

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

#### Targeted Case Management Reimbursement Methodology (LAC 50:XV.10701)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XV.10701 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

As a result of a budgetary shortfall in state fiscal year 2013, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for targeted case management (TCM) services to reduce the reimbursement rates and to revise these provisions as a result of the promulgation of the January 2013 Emergency Rules which terminated Medicaid reimbursement of TCM services provided to first-time mothers in the Nurse Family Partnership Program and TCM services rendered to HIV disabled individuals (*Louisiana Register*, Volume 39, Number 12).

The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for TCM services provided to new opportunities waiver (NOW) recipients in order to adopt a payment methodology based on a flat monthly rate rather than 15-minute increments (*Louisiana Register*, Volume 40, Number 6). This Emergency Rule is being promulgated to continue the provisions of the July 1, 2014 Emergency Rule. This action is being taken to promote the health and welfare of NOW participants by ensuring continued access to Medicaid covered services.

Effective February 28, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for TCM for NOW services.

#### Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part XV. Services for Special Populations

##### Subpart 7. Targeted Case Management

#### Chapter 107. Reimbursement

##### §10701. Reimbursement

A. - H.3.a. ...

I. - J. Reserved.

K. Effective for dates of service on or after July 1, 2014, reimbursement for case management services provided to participants in the new opportunities waiver shall be reimbursed at a flat rate for each approved unit of service.

1. The standard unit of service is equivalent to one month and covers both service provision and administrative costs.

- a. Service provision includes the core elements in:
  - i. §10301 of this Chapter;
  - ii. the case management manual; and
  - iii. contracted performance agreements.
2. All services must be prior authorized.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1040 (May 2004), amended LR 31:2032 (August 2005), amended LR 35:73 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1903 (September 2009), amended LR 36:1783 (August 2010), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:97 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3302 (December 2013), LR 40:1700,1701 (September 2014), LR 41:

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

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

Kathy H. Kliebert  
Secretary

1502#064

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

#### Therapeutic Group Homes Licensing Standards (LAC 48:I.Chapter 62)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 48:I.Chapter 62 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2009. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

In compliance with the directives of R.S. 40:2009, the Department of Health and Hospitals, Bureau of Health Services Financing adopted provisions governing the minimum licensing standards for therapeutic group homes(TGH)in order to prepare for the transition to a comprehensive system of delivery for behavioral health services in the state (*Louisiana Register*, Volume 38, Number 2).

The department promulgated an Emergency Rule which amended the provisions governing TGH licensing standards to revise the current TGH licensing regulations (*Louisiana Register*, Volume 40, Number 7). This Emergency Rule is being promulgated to continue the provisions of the July 20, 2014 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and recipient access to services.

Effective March 19, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the licensing standards for TGH providers.

#### Title 48

### PUBLIC HEALTH—GENERAL

#### Part I. General Administration

##### Subpart 3. Licensing

#### Chapter 62. Therapeutic Group Homes

##### Subchapter A. General Provisions

###### §6203. Definitions

*Active Treatment*—implementation of a professionally developed and supervised comprehensive treatment plan that is developed no later than seven days after admission and designed to achieve the client's discharge from inpatient status within the shortest practicable time. To be considered *active treatment*, the services must contribute to the achievement of the goals listed in the comprehensive treatment plan. Tutoring, attending school, and transportation are not considered *active treatment*. Recreational activities can be considered *active treatment* when such activities are community based, structured and integrated within the surrounding community.

\*\*\*

*Therapeutic Group Home (TGH)*—a facility that provides community-based residential services to clients under the age of 21 in a home-like setting of no greater than 10 beds under the supervision and oversight of a psychiatrist or psychologist.

\*\*\*

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:402 (February 2012), amended LR 41:

##### Subchapter B. Licensing

###### §6213. Changes in Licensee Information or Personnel

A. - C.1. ...

2. A TGH that is under provisional licensure, license revocation, or denial of license renewal may not undergo a CHOW.

D. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:405 (February 2012), amended LR 41:

###### §6219. Licensing Surveys

A. - D. ...

E. If deficiencies have been cited during a licensing survey, regardless of whether an acceptable plan of correction is required, the department may issue appropriate sanctions, including, but not limited to:

1. ...

2. directed plans of correction;
3. provisional licensure;
4. denial of renewal; and/or
5. license revocations.

F. - F.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:406 (February 2012), amended LR 41:

###### §6221. Complaint Surveys

A. - J.1. ...

a. The offer of the administrative appeal, if appropriate, as determined by the Health Standards Section, shall be included in the notification letter of the results of the informal reconsideration results. The right to administrative appeal shall only be deemed appropriate and thereby afforded upon completion of the informal reconsideration.

2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:407 (February 2012), amended LR 41:

###### §6223. Statement of Deficiencies

A. - C.1. ...

2. The written request for informal reconsideration of the deficiencies shall be submitted to the Health Standards Section and will be considered timely if received by HSS within 10 calendar days of the provider's receipt of the statement of deficiencies.

3. - 5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:407 (February 2012), amended LR 41:

###### §6225. Cessation of Business

A. Except as provided in §6295 of this chapter, a license shall be immediately null and void if a TGH ceases to operate.

1. - 3. Repealed.

B. A cessation of business is deemed to be effective the date on which the TGH stopped offering or providing services to the community.

C. Upon the cessation of business, the provider shall immediately return the original license to the department.

D. Cessation of business is deemed to be a voluntary action on the part of the provider. The provider does not have a right to appeal a cessation of business.

E. Prior to the effective date of the closure or cessation of business, the TGH shall:

1. give 30 days' advance written notice to:

- a. HSS;
- b. the prescribing physician; and
- c. the parent(s) or legal guardian or legal representative of each client; and

2. provide for an orderly discharge and transition of all of the clients in the facility.

F. In addition to the advance notice of voluntary closure, the TGH shall submit a written plan for the disposition of client medical records for approval by the department. The plan shall include the following:

1. the effective date of the voluntary closure;

2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed provider's clients' medical records;

3. an appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the client or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing provider, at least 15 days prior to the effective date of closure.

G. