between the actual Medicaid allowable per diem cost and the interim Medicaid per diem reimbursement rate for each covered PRTF patient day.

2. The retrospective rate adjustment will not recognize provider allowable cost beyond the threshold of 125% of the per diem interim reimbursement amount paid during each fiscal year. For example, if the interim Medicaid per diem reimbursement rate is $200, the maximum allowable cost recognized for retrospective rate payments would be $250.

IV. Out-of-State Psychiatric Residential Treatment Facility Reimbursement Rates

A. Out of state psychiatric residential treatment facilities will be reimbursed the lesser of their specific in-state PRTF interim Medicaid per diem reimbursement rate, or 95% of the Louisiana interim Medicaid per diem reimbursement rate as detailed in section III above. The out-of-state PRTF will not be subject to retroactive cost adjustments, or the PRTF cost reporting requirements detailed in Section V below.

V. Psychiatric Residential Treatment Facility (PRTF) Cost Reports

A. All in-state Medicaid-participating psychiatric residential treatment facility providers are required to file an annual Medicaid cost report. The required cost reporting period must correspond to a calendar year basis of January 1 through December 31 for all PRTF providers.

B. All providers shall submit the uniform cost report form prescribed by the Department on an annual basis. Financial information shall be based on the provider's financial records. When records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting.

C. Cost reports shall be submitted on or before the last day of the fifth month after the end of the

provider's fiscal year end.

D. Separate cost reports must be submitted by central/home offices when costs of the central/home office are reported in the PRTF provider's cost report.

E. Failure to maintain records to support the cost report or failure to file a timely cost report may result in penalties determined solely by DHH as described below. Only those costs that are reported, documented and allowable per the Medicare and Medicaid provider reimbursement manual will be recognized as cost by DHH.

F. All cost reports may be subject to an audit or desk review by the DHH audit contractor.

G. If the PRTF provider experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension request must be submitted to DHH prior to the cost report due date. A facility filing a reasonable extension request will be granted an additional 30 days to file their cost reports.

VI. New Psychiatric Residential Treatment Facilities and Change of Ownership of Existing Facilities

A. Changes of ownership exist if the beds of a new owner have previously been certified to participate in the Medicaid program under the previous owner's provider agreement. The acceptance of a CHOW will be determined solely by DHH. Reimbursement will continue to be based on the interim Medicaid per diem reimbursement rate. The rate adjustment process will be determined using the previous owner's cost report information for the applicable time periods.

B. New providers are those entities whose beds have not previously been certified to participate in the Medicaid program. New providers will be reimbursed depending on provider type, in accordance with the PRTF Section II, III, or IV of the State Plan.

VII. Initial and On-going PRTF Rate Setting Methodology:

A. Per diem PRTF rates will be developed as follows:

1. Comparable PRTF rates from other Medicaid programs will be examined.

2. These rates will be adjusted for cost of living variances between Louisiana and the state from which they came.

3. The adjusted rates will be indexed (inflated using the inflation factor) from the home state's rate effective date to March 1, 2012.

4. These rates will then be averaged, or other measures of central tendency will calculated.

5. The rate may be further adjusted to reflect ownership cost variances anticipated or to recognize PRTF specialization. Additional adjustment to the average rates may be made as deemed necessary by DHH.

6. The initial rates will be subject to the retrospective rate adjustment provision contained in Subsection III to mitigate financial risk for both the Medicaid program and its PRTF providers.

B. The Louisiana Medicaid program will collect cost information from providers participating in the PRTF program as indicated in Subsection V. This cost information will be utilized to monitor PRTF rates to ensure the Medicaid per diem reimbursement rates continue to be adequate to attract provider participation in the program, while also ensuring that rates are not excessive.

Provider Qualifications	Eligibility Criteria
Licensed as a PRTF by DHH per LAC 48:I.Chapter 90. The PRTF must be physician directed and meet the requirements of 42 CFR 441.151, including requirements referenced therein to 42 CFR 483 subpart G. The psychiatric facility must be accredited by: • The Joint Commission on the Accreditation of Health Care Organizations • The Council on Accreditation for Children and Family Services • The Commission on Accreditation of Rehabilitation Facilities For inpatient levels of care, a staffing ratio of 1:4 during awake hours (day and evening shifts) is typical, with an emphasis on nursing staff. The Joint Commission does not specify a ratio for adolescent residential treatment. Research and clinical experience regarding therapeutically effective residential care established the 1:4 ratio for mental health workers, as a minimum, in addition to a 1:6 requirement for mental health professionals. MMIS allowed provider types and specialties: • PT 96 Psychiatric Residential Treatment Facility, PS 9B Psychiatric Residential Treatment Facility, • PS FY PRCS Addiction Disorder • PS 8L Hospital Based PRTF, • PS 8P PRTF Other specialization (other than Addiction Disorder	Children under age 21, pre-certified by an independent team employed by the SMO, where: 1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient. 2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. 3. The services can be reasonably expected to improve the recipient's condition or prevent further regression, so that the services will no longer be needed. The independent SMO team pre-certifying the PRTF stay must: 1. Include a physician. 2. Have competence in diagnosis and treatment of mental illness, preferably in child psychiatry. 3. Have knowledge of the individual's situation.

Limitations/Exclusions	Allowed Mode(s) of Delivery
The facility must comply with seclusion and restraint requirements found at LAC 48:I.Chapter 90 and 42 CFR 483 subpart G. *Reasonable activities* includes PRTF treatment provided by and in the facility when it was found, during the initial evaluation or subsequent reviews, to be treatment necessary to address a medical, psychological, social, behavioral or developmental aspect of the child's care per 42 CFR 441.155. The PRTF reasonable activities are child-specific and must be necessary for the health and maintenance of health of the child while he or she is a resident of the facility. The medically necessary care must constitute a need that contributes to the inpatient treatment of the child and is dependent upon the expected length of stay of the particular child in that facility (e.g., dental hygiene may be necessary for a child expected to reside in the facility for 12 months but not 30 days).	On-site

Additional Service Criteria
Services for Medicaid-eligible residents not provided by and in the facility and reflected on the active treatment plan are not reimbursable by Medicaid.

Chapter 6: Outpatient Therapy by Licensed Practitioners

Outpatient Therapy Services by Licensed Practitioners

Section 6.1: Other Licensed Practitioner Outpatient Therapy

Definition	
Individual, family, group outpatient psychotherapy and mental health assessment, evaluation and testing.	
Provider Qualifications	**Eligibility Criteria**
A licensed mental health practitioner is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance abuse, acting within the scope of all applicable State laws and their professional license. A LMHP includes individuals licensed to practice independently: • Medical psychologists • Licensed psychologists • Licensed clinical social workers • Licensed professional counselors • Licensed marriage and family therapists • Licensed addiction counselors • Advanced practice registered nurses – must be a nurse practitioner specialist in adult psychiatric and mental health, and family psychiatric and mental health, or a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health and child-adolescent mental health and may practice to the extent that services are within the APRN's scope of practice Note: Psychiatrists are covered under the physician section of the State plan. However, psychiatrists often are employed by agencies that employ other licensed practitioners. For ease of reference, psychiatrist codes often billed under agencies are included in this section of the provider manual. However, psychiatrists may bill any codes under the physician section of the State Plan for which he or she may be qualified. Note that prior authorization or authorization beyond an initial authorization level of benefit is not a required CMS element for psychiatrist services under the Louisiana State Plan; however, the Statewide Management Organization may choose to require prior authorization for psychiatrist services or may prior authorize psychiatrist services beyond an initial authorization level of benefit at their option. In general the following MMIS provider types and specialties may bill these codes according to the scope of practice outlined under State Law. The specific provider types and specialties are permitted to bill each code is noted in the Excel rate sheet. • MMIS PT 77 Mental Health Rehab PS 78 MHR • MMIS PT 74 Mental Health Clinic PS 70 Clinic / Group • MMIS PT 70 EPSDT (School Board) PS 44 Public Health • MMIS PT 18 Community Mental Health Center PS 5H CMHC	All Medicaid-eligible children who meet medical necessity criteria. All Medicaid-eligible adults meeting 1915(i) coverage. All non-Medicaid-eligible children who are eligible to receive services through the OJJ, DCFS and the OBH.

• MMIS PT 31 Psychologist State Plan Services (EPSDT and 1915(i)) PS
  o 62 Cross-Over Program Only
  o 95 PBS Program Only
  ▪ Subspecialty
  ▪ 6A Psychologist - Clinical
  ▪ 6B Psychologist - Counseling
  ▪ 6C Psychologist - School
  ▪ 6D Psychologist - Developmental
  ▪ 6E Psychologist - Non-declared
  ▪ 6F Psychologist - All Other
  o 96 Both Cross-Over and PBS Programs
  ▪ Subspecialty
  ▪ 6A Psychologist - Clinical
  ▪ 6B Psychologist – Counseling
  ▪ 6C Psychologist - School
  ▪ 6D Psychologist - Developmental
  ▪ 6E Psychologist - Non-declared
  ▪ 6F Psychologist - All Other
• MMIS PT AG Behavioral Health Rehabilitation Provider Agency PS 8E CSoC/ Behavioral Health
• MMIS PT 68 Substance Abuse and Alcohol Abuse Center PS 70 Clinic / Group
• MMIS PT 38 School Based Health Center PS 70 Clinic / Group
• MMIS PT 73 Social Worker (Licensed/Clinical) PS 73 Social Worker
• MMIS PT AK Licensed Professional Counselor (LPC) State Plan Services (EPSDT and 1915(i)) PS 56 LPC
• MMIS PT AH Licensed Marriage & Family Therapists (LMFT) State Plan Services (EPSDT and 1915(i)) PS 8A
• MMIS PT AG Behavioral Health Rehabilitation Agency (Atypical) State Plan Services (EPSDT and 1915(i)) PS 8E CSoC/ Behavioral Health
• MMIS PT 19 or 20 Physician	

Limitations/Exclusions	**Allowed Mode(s) of Delivery**
Providers cannot provide services or supervision under this section if they are a provider who is excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. In addition, they may not be debarred, suspended or otherwise excluded from participating in procurement activities under the State and federal laws, regulations and policies, including the federal Acquisition Regulation, Executive Order No.12549 and Executive Order No. 12549. In addition, providers who are an affiliate, as defined in the federal Acquisition Regulation, of a person excluded, debarred, suspended or otherwise excluded under State and federal laws, regulations and policies may not participate.	• Individual • Family • Group • On-site • Off-site • Tele-video

All services must be authorized. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery. The SMO is required to have initial authorization limits for all psychological testing not to exceed six hours annually. All neuropsychological testing must be prior authorized. Service providers that offer addiction services must demonstrate competency, as defined by the DHH, State law (Act 803 of the Regular Legislative Session 2004) and regulations. Anyone providing addiction or behavioral health services must be certified by the DHH, in addition to their scope of practice license. LMFTs and LACs are not permitted to diagnose under their scope of practice under State law. LPCs are limited to rendering or offering prevention, assessment, diagnosis and treatment of mental, emotional, behavioral, and addiction disorders requiring mental health counseling in accordance with scope of practice under state law found in La. Revised Statute 37:1103 et seq. LPCs can diagnose, assess, treat, etc., as long as they comply with Act 320, which requires ongoing treatment and consultation with either an MD or medical psychologist, etc. LMFTs may provide professional marriage and family therapy services, meaning LMFTs can assess, treat, provide psychotherapy, etc. but only while rendering professional marriage and family therapy services. LMFTs and LPCs may not provide interpretation of medical tests or pharmacological monitoring. Per the State's practice act and consistent with State Medicaid regulation, medical and licensed psychologists may supervise up to two unlicensed assistants or post-doctoral individuals in supervision for licensure. LMFTs may practice and provide marriage and family therapy, etc. – Individual, group, family therapy allowed; assessment is permitted as well, but all treatment is restricted to marriage and family therapy issues. LMFTs and LACs are not permitted to render diagnosis of mental, emotional or addictive disorders but may perform assessments within their scope of practice. Commensurate with R.S. Title 37, Chapter 13, 37 and Act No 320, LPCs may render or offer prevention, assessment, diagnosis and treatment, which includes psychotherapy of mental, emotional, behavioral and addiction disorders to individuals, groups and organizations, which is consistent with their professional training. In accord with Act 320, LPCs are not authorized to assess, diagnose or provide treatment to any individual suffering from the serious mental illnesses listed below, unless that individual is under the active care of a practitioner who is licensed by the Louisiana State Board of Medical Examiners and is authorized	

to prescribe medications in the management of psychiatric illness, and only in the context of ongoing consultation and collaboration with that practitioner. Serious mental illness as referenced in this section include, *but are not limited to,* the following: a. Schizophrenia or schizoaffective disorder b. Bipolar disorder c. Panic disorder d. Obsessive-compulsive disorder e. Major depressive disorder f. Anorexia/bulimia g. Intermittent explosive disorder h. Autism i. Psychosis NOS, when diagnosed in a child under seventeen years of age j. Rett's disorder k. Tourette's disorder l. Dementia LMFTs may practice and provide marriage and family therapy, including the application of psychotherapeutic and family systems theories and techniques in the assessment and treatment of individuals and families, while rendering professional marriage and family therapy services to individuals, couples and families, singly or in groups. APRN: Collaborative Practice Agreement required. APRNs have certified nurse specializations as specified in the authorities' documents (this specialization is not needed for E&M codes 99201-99215 and 99499). APRN with collaborative Practice Agreements and appropriate specialty training may provide 90201-99205, 90805, 90807 and 90809. Inpatient hospital visits are limited to those ordered by the individual's physician. Visits to nursing facilities are allowed for psychologists, if a pre-admission screening and resident review indicates it is medically necessary treatment. Social worker visits are included in the nursing visit and may not be billed separately. Visits to intermediate care facilities for the mentally retarded are not covered. All LMHP services provided while a person is a resident of an institute for mental disease, such as a free-standing psychiatric hospital or psychiatric residential treatment facility, are the content of the institutional service and not otherwise reimbursable by Medicaid. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis, as determined necessary by the Department of Health and Hospitals. A unit of service is defined according to the Health Care Financing Administration common procedure coding system approved code set, unless otherwise specified. Psychiatrists are included in the Other Licensed Practitioner (OLP) Section of the Service Manual as well as being listed	

under Physician in the Physician Section. This repetition is to make it clear that agencies, such as clinics, may bill on behalf of the physicians, including psychiatrists employed or contracting with them. Services provided by psychiatrists are technically covered under the physician section of the Medicaid State Plan.	

Additional Service Criteria

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

All services below have an initial authorization level of benefit. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery:

- Admission evaluation is authorized for five evaluations per calendar year.
- Individual therapy is authorized for 32 hours per calendar year.
- Family therapy is authorized for 40 hours per calendar year.
- Group therapy is authorized for 24 hours per calendar year.
- Psychological testing is authorized for six hours per calendar year.

Face-to-face for OLP includes a therapist in a different room/location from the client/family, but in the same building, with real-time visual and audio transmission from the therapy room and two-way audio transmission between client and/or family member and therapist. If the therapist is working with a single client/family, then family or individual therapy requirements and reimbursement would apply. If the therapist is working with more than one client/family, group therapy requirements and reimbursement would apply. Must be provided by licensed or qualified MA-level staff. MA-level staff must have appropriate oversight when providing treatment through real-time visual and audio transmission. The practice must be in accord with documented EBPs or promising practices approved by OBH (or the SMO). If not in the same building, then telemedicine requirements and reimbursement would apply.

Billing CPT codes with "interactive in their description are used most frequently with kids who do not have the capacity to verbalize complex concepts. However, for adults who, due to injury or disability, have impairments in the ability to communicate verbally, these codes may also be utilized.

Additional information for licensed practitioners who are employees of local education agencies (LEAs) and performing services on a child's individualized education program (IEP).

Medicaid behavioral health services provided in schools are services that are medically necessary and provided in schools to Medicaid recipients in accordance with an IEP. Covered services include the following: school-based health services, including covered behavioral health services, treatment and other measures to correct or ameliorate an identified mental health or substance abuse diagnosis. Services are provided by or through a LEA to children with, or suspected of having, disabilities, who attend public school in Louisiana. These services are not covered if they are performed for educational purposes (e.g., academic testing) or, as the result of the assessment and evaluation, it is determined the service is not reflected in the IEP. Services must be performed by qualified providers as set forth in this SPA and who provide these services as part of their respective area of practice (e.g., psychologist providing a behavioral health evaluation).

Service Limitations:
Services provided in a school setting will only be reimbursed for recipients who are at least three years of age and under 21 years of age and have been determined eligible for Title XIX and IDEA Part B services with a written service plan (an IEP) which contains medically necessary services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under

State law. Medicaid covers §1905(a) medical services addressed in the IEP that are medically necessary and that correct or ameliorate a child's health condition. Medicaid does not reimburse for social or educational needs or habilitative services. Medicaid covered services are provided in accordance with the established service limitations. A LEA may employ these licensed behavioral health practitioners if requirements under the IDEA are met. Individual practitioner requirements for the Medicaid qualifications and Department of Education Bulletin 746, Louisiana Standards for State Certification of School Personnel, must be met prior to a LEA billing for any services of a clinician under Medicaid.

LMHP 42 CFR 440.60 – Other Licensed Practitioners:
The following providers may provide behavioral health services in schools under IEPs under the EPSDT-other licensed practitioners, in Attachment 3.1-A, Item 4.b.

A LMHP is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance abuse, acting within the scope of all applicable State laws and their professional license. A LMHP includes individuals licensed to practice independently:

- Medical psychologists
- Licensed psychologists
- LCSWs
- LPCs
- LMFTs
- LACs

Rate Methodologies in the SPA are as follows and are listed in the Excel portion of the Service manual in this order:

Provider Type	Percent of Louisiana Medicaid Physician Fee Schedule	Rate
Physician	100%	$109.97
Psychologists and APRNs	80%	$ 87.97
LCSW, LPC, LMFT, LAC, BH Other, LEA Other	70%	$ 76.97

Telemedicine:
Consultations, office visits, individual psychotherapy and pharmacological management services may be reimbursed when provided via telecommunication technology. The consulting or expert provider must bill the procedure code (CPT codes) using the GT modifier and will be reimbursed at the same rate as a face-to-face service. The originating site, with the consumer present, may bill code Q3014 (telemedicine originating site facility fee).

Section 6.2: Medical, Physician/Psychiatrist, Outpatient Medical Services

Definition	
Medication management, psychiatric evaluation, medication administration, individual therapy with medical evaluation and management and case consultation.	
Provider Qualifications	**Eligibility Criteria**
Physician, psychiatrist or PA working under protocol of a psychiatrist. Registered nurse working within the scope of practice. If an ARNP is working under protocol of a physician and not individually enrolled in Medicaid for the E&M codes only, then the codes listed below would apply to the same extent that an RN or PA may bill and would bill at 80% of the physician payment if permitted under scope of practice. Individually enrolled APRNs should see the other licensed practitioner section. Collaborative Practice Agreement required. APRNs have certified nurse specializations as specified in the authorities' documents (this specialization is not needed for E&M codes 99201-99215 and 99499). APRN with collaborative Practice Agreements and appropriate specialty training, may provide 90201-99205; 90805, 90807, and 90809. MMIS allowed provider types and specialties: • MMIS PT 19 or 20 Physician	All Medicaid-eligible individuals who meet medical necessity criteria. All non-Medicaid-eligible children who are eligible to receive services through OJJ, DCFS and OBH.
Limitations/Exclusions	**Allowed Mode(s) of Delivery**
All services below have an initial authorization level of benefit. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery. Psychiatrists will bill the SMO. Physicians in PCP offices will bill CCN-P directly for CCN-P enrollees or the Medicaid Management Information System for FFS enrollees. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) bill CCN for CCN enrollees only and will otherwise bill the SMO for SMO enrollees' behavioral health care. The SMO will call the State Medicaid manager for FQHCs and RHCs to obtain the facility-specific rates for FQHCs and RHCs. All costs for primary care provider visits for Medicaid enrollees with a primary diagnosis of behavioral health are excluded from the behavioral health program and in the FFS program (unless provided to a CCN-P enrollee). The following services for Medicaid managed care enrollees in MCOs (e.g., CCN-P) will be excluded from the behavioral health program and included in the MCO prepaid rates: • Acute detoxification (revenue codes of 116, 126, 136, 146, 156, as well as 202 and 204, with DT diagnoses to accommodate for DT) • Mental health services provided in a medical (physical health)	• Individual • On-site • Off-site • Tele-video

Medicaid MCO member's PCP or medical office (i.e., physician, Doctor of Osteopathic Medicine or RHC, other than services provided by a psychiatrist) • Mental health services provided in a FQHC • Emergency room services, except services provided to members with primary codes of 290 through 319 For non-MCO enrollees, all mental health and substance abuse inpatient services (with a primary BH diagnosis), psychiatrist and outpatient hospital services (with a primary BH diagnosis), are included in this program for members of the prepaid inpatient health plan.	
Additional Service Criteria	
Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's medical record. Billing CPT codes with "interactive in their description are used most frequently with kids who do not have the capacity to verbalize complex concepts. However, for adults who, due to injury or disability, have impairments in the ability to communicate verbally, these codes may also be utilized.	

Section 6.3: Behavioral Health in a FQHC

Definition	
Behavioral health services for non-Community Care Network Medicaid enrollee in a FQHC.	
Provider Qualifications	**Eligibility Criteria**
Any behavioral health service for a non-CCN-P Medicaid enrollee in a FQHC. Medicaid enrollees enrolled in a CCN-P plan will receive FQHC services through the CCN-P. MMIS allowed provider types and specialties: • PT 72 FQHC	All Medicaid-eligible adults and children who meet medical necessity criteria. All non-Medicaid eligible children who are eligible to receive services through OJJ, DCFS and OBH.
Limitations/Exclusions	**Allowed Mode(s) of Delivery**
Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) bill CCN for CCN enrollees only and will otherwise bill the SMO for SMO enrollees' behavioral health care. The SMO will call the State Medicaid manager for FQHCs to obtain the facility-specific rates for FQHCs.	• Individual • Family • Group • On-site • Off-site • Tele-video

Addenda

Addendum A: Medicaid medical necessity definition and EPSDT exceptions policy

RULE: DHH Bureau of Health Services Financing (BHSF)
Louisiana Register Vol. 37, No. 01 341 *January 20, 2011*

Medical Necessity Criteria (LAC 50:I.1101)

Editor's note: This Rule is being repromulgated to correct a typographical error. The original rule may be viewed in its entirety on pages 2563-2564 of the November 20, 2010 edition of the *Louisiana Register*.

The DHH BHSF has adopted LAC 50:I.Chapter 11in the Medical Assistance program, as authorized by R.S.36:254, and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50
PUBLIC HEALTH MEDICAL ASSISTANCE
Part I. Administration
Subpart 1. General Provisions
Chapter 11. Medical Necessity
§1101. Definition and Criteria

A. Medically necessary services are defined as those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

B. In order to be considered medically necessary, services must be:

   (1) Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction.

   (2) Those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient.

C. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and neither more nor less than what the recipient requires at that specific point in time.

D. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary".

The Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his discretion on a case-by-case basis.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and Title XIX of the Social Security Act.
HISTORICAL NOTE: Promulgated by the DHH BHSF, Louisiana Rule (LR) 36:2563 (November 2010), repromulgated LR 37:341 (January 2011). 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.

Bruce D. Greenstein
Secretary
1101#087

Procedure for non-covered EPSDT service identified as medically necessary for a CFT

For a non-covered service in the Louisiana State Plan:

1. As much information regarding the recipient is gathered, including age, diagnosis, condition and medical records relative to the service being requested.

2. Information regarding the provider, enrollment status and qualifications for rendering service, as appropriate, is gathered.

3. Information regarding the requested service is gathered. This information would include, but not be limited to, reasons/policy for non-coverage, applicable rules and SPA, alternative services, etc. All supporting information for coverage and medical necessity in individual cases is gathered.

4. This information is presented to the Medicaid medical director.

5. The Medicaid medical director reviews as much information on the recipient as possible, the prospective provider and the requested service, to determine if the service being requested is medically necessary, if other possible treatment options exist and/or if there are rules, SPA or federal regulations impacting coverage decision.

6. If approved for medical necessity, then a determination of availability of federal financial participation (FFP) is made. If FFP is not available due to federal regulations, then a recommendation for coverage and a request to pay out of all State funds is forwarded for approval to the Medicaid director. If the service is determined medically necessary, but is investigational or experimental, then recommendation is sent to the medical director for consideration of final approval and appropriate match rate.

7. The payment of authorized services that are normally not a Medicaid-covered benefit are specially handled through the system to ensure payment for the specified recipient occurs and no other non-intended recipients' services are paid. The SMO will submit an invoice, including the approved EPSDT exceptions and supporting encounter data for the claims for the EPSDT with an EP modifier. The Medicaid Management Information Systems (MMIS) will accept all encounters with an EP modifier but will create a report for the State to do 100% verification reviews for audit purposes. Reimbursement for any inappropriately approved EPSDT exceptions will be recouped from the SMO and provider by the State.

   EP modifier – Service provided as part of Medicaid EPSDT program.

Addendum B: Therapeutic foster care and non-medical group homes (only service components listed are Medicaid reimbursable)

Therapeutic foster care (Only service components listed are Medicaid reimbursable):

Therapeutic foster care (TFC) services are defined as community-based surrogate family services provided to children living in foster care, who require an intensive period of treatment. TFC services work in partnership with the child, the child's family and other persons identified by the family, Child and Family Team, and placing agency towards the goals outlined in the family's and/or child's plan of care. TFC services allow the child to benefit from a home environment and community-based setting while receiving additional intensive treatment and clinical services, as needed. Children are assessed to need this level of placement through a CANS screening that demonstrates TFC is a sufficient level and regular basic foster care is not a sufficient level. Children in this program are placed in foster families (one or two children per family), whose members are trained and can provide a structured environment in which participants can learn social, and display age appropriate, emotional skills.

The primary goal of TFC service is to decrease problem behavior and to increase developmentally appropriate normative and pro-social behavior in children and adolescents who are in need of out-of-home placement in order to facilitate a permanent placement or less restrictive family placement upon discharge from TFC. TFC treatment goals are accomplished by providing children whose special needs can be met in a therapeutic family setting, with close supervision, fair and consistent limits, and predictable consequences for rule breaking, a supportive relationship with at least one mentoring adult and reduced exposure to peers with similar problems. TFC intervention is multi-faceted and occurs in multiple settings. TFC services are a blend of natural and community supports, TFC agency provided services, department provided services, and Medicaid provided services. Both the TFC Intervention and other Services are decided upon through the Child and Family Team process.

Services Provided by Child Placing Agency as part of their non-Medicaid rate, including Board and Care

- Meet Louisiana child placing agencies licensing standards
- Behavioral parent training and support for TFC foster parents
- Recruit and certify highly skilled foster parents
- Siblings shall be placed together in TFC homes, if one of the children qualifies for TFC placement. If the other child does not qualify for TFC services, he/she shall receive the basic foster care board rate
- Respite and babysitting is coordinated by and often provided by Child Placing Agency.
- Recreation opportunities are provided to youth using community and natural supports. (Recreation reimbursable expenses are provided to children in accordance to department policy for specific child.)
- Transportation – the TFC foster parent is primarily responsible for the transportation needs of the child. Medicaid transportation is a resource for medical appointments. Home visits for children in DCFS and OJJ custody are the responsibility of the department. FC Foster parents are reimbursed mileage at state rate for allowable transportation. Special transportation circumstances (EX: high levels of transportation and out of town trips) are discussed and planned for through Child and Family Team process and/or with TFC agency or department staff for resolution.
- Basic Board and Care
- Supervision and support meetings to foster home and individual meetings with child are conducted at least as frequently as required by licensing regulations.
- Crisis Mental Health Support - TFC Agency staff provide telephone and/or in person response within 60 minutes to TFC parents when there is a mental health or other crisis.

Services Provided by community providers enrolled with the SMO and/or Child Placing Agency. (Child Placing Agency can be a community provider enrolled with the SMO.) Service may be billable by the SMO to Medicaid or to referring department/office.

- Family therapy is provided to child and biological parents utilizing licensed community providers enrolled with the SMO
- Individual therapy is provided to child utilizing licensed community providers enrolled with the SMO
- Group therapy is provided to child utilizing licensed community providers enrolled with the SMO
- Behavioral parent training for TFC foster parents specific to child's needs is provided to child utilizing licensed community providers enrolled with the SMO
- Skills training for children utilizing community practitioners enrolled with the SMO
- Supportive therapy for children utilizing licensed community providers enrolled with the SMO. (Placement in or discharge from a TFC home should not be cause to change from one community therapist to another when logistical issues can be worked out.)
- Crisis Intervention is provided to child utilizing licensed community providers enrolled with the SMO. (Services provided by LMHPs are billed separately.)
- TFC children identified as Special education students receive needed school-based behavioral interventions and academic supports, utilizing a school district providing services on an IEP. The child placing agency may collaboratively work with the school to provide needed school based services for child (General and/or Special Education) using community-based providers enrolled with the SMO.
- Psychiatric consultation and medication management, when needed, utilizing licensed community providers enrolled with the SMO
- Transportation to medical appointments is provided to youth utilizing licensed community providers enrolled with Medicaid transportation services.
- Respite, when needed, is provided to child and foster parents utilizing licensed community providers enrolled with the SMO. Respite services may be also be funded through the custodial agency. **Not sure how to word this.Karla and Melba will follow up on the issue of what respite services the departments want the TFC parent to have when not Medicaid billable respite. Amanda to follow-up on Medicaid acceptable reasons for respite, e.g. family death in TFC foster parent's family.**
- Age Appropriate Independent Living Services provided to all children through individual training by TFC agency through staff and/or foster parent. May also be provided utilizing licensed community providers enrolled with the SMO.
- Chafee Independent Living Services classes and training provided to all age appropriate youth in DCFS and OJJ custody through Chafee Independent Living Services providers contracted with DCFS. These are not Medicaid billable services.
- Case Management is provided to all TFC youth by the TFC agency staff managing all services, supports, education services and family contacts. We need follow-up as to whether these are Medicaid billable services. Can this include "utilizing licensed community providers enrolled with the SMO "
- TFC parents may provide coaching and modeling of parenting skills to parents of youth. We need follow-up as to whether these are Medicaid billable services. Can this include "utilizing licensed community providers enrolled with the SMO "
- Aftercare resources are provided to youth upon discharge from TFC Home utilizing licensed community providers enrolled with the SMO. These services will be planned through the Child and Family team process.

Non-Medical group home (only service components listed are Medicaid reimbursable) revisions:

Non-Medical group homes (NMGHs) are a residential setting for up to 16 beds. Children are placed in a NMGH when screened to need this level of care through the CANS. This basic type of placement should be limited to children whose needs cannot be met in their own home, foster home or children who have reached their treatment goals in a more restrictive setting and are ready to be "stepped down" into a lesser restrictive setting. Services provided in a group home setting must be provided by a community practitioner certified and credentialed by the SMO to provide those services. Children are assessed to need this level of placement through a CSoC screening tool that demonstrates NMGH is a sufficient level and regular basic foster care is not a sufficient level. Both the NMGH intervention and other services are decided upon through the Child and Family Team process (or SMO Care Management where wrap-around services are not available) and SMO authorization. The NMGH staff are required to participate in the Child and Family Team process. For the child entering placement, group home provides a chance to work on issues in a structured, safe and orderly environment. Group home care presents an opportunity to improve the safety, permanency and well-being of a child through a specialized offering of services that are flexible to meet the particular needs of a child and his or her family or other permanency resource.

Requirements for all NMGHs and basic group home sub-type:

- Be licensed by DCFS as a child residential facility for 16 or fewer beds
- All group homes and their agencies must meet and abide by federal IMD limitations on payment
- The basic level of care requires a setting, which provides room and board.
- NMGHs services and rates have no treatment component
- The facility provides an environment where treatment can be effective, but no treatment is provided by facility staff. The SMO will encourage effective milieu for this level of care, including reinforcement of skill building taught in treatment
- The NMGHs will coordinate and provide transportation and linkages to community providers enrolled with the SMO for behavioral health treatment of residents
- The NMGHs will coordinate and provide transportation and linkages to community providers enrolled with the SMO for physical health treatment of residents
- Basic group homes may have children that need BH care (BH diagnosis or psychotropic medications)
- Ensure that Crisis intervention (CI) is obtained, as needed
- Children living in basic group homes attend school in public school system
- Basic group home staff should have special training in working with at-risk children and in CI strategies
- The trained staff provides 24-hour supervision
- Shall participate in the OJJ service planning conference, DCFS family team conferences or WAA CFT to plan for the child and support the permanency goal of the child
- Services provided by community providers enrolled with the SMO within the residential setting shall be individualized, strength-based and culturally competent and guided by a service planning team that includes residential staff, community providers, natural supports, child and family (extended family, birth family, adoptive family, etc.) as appropriate. Goals in the service plan and services offered shall support timely movement through the continuum and DCFS permanency goals for the child (Service component outside NMGH fee)
- Shall support child's relationship with family through allowing in-person visits in the facility or contact via phone, mail, email, etc. or by providing the child transportation to attend scheduled visits with family members in accordance with the child's case plan
- Shall provide education and support to the child's parent(s) to develop parental capacity and to prepare them for resuming care of the child, as applicable, and as planned through the planning process

- Shall collaborate with providers of other services in the continuum, as well as community providers, to ensure transition through the continuum and linkage to community services to support permanency goals
- The need for NMGH Services offered to children and families shall be continually assessed for effectiveness no less than quarterly
- Shall make every effort to transport child back to school of origin, when determined appropriate by parent(s) or custodial agency
- Shall submit quarterly reports to the parent or custodial agency describing services provided by community providers during the months and the child's and provider's progress toward achieving the goals as outlined in the plan of care

Additional requirements for group home diagnostic centers/step-down:

- Meet all requirements for all NMGHs and Basic Group Home sub-types
- The diagnostic centers shall be used to provide intensive, short-term placement for children with a specific goal of a complete assessment of the child's and family's needs
- The diagnostic center will coordinate and provide transportation and linkages to community providers enrolled with the SMO for the full array of assessments needed for behavioral health, medical, social and developmental needs of residents
- The placement shall not exceed sixty (60) days
- The SMO will ensure that discharge planning shall begin at admission to ensure transition of the child prior to the 60-day timeline. Complete a discharge summary within 14 days for planned discharges or, immediately, for unplanned discharges

Additional requirements for mothers with infant group home:

- Meet all requirements for all NMGHs and basic group home sub-types
- This program provides a living arrangement for pregnant teenagers, which allows the young mother and her infant to remain in the placement after the birth of her child
- The program assists with care for the infant during the hours that the young mother is attending an educational/vocational program, developing her skills in parenting and preparing for independent living with the assistance of the provider
- The program design should accept pregnant mothers at any stage of pregnancy and provide services for a maximum of 18 months following the birth of the baby:
    - For infants in custody of DCFS, the regular board rate will be paid to the provider. For non-custody infants of a mother who is in foster care, the provider may receive a special board payment of up to $264 monthly (this payment is not eligible for the adult former foster children in the Young Adults Program)
- Shall ensure that the mother receives routine and emergency medical care, including pre-natal and post-natal care
- Shall provide assistance to the mother in arranging child care and other needed services for the infant
- Shall ensure that community providers provide group or individual counseling regarding decision making for the mother and her infant, responsibilities of parenthood and conflict resolution
- Transition planning to a permanent living arrangement for the child and baby shall begin within three months following the birth of the child
- Provider shall not be responsible for providing direct care services to the non-custody infant, other than supervision. Providers are responsible for ensuring that adequate care of infants is provided by their mother
- Transportation services are allowable, if the mother is present

Addendum C: Additional service criteria for EBPs

Assertive Community Treatment (ACT) service description and requirements
Service definition: ACT services are therapeutic interventions that address the functional problems of individuals who have the most complex and/or pervasive conditions associated with a major mental illness or co-occurring addictions disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the individual's ability to cope and relate to others and enhancing the highest level of functioning in the community.

Interventions may address adaptive and recovery skill areas, such as supportive or other types of housing, school and training opportunities, daily activities, health and safety, medication support, harm reduction, money management and entitlements and service planning and coordination.

a. The primary goals of the ACT program and treatment regimen are:

- To lessen or eliminate the debilitating symptoms of mental illness each individual consumer experiences and to minimize or prevent recurrent acute episodes of the illness
- To meet basic needs and enhance quality of life
- To improve functioning in adult social and employment roles and activities
- To increase community tenure
- To lessen the family's burden of providing care

b. The fundamental principles of this program are that:

- The ACT team is the primary provider of services and, as such, functions as the fixed point of responsibility for the consumer
- Services are provided in the community
- The services are person-centered and individualized to each particular person

Target population
ACT serves persons who have a SPMI listed in the diagnostic nomenclature (current diagnosis per DSM IV) that seriously impairs their functioning in the community.

a. The individual must have one of the following diagnoses:
   - Schizophrenia
   - Other psychotic disorder
   - Bipolar disorder
   - Major depressive disorder

b. These may also be accompanied by any of the following:
   - Substance abuse disorder
   - Developmental disability

c. Include one or more of the following service needs:
   - Two or more acute psychiatric hospitalization and/or four or more emergency room visits in the last six months
   - Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life

- Two or more interactions with law enforcement in the past year for emergency services due to mental illness or substance abuse (this includes involuntary commitment, ACT/forensic assertive community treatment (FACT))
- Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided
- One or more incarcerations in the past year related to mental illness and/or substance abuse (FACT)
- Psychiatric and judicial determination that FACT services are necessary to facilitate release from a forensic hospitalization or pre-trial to a lesser restrictive setting (FACT)
- Recommendations by probation and parole, or a judge with a FACT screening interview, indicating services are necessary to prevent probation/parole violation (FACT)

d. Must have one of the following:
- Inability to participate or remain engaged or respond to traditional community-based services
- Inability to meet basic survival needs, or residing in substandard housing, homeless or at imminent risk of becoming homeless
- Services are necessary for diversion from forensic hospitalization, pretrial release or as a condition of probation to a lesser restrictive setting (FACT)

e. Must have three (3) of the following:
- Evidence of co-existing mental illness and substance abuse/dependence
- Significant suicidal ideation, with a plan and ability to carry out within the last two (2) years
- Suicide attempt in the last two (2) years
- History of violence due to untreated mental illness/substance abuse within the last two (2) years
- Lack of support systems
- History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability
- Threats of harm to others in the past two (2) years
- History of significant psychotic symptomatology, such as command hallucinations to harm others
- Global assessment of functioning of 50 or less

f. Exception criteria:
- The individual does not meet medical necessity criteria I or II, but is recommended as appropriate to receive ACT services by the funding agency or designee, the ACT team leader, clinical director and psychiatrist, in order to protect public safety and promote recovery from acute symptoms related to mental illness

Program requirements
ACT services must be provided by an interdisciplinary team. Individuals on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance abuse treatment; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that individuals obtain the basic necessities of daily life; direct assistance to ensure that individuals obtain supportive housing, as needed; and education, support, and consultation to individuals' families and other major supports. ACT is a medical, comprehensive case management and psychosocial intervention program provided on the basis of the following principles:

1. The service is available 24 hours a day, seven days a week

2. An individualized service plan and supports are developed

3. At least 90% of services are delivered as community-based outreach services

4. An array of services are provided based on individual patient medical need

5. The service is consumer-directed

6. The service is recovery-oriented

The ACT team must:

1. Operate a continuous after-hours on-call system with staff that is experienced in the program and skilled in CI procedures. The ACT team must have the capacity to respond rapidly to emergencies, both in person and by telephone.

2. Provide mobilized CI in various environments, such as the recipient's home, schools, jails, homeless shelters, streets and other locations.

3. Arrange or assist consumers to make a housing application, meet their housing obligations and gain the skills necessary to maintain their home.

4. Be involved in psychiatric hospital admissions and discharges and actively collaborate with inpatient treatment staff.

The ACT program provides three levels of interaction with the participating individuals:

1. Face-to-face encounter – At least 60% of all ACT team activities must be face-to-face, with approximately 90% of these encounters occurring outside of the office.

2. Collateral encounter – Collateral refers to members of the recipient's family or household or significant others (e.g., landlord or property manager, criminal justice staff and employer) who regularly interact with the recipient and are directly affected by, or have the capability of affecting, his or her condition and are identified in the service plan as having a role in treatment. A collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g., meeting with a shelter staff person who is assisting an ACT recipient in locating housing).

3. Assertive outreach – Refers to the ACT team being 'assertive' about knowing what is going on with an individual and acting quickly and decisively when action is called for, while increasing client independence. The team must closely monitor the relationships that the individual has within the community and intervene early if difficulty arises.

ACT staff must provide a minimum of six encounters with the service recipient or collateral contacts monthly and must document clinically appropriate reasons if this minimum number of encounters can not be made monthly.

The teams will provide comprehensive, individualized services, in an integrated, continuous fashion, through a collaborative relationship with persons with SPMI.

The ACT program utilizes a treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse and has gradual expectations for abstinence.

The teams will provide the following supports and services to consumers:

1. Needs assessment and individualized care plan development:
    a. This will include items relevant for any specialized interventions, such as linkages with the forensic system for consumers involved in the judicial system. In particular, the assessment will include:

Items related to court orders, identified within 30 days of admission and updated every 90 days or as new court orders are received.

2. Crisis assessment and intervention.

3. Symptom management and mediation.

4. Individual counseling.

5. Medication administration, monitoring, education and documentation.

6. Skills training in activities related to self-care and daily life management, including utilization of public transportation, maintenance of living environment, money management, meal preparation, locating and maintaining a home, skills in landlord/tenant negotiations and renter's rights and responsibilities.

7. Social skills training necessary for functioning in a work, educational, leisure or other community environment.

8. Peer support.

9. Addiction treatment and education, including counseling, relapse prevention, harm reduction, anger and stress management.

10. Referral and linkage or direct assistance to ensure that individuals obtain the basic necessities of daily life, including medical, social and financial supports.

11. Education, support and consultation to individuals' families and other major supports.

12. Monitoring and follow-up to help determine if psychiatric, substance abuse, mental health support and health related services are being delivered, as set forth in the care plan, adequacy of services in the plan and changes, needs or status of consumer.

13. The team will assist the consumer in applying for benefits. This includes Social Security Income, Medicaid and Patient Assistance Program enrollment.

14. For those clients with forensic involvement, the team will liaise with the forensic coordinators, providing advocacy, education and linkage with the criminal justice system to ensure the consumer's needs are met in regards to their judicial involvement, and that they are compliant with the court orders.

15. Service provision for ACT will be based on comprehensive history and ongoing assessment of:
    a. Psychiatric history, status and diagnosis
    b. Level of Care Utilization System (LOCUS)
    c. Telesage Outcomes Measurement System, as appropriate
    d. Psychiatric evaluation
    e. Housing and living situation
    f. Vocational, educational and social interests and capacities
    g. Self-care abilities
    h. Family and social relationships
    i. Family education and support needs
    j. Physical health
    k. Alcohol and drug use
    l. Legal situation
    m. Personal and environmental resources

Each of these assessments will be completed within 30 days of admission. The LOCUS, psychiatric evaluation and treatment plan will be updated every six months, with an additional LOCUS score being completed prior to discharge.

Provider requirements for OBH ACT teams under contract as of 2011:
Initially, the SMO will be required to contract with the OBH ACT teams that are under OBH contract as of 2011 and meet national fidelity standards. Any ACT services provided to inmates of a public institution must be paid for out of non-Medicaid funds. For those OBH contractors, the following requirements must continue to be met:

The following guidelines will apply to the provision of services by a forensic coordinator:

1. The majority of services will be provided in the home, community or jail where the consumer is, rather than in an office, unless requested by the consumer; the goal of the forensic coordinator should be to have at least 80% of all face-to-face contacts with consumers occurring outside the office. Note: all services provided in jail must be financed via non-Medicaid funding sources.

2. Services will be provided twenty-four (24) hours a day, seven (7) days a week.

3. For consumers not affiliated with an ACT program, the forensic coordinator will assume responsibility for providing services required to assist the individuals in maintaining community placement in safe, affordable housing.

4. As appropriate, the forensic coordinator shall utilize a “housing first” approach and will demonstrate the ability to assist individuals in finding and maintaining safe affordable housing of the consumer’s choice.

5. Forensic coordinators will be familiar with the needs of each of their consumers served by the ACT team and be capable of working in collaboration with the team.

6. Forensic coordinators will meet with their consumers a minimum of once a week.

7. Forensic coordinators will meet with the ACT teams no fewer than once a week to discuss mutual consumers.

8. The forensic coordinators will have responsibility for crisis services for non-ACT consumers by providing 24-hour coverage, with staff being available either by phone or in person, as appropriate, to help diffuse crisis situations in an effort to maintain community status. They will also be available to the ACT team in the event of a crisis related to a jointly-served consumer.

9. When hospitalization on a non-ACT consumer is unavoidable, the forensic coordinator will be involved in both the admission and discharge process (in a minimum of 95% of incidents), providing for continuity of care. They will work with the hospitals to ensure that continuity of care occurs. Note: ACT services provided in a hospital would be included as content of service by the hospital and reimbursed by the hospital.

10. When consumers are released from jail or the hospital as unrestorable, or on conditional release, the forensic coordinator will be involved in the discharge process, providing for continuity of care. For ACT clients, this process will be coordinated with the ACT team.

11. The services will be provided as long as the individual meets eligibility for services, with the client being transitioned to an alternate level of care, as appropriate. This process should adhere to OBH-developed admit and discharge criteria/protocol.

12. Assertive engagement mechanisms will be utilized to maintain consumers in services.

13. An appropriate level of services will be provided to each consumer, with frequency and duration of each contact being provided at a level specific to consumer need, at a minimum of one hour per week.

14. The forensic coordinator will provide support (i.e., education, advocacy) to the consumer's support network, inclusive of family, friends, employers, landlords, probation officers and others within the criminal justice system, advocating on the consumer's behalf and assisting these supporters in better working with the consumer's themselves.

15. Forensic coordinators will refer non-ACT consumers to appropriate treatment, ensuring that all treatment needs are met, that the consumer follows through with attending appointments and is working towards treatment goals.

16. The forensic coordinator will develop and implement a quality assurance program designed to ensure services are consistently delivered to consumers in accordance with the Statement of Work and in alignment with community forensic services requirements. The program will also ensure that services are consumer-driven and recovery-oriented. Results of quality assurance activities will be written and submitted to the department on a monthly basis.

Provider qualifications for all ACT teams
The SMO may contract with additional ACT teams meeting national fidelity standards. Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation and support services 24 hours a day, seven days per week. Each ACT team shall have the capacity to provide the frequency and duration of staff-to-program participant contact required by each recipient's individualized service plan.

Each ACT team shall have the capacity to increase and decrease contacts based upon daily knowledge of the program participant's clinical need, with a goal of maximizing independence. The team shall have the capacity to provide multiple contacts to persons in high need and a rapid response to early signs of relapse. The nature and intensity of ACT services are adjusted through the process of daily team meetings. Each ACT team shall include at least:

- One qualified ACT team leader
- One board-certified or board-eligible psychiatrist
- Two nurses, at least one of whom shall be a RN
- One other licensed mental health professional
- One licensed substance abuse professional
- One employment specialist
- One housing specialist
- One peer specialist

Each ACT team shall have a staff-to-individual ratio that does not exceed 10:1. Any ACT team vacancies that occur will be filled in a timely manner to ensure that these ratios are maintained. All professional staff must be currently and appropriately licensed by the applicable professional board. Prior to providing the service, each member receives an assessment of initial training needs based on the skills and competencies necessary to provide ACT services. Each staff person must meet the required skills and competencies within six months of their employment on an ACT team. Successful completion of DHH-approved ACT team training can satisfy this requirement.

Planning and documentation requirements:
A comprehensive assessment must be completed within 40 days of admission to the program. A service plan, responsive to the individual's preferences and choices and signed by the individual, must be developed and in place at the time services are rendered. Each individual service plan must consist of the following:

1. The individual's specific mental illness diagnosis.

2. Plans to address all psychiatric conditions.

3. The individual's treatment goals and objectives (including target dates), preferred treatment approaches and related services.

4. The individual's educational, vocational, social, wellness management, residential or recreational goals, associated concrete and measurable objectives and related services.

5. The individual's goals and plans, and concrete and measurable objectives necessary for a person to get and keep their housing.

6. When psycho-pharmacological treatment is used, a specific service plan, including identification of target symptoms, medication, doses and strategies to monitor and promote commitment to medication, must be used.

7. A crisis/relapse prevention plan, including an advance directive.

8. An integrated substance abuse and mental health service plan for individuals with COD.

Documentation shall be consistent with the ACT Fidelity Scale. The individual service plan will include input of all staff involved in treatment of the individual, as well as involvement of the individual's and collateral others' of the individual's choosing. In addition, the plan must contain the signature of the psychiatrist, the team leader involved in the treatment and the individual's signature (refusals must be documented). The individual service plan is reviewed and updated every six months. A tracking system is expected of each ACT team for services and time rendered for or on behalf of any individual.

Service exclusions
This service may not be billed in conjunction with other rehabilitation services.

Billing and reimbursement
The capitated SMO will develop reimbursement rates for this EBP service under CPST when provided to Medicaid adults who are not inmates. Intensive case management is not an EBP and may be billed under a combination of licensed practitioner, PR and CPST.

Note: Individualized substance abuse treatment will be provided to those consumers for whom this is appropriate; co-occurring disorder treatment groups will also be provided off-site of the ACT administrative offices, though they do not take the place of individualized treatment. Substance abuse/mental health treatment will also include dialectical behavioral therapy, CBT and motivational enhancement therapy.

Multi-systemic therapy

Definition:
Multi-systemic therapy (MST) provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services are primarily provided in the home, but workers also intervene at school and in other community settings. All MST services must be provided to, or directed exclusively toward, the treatment of the Medicaid-eligible youth.

Target population characteristics:
MST services are targeted for youth primarily demonstrating externalizing behaviors, such as conduct disorder, antisocial or illegal behavior or acts that lead to costly and, oftentimes, ineffective out-of-home services or excessive use of child-focused therapeutic support services. Depression and other disorders are considered, as long as the existing mental and BH issues manifest in outward behaviors that impact multiple systems (i.e., family, school, community). Youth with substance abuse issues may be included if they meet the criteria below, and MST is deemed clinically more appropriate than focused drug and alcohol treatment.

- Referral/target ages of 12-17 years
- Youth exhibits significant externalizing behavior, such as **chronic or violent juvenile offenses**
- Child is at risk for out-of-home placement or is transitioning back from an out-of-home setting
- Externalizing behaviors symptomatology, resulting in a DSM-IV (Axis I) diagnosis of conduct disorder or other diagnoses consistent with such symptomatology (octachlorodibenzo-p-dioxin, behavioral disorder not otherwise specified, etc.)
- Ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems
- Less intensive treatment has been ineffective or is inappropriate
- The youth's treatment planning team or CFT recommends that he/she participate in MST
- Functional impairment must not solely be a result of pervasive developmental disorder or mental retardation

MST services may not be clinically appropriate for individuals who meet the following conditions:

1. Youth who meet the criteria for out-of-home placement due to suicidal, homicidal or psychotic behavior.

2. Youth living independently, or youth whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends or other potential surrogate caregivers.

3. The referral problem is limited to serious sexual misbehavior.

4. Youth has a primary diagnosis of autism spectrum disorder or mental retardation.

5. Low-level need cases.

6. Youth who have previously received MST services or other intensive family- and community-based treatment.

   <u>Exception:</u> Youth may be allowed an additional course of treatment if all of the following criteria are met:
   a. MST program eligibility criteria are currently met
   b. Specific conditions have been identified that have changed in the youth's ecology, compared to the first course of treatment

c. It is reasonably expected that successful outcomes could be obtained with a second course of treatment
d. Program entrance is subject to prior authorization by the SMO

Criteria for continuing services

Individuals receiving MST services must meet all of the following criteria for continuing treatment with MST:

1. Treatment does not require more intensive level of care.

2. The treatment plan has been developed, implemented and updated based on the youth's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated.

3. Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address the lack of progress are evident.

4. The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.

Criteria for discharge from services

Individuals who meet the following criteria no longer meet medical necessity criteria for MST and shall be discharged from MST treatment:

1. The recipient's treatment plan goals or objectives have been substantially met.

2. The recipient meets criteria for a higher or lower level of treatment, care or services.

3. The recipient, family, guardian and/or custodian are not engaging in treatment or not following program rules and regulations, despite attempts to address barriers to treatment.

4. Consent for treatment has been withdrawn, or youth and/or family have not benefitted from MST, despite documented efforts to engage, and there is no reasonable expectation of progress at this level of care, despite treatment.

Covered services

Philosophy* and *treatment approach

The MST approach views individuals as being surrounded by a natural network of interconnected systems that encompass individual, family and extra-familial (peer, school and neighborhood) factors. The MST approach believes that it is often necessary to intervene in a number of these systems to achieve positive results. All interventions implemented during treatment come from evidenced-based treatment approaches. Through a combination of direct service contacts and collateral contacts, significant improvement in family functioning occurs, thereby reducing the need for continued professional services.

MST is based on the philosophy that the most effective and ethical way to help children and youth is by helping their families. MST views caregivers as valuable resources, even when they have serious and multiple needs of their own. One goal of MST is to empower caregivers to effectively parent their children. MST treatment reaches across all of the youth's life domains and is highly individualized around each case, as described below.

MST treatment principles

1. The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context.

2. Therapeutic contacts emphasize the positive and use systemic strengths as levers for change.

3. Interventions are designed to promote responsible behavior and decrease irresponsible behavior among family members.

4. Interventions are present-focused and action-oriented, targeting specific and well-defined problems.

5. Interventions target sequences of behavior within and between multiple systems that maintain the identified problems.

6. Interventions are developmentally appropriate and fit the developmental needs of the youth.

7. Interventions are designed to require daily or weekly efforts by family members.

8. Intervention effectiveness is evaluated continuously from multiple perspectives, with the provider assuming accountability for overcoming barriers to successful outcomes.

9. Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.

These nine principles guide treatment and the development of interventions to address referral behaviors. The treatment theory draws from social-ecological and family systems theories of behavior. Supervision and consultation to staff are focused on facilitating use of the MST model, and a variety of measures are in place to monitor a program's adherence to the MST model and ensure that fidelity to the model is maintained to the greatest extent possible (as described below).

Goals

MST is designed to accomplish the following:

1. Reduce the frequency of referral behaviors and increase pro-social behaviors, reduce symptoms, maladaptive and externalizing behaviors, so that the child/youth can be treated in a lower level of community-based care. Child/youth no longer demonstrating ongoing risk of deliberate attempts to inflict serious injury on self or others.

2. Decrease association with deviant peers and increase association with pro-social peers and involvement in positive recreational activities.

3. Help caregivers develop effective parenting skills and skills to manage the consumer's mental health needs, improve caregiver decision-making and limit setting.

4. Improve family relationships.

5. Improve school or vocational success, as indicated by improved grade point average, a decrease in disciplinary referrals, unexcused absences and tardies and/or a decrease in job terminations.

6. Support involvement in restorative measures, such as community services, if involved with Juvenile Justice (Office of Children, Youth and Families resources will oversee and fund the participation in restorative measures, rather than the MST service provider).

7. Reduce likelihood of out-of-home placement and reduce the utilization of out-of-home therapeutic resources (i.e., therapeutic foster care, residential treatment facility, etc.).

8. Develop natural supports for the consumer and family.

Specific treatment goals will always be individualized and tied to BH needs.

Specific design of the service:
On average, a youth receives MST for three to six months but, typically, no longer than six months. The therapist meets with the youth or family at least weekly but often multiple times per week, depending on need. Families typically see therapists less frequently as they get closer to discharge. On average, families receive about 60 hours of face-to-face treatment over a four-month period, as well as about 35 hours of non-direct contact provided to the ecology of the youth (e.g., consultation and collaboration with other systems). Services occur in the family's home or community at times that are convenient for the family. Staff members are expected to work on weekends and evenings, for the convenience of their clients. Therapists and/or their supervisors are on call for families 24/7. Supervisors are available to therapists around-the-clock for support. Each therapist carries a small caseload (four to six families) at any one time.

MST includes:

- Assessment
- Ongoing treatment planning
- Family therapy
- Parent counseling (related to empowering caregivers to parent effectively and address issues that pose barriers to treatment goals)
- Consultation to and collaboration with other systems, such as school, juvenile probation, children and youth and job supervisors
- Individual therapy may occur but is not the primary mode of treatment
- Referral for psychological assessment, psychiatric evaluation and medication management, if needed

MST therapists do not provide individual therapy to caregivers or other family members, nor do they provide marital therapy beyond addressing couples' issues that directly impact the youth's treatment.

MST is a practical and goal-oriented treatment that specifically targets the factors in a youth's social network that are contributing to the problem behaviors. Specific treatment techniques draw from therapies with the most empirical support, such as cognitive, cognitive behavioral, behavioral and pragmatic family therapies, such as structural family therapy. Interventions are developed based on an assessment of the "fit" for a specific behavior (specifically, what factors are driving the behavior, which are always individualized). Interventions always target specific, well-defined problems, focus on present conditions and are action-oriented. Families are often given "assignments" that require daily or weekly efforts, capitalize on strengths, build skills and encourage responsible behavior by the youth and family. By empowering caregivers to address their families' needs, MST interventions promote generalization and maintenance of positive changes. The help of natural supports, such as extended family or school, is often enlisted. Therapists are totally responsible for engaging the family and other key participants in the youth's environment (e.g., teachers, school administrators, community members, workers from agencies with mandated involvement). MST requires a solution-focused, strengths-based orientation from therapists.

The effectiveness of interventions is closely monitored from week-to-week from multiple perspectives (e.g., caregivers, identified youth, teachers and the MST team). While overarching goals are established at the beginning of treatment, specific, measurable objectives are set each week. Family members and therapists work together to design the treatment plan, which ensures family involvement. However, therapists and the provider agency are held accountable for achieving change and for positive case outcomes.

The MST program has a hands-off policy and does not utilize any restraints or restrictive procedures.

Description of individualization for youth and family

Treatment planning
Upon receiving a referral, A CFT meeting is scheduled, and an initial treatment plan is developed before services begin. A licensed practitioner must recommend and oversee the service on an ongoing basis. Required information is sent to the behavioral health-managed care organization (BH-MCO) to request prior authorization, usually for six months of service.

The CFT includes the client, family, referral source, a representative of the BH-MCO and representatives of other systems involved with the child (e.g., OJJ, DCFS, OBH). If the youth presents with behavioral issues impacting school, a representative of the school district is asked to participate. The team may also include friends, extended family and any other parties requested by the youth and caregiver(s).

The treatment plan is developed by the CFT, based on the referral behaviors and the goals of the youth and family. The treatment plan is discussed, put into writing by the MST therapist and signed by the caregiver and the youth, if age 14 or older. Overarching goals are established at the beginning of treatment, while specific objectives are updated each week and closely monitored.

Cultural concerns:
MST treatment is attuned to the importance of ethnicity and culture for all clients referred for services. Cultural values and concerns should be reflected in the MST therapist's assessment of the youth and family and incorporated into interventions, as appropriate. Weekly clinical supervision should include responsiveness to problems related to racism or discrimination. Cultural competence may be addressed in MST booster trainings if it is identified as an area of need by the MST supervisor and system supervisor.

Child integration to community:
The treatment objectives must demonstrate that MST focuses on community integration by striving to reduce out-of-home placements, improve school attendance and academic success and build natural supports for the family and so on.

By maintaining the youth within the community, the least restrictive environment, MST treatment interventions strengthen the family and youth's relationship with community resources and the people managing them. This is important for creating sustainable treatment outcomes. Also, the MST model is strengths-focused and competency-based in its treatment approach. The general goal of MST is to promote increased emotional and social health in youth and families.

Provider qualifications:
Agencies must be licensed to provide MST services by MST Services, Inc. or any of its approved subsidiaries. An MST agency must be a BH/substance abuse provider organization, which is a legally recognized entity in the United States and is qualified to do business in Louisiana and meets the standards established by the BHSF or its designee.

The provider will provide all client services. MST therapists and supervisors are employees of the provider. Ultimate responsibility for services provided lies with the provider. The provider contracts with a network partner for training, supervision and monitoring of services. This occurs primarily through an MST system supervisor provided by the network partner. Network partner status, granted to the network partner's MST

program by MST Services, allows for the development of MST teams supported and monitored directly by the network partner. The provider also has a contractual relationship with MST Services, allowing the provider to deliver the licensed MST model.

Staff education level/qualifications and training topics

Education/qualifications:
The MST program at the provider consists of one or more MST teams, each with an MST clinical supervisor and two to four MST therapists. There is a system supervisor from the network partner, who is responsible for the clinical fidelity of the MST team. All staff will have background checks on file before working alone with youth and families.

A. MST clinical supervisor: The supervisor for an MST team is an independently licensed master's-level mental health professional with a graduate degree in a clinical mental health field and experience providing mental health treatment. A minimum of three years experience is preferred. The supervisor facilitates weekly team supervision, reviews weekly case summaries in preparation for supervision and is available to therapists 24/7. The MST supervisor will, at times, take therapy cases, if needed, due to demand and staff availability. A full-time supervisor may supervise two teams; a half-time supervisor may supervise one team. Clinical services and supervision must be provided by licensed BH practitioners in accordance with their respective licensing board regulations. All practitioners must hold an unrestricted Louisiana license.

B. MST therapist: Therapists are master's-level mental health professionals with graduate degrees in a clinical field, a background in family, youth and community service and a minimum of two years experience preferred. Highly skilled bachelor's-level professionals may be selected, with certain hiring conditions. These conditions include: (1) education in a human services field, (2) a minimum of three years experience working with family and/or children/youth services and (3) the provider has actively recruited for master's-level therapists but has not found any acceptable candidates *or* the bachelor's-level applicant is clearly better qualified than the master's-level applicants. Bachelor's level staff must have a degree in social work, counseling, psychology or a related human services field and must have at least three years of experience working with the target population (children/adolescents and their families) Therapists are responsible for providing direct service to a caseload of four to six families. The expectation is that the usage of bachelor's-level staff will not exceed one bachelor's-level staff person for every two master's-level staff persons per team.

C. MST system supervisor (MST consultant from the network partner): The system supervisor is a master's-level, mental health professional with a graduate degree in a clinical field and experience as an MST clinical supervisor. The system supervisor provides weekly clinical consultation to the MST teams, monthly clinical consultation to the MST supervisors, quarterly booster trainings for the MST teams and monitors adherence to the MST model. A network manager from MST Services is assigned to the network partner to monitor and train system supervisors.

Training:
System supervisors are responsible for the training of MST therapists and MST clinical supervisors. All therapists and supervisors attend a 30-hour (five-day) MST orientation training within two months of hire. This training covers such topics as: engagement and alignment, parent–child interventions, marital interventions, school-based interventions, confidentiality and ethics, peer interventions, social supports, individual interventions, safety issues, substance abuse interventions and psychiatric consultation. All participants take a test at the end of the training week. Individual results of the tests are used to identify areas of strength and weakness for continued clinical development.

Booster trainings are conducted for one and a half days each quarter. The entire MST team attends a full day of booster training (minimum seven hours), while the half-day (minimum three and a half hours) may be

attended by the entire team or only the supervisors. Topics for booster trainings are derived from planning discussions between the system supervisor and MST clinical supervisors as they reflect on challenges over the previous months. Examples of booster trainings include family contracting, interventions for families affected by divorce, safety planning, preventing burnout, caregiver substance abuse and school-based assessment and intervention. Orientation and booster trainings are led by MST-licensed system supervisors.

Supervision:
Intensive supervision and clinical consultation are an integral part of the MST model and are focused on promoting consistent application of the MST model to all cases. Training is monitored through the licensing agreements and contractual arrangement that the provider has with the network partner, and they with MST Services.

Supervision and consultation in MST includes the following:

- MST therapists receive weekly team supervision with their MST supervisor, typically lasting two hours. If an MST supervisor has two teams, supervision is provided separately to each team. Prior to supervision meetings, the supervisor reviews weekly case summaries, makes notes and creates an agenda for the supervision meeting.

- Each MST team receives weekly telephone consultation from an MST system supervisor, typically for one hour. Each week the system supervisor reviews case summaries and MST clinical supervisor notes, in preparation for the consultation session.

- Each MST therapist has a clinical plan (professional development plan) to guide him/her to effective levels of MST adherence.

- MST clinical supervisors are available around-the-clock to provide support to MST therapists.

- The MST clinical supervisors receive monthly telephone consultation from the system supervisor to monitor and develop their supervisory effectiveness. This supervision involves close review of audiotapes of supervision sessions and case reviews.

Monitoring and assessment of service delivery: The licensing agreement and contracts between MST Services, the network partner and the provider include monitoring activities to ensure fidelity to the MST model, as described below. Adherence to the model is monitored through the administration of two measures:

Therapist Adherence Measure-Revised (TAM-R): This is an objective, standardized instrument that evaluates a therapist's adherence to the MST model as reported by the primary caregiver of the family. It has been shown to have significant value in measuring a MST therapist's adherence to MST principles and to predicting treatment outcomes. The TAM-R has been validated in clinical trials with serious chronic, juvenile offenders and is now implemented by all licensed MST programs. The TAM-R takes 10 to 15 minutes to complete. It is administered during the second week of treatment and every four weeks thereafter. A staff person will contact the family in-person or by phone to complete the measure. Data is entered onto an online database managed by the MST Institute, and results are reviewed by the MST supervisor and therapist.

Supervisor Adherence Measure (SAM): This measure evaluates the MST clinical supervisor's adherence to the MST model of supervision. This 10 to 15 minute measure is completed by MST therapists, who are prompted to complete the SAM every two months and enter their responses directly onto the on-line database. Results are shared with the MST system supervisor, who then shares a summary of the feedback with the MST clinical supervisor during a consultation meeting.

The online database also collects case-specific information, including the percent of cases successfully completing MST and whether specific instrumental and ultimate outcomes have been achieved at discharge.

The provider will ensure that the MST program collects TAM-R and SAM, as required by the model, and that this and other data is entered into the online database in a timely fashion.

Every six months, a program implementation review is completed by the system supervisor and MST clinical supervisor for each team. This review includes completion of a program review form (a checklist of characteristics considered critical to the success of an MST program), a narrative summary of the program's strengths and weaknesses and recommendations. This review is used to monitor the team's fidelity to the model and troubleshoot problem areas.

Exclusions:
MST services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These may be provided and billed separately for a recipient receiving MST services.

MST shall not be billed in conjunction with the following services:

1. BH services by licensed and unlicensed individuals, other than medication management and assessment.

2. Residential services, including professional resource family care.

Billing:
Only direct staff face-to-face time with the child or family may be billed. Time spent in travel, transporting children, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly. Medicaid funding may not reimburse for children in the custody of OJJ, who reside in detention facilities, public institutions or secure care and are inmates of a public institution. If the child is in OJJ custody, but not in a public correctional institution (i.e., is outpatient), Medicaid will reimburse for the MST except for the oversight of restorative measures, which is an OJJ function. Medicaid will also not reimburse for services provided to children who are residents of IMDs (i.e., institutions with greater than 16 beds, where more than 50% of the residents require treatment for BH conditions). Medicaid participates in services provided by a school employee when an IEP is developed. Medicaid also does not pay when the vocational supports provided via MST qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available.

Homebuilders
Homebuilders is an intensive, in-home program providing CBT through family therapy and parent training for families with children (birth to 18 years) demonstrating the following characteristics:

- Antisocial behavior and alienation/delinquent beliefs/general delinquency involvement/drug dealing
- Favorable attitudes toward drug use/early onset of alcohol and other drug use, alcohol and/or drug use
- Early onset of aggression and/or violence
- Victimization and exposure to violence

The primary intervention components of the Homebuilders model are engaging and motivating family members, conducting holistic, behavioral assessments of strengths and problems, developing outcome-based goals, using evidence-based cognitive/behavioral interventions, teaching skills to facilitate behavior change and developing and enhancing ongoing supports and resources. Homebuilders programs have been successfully implemented in diverse and multi-ethnic/multicultural communities across the United States and other countries.

Target population:

The children are returning from, or at risk of, placement into foster care, group or residential treatment, psychiatric hospitals or juvenile justice facilities. Homebuilders is specifically aimed toward children identified with:

- Family functioning issues
- Trauma exposure
- Academic failure
- Incorrigibility
- Academic problems
- Delinquency

Louisiana also utilizes Homebuilders for children with serious behavior problems at home and/or school including non-compliance with parental or school rules, fighting (physical and verbal) with peers and parents/caregivers, serious tantrums and acting out behaviors, running away, substance use, behaviors that might be related to attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder, anxiety and mood disorders, reactive attachment disorder, etc. Withdrawn behaviors (depression) and suicidal behaviors also need to be included. Any child who is at risk of psychiatric or residential placement or about to move to a more restrictive environment due to their behavioral/emotional problems.

Families will often demonstrate:

- Family history of problem behavior/parent criminality
- Family management problems/poor parental supervision and/or monitoring
- Child victimization and maltreatment
- Pattern of high family conflict
- Poor family attachment/bonding
- Family violence
- Having a young mother
- Broken home
- Sibling antisocial behavior
- Parental use of physical punishment, harsh and/or erratic discipline practices
- Substance abuse and/or mental health (depression/mood disorders, anxiety, etc.)

Therapeutic goals
The Homebuilders model is designed to eliminate barriers to service while using research-based interventions to improve parental skills, parental capabilities, family interactions, children's behavior and family safety. Specifically, the goals are to improve each child's perception of social support from adults and peers, to improve actual social support, such as improved/increased social and emotional support from adults/peers and to improve the family's ability to support the child with the identified behaviors through:

- Effective parenting
- Good relationship with parents/bonding or attachment to family
- Opportunities for pro-social family involvement
- Having a stable family
- Rewards for pro-social family involvement
- Improved family environment, improved parental capabilities, improved family interactions, improved child well-being and child behavior and improved family safety
- Improved child/teen behavior (changing identified problem behaviors)

The core program strategies are:

- **Accessibility.** Services are provided in the family's home and community (e.g., school) at times convenient to families, including evenings, weekends and holidays. Homebuilders therapists are available 24 hours per day, seven days a week, for CI.
- **Flexibility.** Intervention strategies and methods are tailored to meet the needs, values and lifestyles of each family.
- **Time-limited and low caseload.** Families receive four to six weeks of intensive intervention with up to two "booster sessions". Therapists typically serve two families at a time and provide 80 to100 hours of service, with an average of 45 hours of face-to-face contact with the family.
- **Strengths-based.** Therapists help clients identify and prioritize goals, strengths and values and help them use and enhance strengths and resources to achieve their goals.
- **Ecological/holistic assessment and individualized treatment planning.** Assessments of family strengths, problems and barriers to service/treatment and outcome-based goals and treatment plans are completed collaboratively with each family.
- **Research-based treatment practices.** Therapists use evidence-based treatment practices, including motivational interviewing, behavioral parent training, CBT strategies and relapse prevention. Therapists teach family members a variety of skills, including child behavior management, effective discipline, positive behavioral support, communication skills, problem-solving skills, resisting peer pressure, mood management skills, safety planning and establishing daily routines.
- **Support and resource building.** Therapists help families assess their formal and informal support systems and develop and enhance ongoing supports and resources for maintaining and facilitating changes.
- **Critical thinking framework.** Therapists, supervisors and managers use a critical thinking framework for assessing, planning, implementing and evaluating progress and outcomes.

Limitations:
When Homebuilders is utilized for clinical goals of a Medicaid eligible individual, Medicaid will reimburse. When Homebuilders is utilized for the clinical goals of a non-Medicaid individual or other goals consistent with the Homebuilders model, the referring agency or the family will reimburse. Homebuilders may also be a "step-down" service where children are transitioning from a more restrictive to a less restrictive placement (such as a move from a group home to foster home or relative. Finally, Homebuilders may be used for stabilization referrals (e.g. to stabilize a foster placement that is at risk of dissolution) as long as the child demonstrates the listed characteristics.
http://www.ojjdp.gov/mpg/mpgProgramDetails.aspx?ID=341

Family functional therapy (FFT):
The provider agency must have a current license issued by the DHH. The licensed entity has agreed to assume responsibility for this service under its license. The provider contracts with FFT, Inc. for training, supervision and monitoring of services. This occurs primarily through a FFT national consultant. The provider will also have a contractual relationship with FFT Inc., allowing the provider to deliver the licensed FFT model.

FFT services are targeted for youth primarily demonstrating externalizing behaviors which affect family functioning. Youth behaviors include antisocial behavior or acts, violent behaviors and other behavioral issues that impair functioning. Youth may also meet criteria for a disruptive behavior disorder (ADHD, oppositional defiant disorder and/or conduct disorder). Youth with other mental health conditions, such as anxiety and depression, may also be accepted as long as the existing mental and BH issues manifest in outward behaviors that impact the family and multiple systems. Youth with substance abuse issues may be included if they meet the criteria below, and FFT is deemed clinically more appropriate than focused drug and alcohol treatment. However, acting out behaviors must be present to the degree that functioning is impaired and the following terms are met:

- Youth, ages 10-18, typically referred by other service providers and agencies on behalf of the youth and family, though other referral sources are also appropriate.

- At least one adult caregiver is available to provide support and is willing to be involved in treatment.
- An Axis 1 DSM-IV-TR diagnosis as primary focus of treatment. Symptoms and impairment must be the result of a primary disruptive/externalizing behavior disorder, although internalizing psychiatric conditions and substance abuse disorders may be secondary.
- Functional impairment not solely a result of pervasive developmental disorder or intellectual disability.
- Youth displays externalizing behavior which adversely affects family functioning. Youth's behaviors may also affect functioning in other systems.
- Documented medical necessity for an intensive in-home service.
- Youth's interagency service planning team recommends that he/she participate in FFT.

FFT is deemed a best practice/family-based approach to providing treatment to youth who are between the ages of 10 and 18 and are exhibiting significant externalizing behaviors. It is a systems-based model of intervention/prevention, which incorporates various levels of the client's interpersonal experiences to include cognitive, emotional and behavioral experiences, as well as intrapersonal perspectives which focus on the family and other systems (within the environment) and impact the youth and his or her family system. FFT is a strengths-based model of intervention, which emphasizes the capitalization of the resources of the youth, their family and those of the multi-system involved. Its purpose is to foster resilience and ultimately decrease incidents of disruptive behavior for the youth. More specifically, some of the goals of the service are to reduce intense/negativistic behavioral patterns, improve family communication, parenting practices and problem-solving skill, and increase the family's ability to access community resources.

The FFT model of intervention/prevention is based on three core principles for understanding the following three components of the treatment: the clients who are served, the problems the youth and families are faced with and the process of providing the therapeutic service. More specifically, the three core principles can be generally defined as:

- Core Principle One: Understanding clients – This is a process whereby the therapist comes to understand the youth and family in terms of their strengths on the individual, family system and multi-systemic level.
- Core Principle Two: Understanding the client systemically – This is a process whereby the therapist conceptualizes the youth's behaviors in terms of their biological, relational, family, socio-economic and environmental etiology. Subsequently, the therapist assesses the youth's relationships with family, parents, peers, their school and their environment and how these roles/relationships contribute to the maintenance and change of problematic behaviors.
- Core Principle Three: Understanding therapy and the role of the therapist as a fundamentally relational process – This is a process where the therapist achieves a collaborative alliance with the youth and family. Subsequently, the therapist ensures that the therapy is systematic and purposeful, while maintaining clinical integrity. More specifically, the therapist follows the model but also responds to the emotional processes (needs/feelings/behaviors) that occur in the immediacy during clinical practice.

Specific design of the service:
On average, a youth receives FFT for approximately three to four months. Over the course of this three-month period, the therapist works with the family in nine to 14 one- to two-hour sessions for less severe cases and up to 26-32 one- to two-hour sessions for youth with more substantial acting-out behaviors. The frequency of the sessions varies on a case-by-case basis and over the course of the treatment; sessions could occur daily to weekly, as needed. Services occur in the family's home or community and at times that are convenient for the family. FFT is carried out in the context of three distinct phases. Each phase consists of an assessment, goal-setting and an intervention component; all services rendered are carried-out based upon the theoretical framework of the three core principles.

The intervention program itself consists of five major components, in addition to pretreatment activities: (1) Engagement in change, (2) Motivation to change, (3) Relational/Interpersonal assessment and planning for behavior change, (4) Behavior change and (5) Generalization across behavioral domains and multiple systems:

- **Pretreatment:** The goals of this phase involve responsive and timely referrals, a positive "mindset" of referring sources and immediacy. Activities include establishing collaborative relationships with referring sources, ensuring availability, appraising multidimensional (e.g., medical, educational, justice) systems already in place and reviewing referral and other formal assessment data.
- **Engagement phase:** The goals of this phase involve enhancing perception of responsiveness and credibility, demonstrating a desire to listen, help, respect and "match" and addressing cultural competence. The main skills required are demonstrating qualities consistent with positive perceptions of clients, persistence, cultural/population sensitivity and matching. Therapist focus is on immediate responsiveness and maintaining a strength-based relational focus. Activities include high availability, telephone outreach, appropriate language and dress, proximal services or adequate transportation, contact with as many family members as possible, "matching" and respectful attitude.
- **Motivation phase:** The goals of this phase include creating a positive motivational context, minimizing hopelessness and low self-efficacy and changing the meaning of family relationships to emphasize possible hopeful experience. Required phase skills consist of relationship and interpersonal skills, a nonjudgmental approach, plus acceptance and sensitivity to diversity. Therapist focus is on the relationship process, separating blaming from responsibility while remaining strength-based. Activities include the interruption of highly negative interaction patterns and blaming (e.g., divert and interrupt), changing meaning through a strength-based relational focus, pointing process, sequencing and reframing of the themes by validating negative impact of behavior, while introducing possible benign/noble (but misguided) motives for behavior. Finally, the introduction of themes and sequences that imply a positive future are important activities of this phase.
- **Relational assessment phase:** The goals of relational assessment include eliciting and analyzing information pertaining to relational processes, as well as developing plans for behavior change and generalization. The skills of perceptiveness and understanding relational processes and interpersonal functions are required. The focus is directed to intrafamily and extrafamily context and capacities (e.g., values, attributions, functions, interaction patterns, sources of resistance, and resources and limitations). Therapist activities involve observation, questioning; inferences regarding the functions of negative behaviors and switching from an individual problem focus to a relational perspective.
- **Behavior change phase:** Behavior change goals consist of skill building, changing habitual problematic interactions and other coping patterns. Skills, such as structuring, teaching, organizing and understanding behavioral assessment, are required. Therapists focus on communication training, using technical aids, assigning tasks and training in conflict resolution. Phase activities are focused on modeling and prompting positive behavior, providing directives and information and developing creative programs to change behavior, all while remaining sensitive to family member abilities and interpersonal needs.
- **Generalization phase:** The primary goals in the generalization phase are extending positive family functioning, planning for relapse prevention and incorporating community systems. Skills include a multisystemic/systems understanding and the ability to establish links, maintain energy and provide outreach. The primary focus is on relationships between family members and multiple community systems. Generalization activities involve knowing the community, developing and maintain contacts, initiating clinical linkages, creating relapse prevention plans and helping the family develop independence.

Additional points to cover:
Each of the above phases includes an assessment, goal-setting and intervention phase. Information related to how the proposed program will carry out these elements should be included for each phase.

Description of individualization for youth and family:
The FFT must work with any treatment planning team, including WF, through CSoC to develop an individualize treatment plan.

FFT's requirements for measuring individual outcome include the following:

There are four domains of assessment used to monitor progress towards goals:

1. Client assessment (through the use of the outcomes questionnaire (OQ) family measures pre-assessment, risk and protective factors assessments pre-assessment, relational assessment):
   - Helps understand individual, family and behavior in a context functioning
   - Adds to clinical judgment, helps target behavior change targets, tool in treatment

2. Adherence assessment (through the use of the counseling process questionnaire and Clinical Services System (CSS) tracking/adherence reports, global therapist ratings):
   - Identify adherence to FFT to enhance learning and supervision
   - Judge clinical progress, monitor clinical decisions

3. Outcome assessment (through the use of therapist outcome measure, counseling outcome measure parent/adolescent and post assessment OQ family measures and post risk and protective factors assessment):
   - To understand the outcome of your work – accountability
   - Changes in client functioning (pre-post)

4. Case monitoring and tracking (client service system reports)
   - Every client contact/planned contact, outcome of that contact (helps monitor practice)

Cultural and ethical concerns:
FFT treatment is attuned to the importance of ethnicity and culture for all clients referred for services. Cultural values and concerns are addressed in the context of the family system and the multi-systems which influence the intervention. Cultural sensitivity is an integral part of understanding the child and family from a systems perspective. FFT can be carried out by therapists from diverse backgrounds. Thus, intervention involves the use of fostering resilience and identifying resources within the family systems and multi-systems. Inevitably, this will include understanding the family and multi-systems within the context of their cultural backgrounds.

Child integration to community:
The treatment objectives listed in Section 8 demonstrate that FFT focuses on fostering resilience for youth and family and capitalizing on resources within the family system and multi-systems (to include the community). Thus, in order to achieve generalization, the youth and family need to demonstrate their ability to utilize resources within the community and demonstrate integration prior to discharge.

The FFT model is consistent with the Child and Adolescent Services System Program principles, which are critical treatment standards important to all families in Louisiana. For example, by maintaining the youth within the community, the least restrictive environment, FFT treatment interventions strengthen the family and youth's relationship with community resources and the people managing them. This is important for creating sustainable treatment outcomes. FFT is delivered as an in-home community-based service. FFT clinicians cannot directly bill for travel time. The FFT workers do not generally have security guards assisting when going to an individual's home.

Staff education level/qualifications and training topics

Education/qualifications:

<u>FFT therapists</u>
The FFT program at the provider level will consist of one site. This site will be comprised of (three to eight) therapists. Therapists are master's-level staff with graduate degrees in a clinical field. Other human service degrees may be accepted. Highly skilled bachelor's-level professionals may also be selected under certain

hiring conditions. These conditions include: (1) the provider has actively recruited for master's-level therapists but has not found any acceptable candidates *or* the bachelor's-level applicant is clearly better qualified than the master's-level applicants and (2) the bachelor's degree must be in a human services field. A degree in a mental health field is preferred.

All FFT therapists must have a background in family, youth and community service and a minimum of two years experience working with children, adolescents and families. FFT therapists will meet the guidelines for training outlined below.

FFT site supervisor
At the cessation of Phase One, (approximately nine to twelve months after the initial training) the FFT site supervisor is expected to emerge and be appointed. The site can appoint a site supervisor prior to the cessation of Phase Two; however, it is expected that, regardless, this person follow FFT training guidelines which are outlined below.

Site supervisors are master's-level mental health professionals with graduate degrees in a clinical discipline. A background in family, youth and community service and a minimum of two years experience working in these areas is required.

FFT national consultant
The provider will work with a national FFT national consultant, who will provide the monitoring, supervision, and training during the first two phases (typically the first two years) of site implementation. This person will have been involved in the delivery of FFT services for five years, has been a site supervisor, had supervisory training and is employed by FFT, LLC.

All staff will have background checks on file before working alone with youth and families.

Training:
The following is the process the provider will use to become an approved site by FFT, LLC. This training regiment will be completed in order to ensure fidelity to the FFT model.

1. The provider will appoint individual therapists who have met the criteria for education and qualifications outlined above.

2. After the provider has identified appropriate staff, they will call FFT, LLC. to set-up the initial one-day orientation training. The provider has arranged for their team and all stakeholders to attend in order to learn the process of referring youth for FFT in the providers' particular community. During this training, the site members will have learned successful implementation of FFT to include use of assessment tools and protocols and the use of the CSS. At the cessation of this training, the provider will have agreed to have at least five referrals for FFT for each team member to begin with after they have completed the next training session, which is the initial clinical training (CT1).

3. Approximately one to two weeks after the initial one-day orientation training, the provider will arrange to have all FFT therapists attend the CT1 training. This will be conducted over a two-day period and be carried out on the site of the provider. An FFT developer or national consultant will conduct this training.

4. **Six weeks post CT1, the site is eligible for site certification.**

5. Immediately following the initial training, the therapists at the provider sites will begin to see their cases and engage in weekly supervision with the FFT national consultant. Each weekly supervision session will be conducted for approximately one hour. The National consultant will use a staffing procedure which reinforces the model, will review all CSS paperwork and provide feedback to the team or teams. In addition, the provider will ensure that the FFT team/teams are meeting for an additional hour per week for peer supervision.

6. At six weeks, four to five months, and eight to ten months after the initial clinical training, the FFT national consultant will come to the provider's site and complete two-day follow-up trainings. All FFT therapists employed by the provider will attend the follow-up trainings. The purpose of these follow-up trainings will be to review phase goals and assessments, update therapists on current events or changes and to provide specialized training to the team in regard to their specific cases.

7. At six months following CT1, the provider's FFT team/teams will attend the second clinical training (CT2). This will be conducted by the FFT developers or the national consultant. (Please note this is a new requirement by FFT, LLC.).

8. At approximately nine months, a lead should emerge or have been appointed, who will serve as the FFT supervisor. The provider will ensure that this staff member attends the FFT externship. This externship will consist of three, three-day trainings occurring every month during the duration of the externship. This training will be conducted by FFT externship trainers. At the cessation of this externship, it will be determined whether the selected FFT supervisor will continue to serve in this role.

9. Once the site supervisor has completed the externship and is deemed qualified, the provider will be considered to be in Phase Two (approximately Year Two). At this time, the provider will ensure that the supervisor attends supervision trainings (two trainings), and he or she will begin taking over the supervision of the FFT therapists. The site supervisor and therapists will also take part in one two-day training session conducted on site by the FFT national consultant.

10. Should there be any staff turnover, the provider will ensure that new FFT therapists attend the replacement trainings either in–state, if offered, or out-of-state, if need be.

Supervision
Intensive supervision and clinical consultation are an integral part of the FFT model and are focused on promoting consistent application of the FFT model to all cases. Supervision is built into the training protocol and certification process.

Supervision in FFT includes the following:

- The FFT national consultant will provide the monitoring, supervision and training during the first two years of the provider's implementation of FFT:
  - This supervision will include one, one-hour weekly phone consult with the site during Year One of implementation.
  - During Year Two, the FFT national consultant will provide two one-hour supervision sessions to the site supervisor in training.
- During Year Two of implementation, the provider's site supervisor will provide oversight to the therapists and will complete all required trainings outlined by FFT, LLC. The site supervisor will hold one-hour weekly sessions with the therapists.
- FFT therapists at the provider will also engage in one one-hour weekly peer supervision sessions during Year One. During Year Two, this requirement is left up to the site. Typically, the site supervisor holds one- to two-hour weekly supervisions then. Please indicate your site's intention regarding these supervision times.
- Phase/Year Three is considered a maintenance phase. A national consultant is assigned to monitor the site monthly through a call with the site supervisor, and this national consultant will do one site visit per year.

Additional supervision
Child psychiatrists and/or psychologists or medical psychologists provide consultation to the FFT teams, as needed. Psychiatrists and/or psychologists are employees/subcontractors of the provider. All analysis of problem behaviors must be performed under the supervision of a licensed psychologist/medical psychologist.

Monitoring and assessment of service delivery:
The provider will assess and monitor the delivery of the FFT service via the use of the CSS. This is an online data base which has been originated by FFT, LLC. The type of data collected by the CSS includes:

- Assessments of risk and protective factors (Risk and Protective Factors Assessment)
- Relationship assessments (this is embedded in the progress note)
- Individual functioning (pre- and post-intervention) (OQ-45.2)
- Functioning within the context of the assessments (pre- and post-intervention) YOQ 2.01 and YOQ SR
- Assessments of family and therapist agreement (Counseling Process Questionnaire (CPQ))
- Adherence ratings (CPQ and weekly adherence ratings – by national consultant in Year One and by site supervisor in Year Two and beyond)
- Competence ratings (FFT global therapist rating)
- Completion rates (CSS closed case summary)
- Drop-out rates (CSS closed case summary)
- Time of drop-out (CSS closed case summary or case review report)
- Outcome data (family and therapist perspective) at time of discharge (TOM, COM-A and COM-P)

Each FFT therapist will receive a log on and password for the CSS for referencing their own clients only. The provider will receive an administrator/evaluator log on and password. The FFT national consultant will also have access to the data from the CSS.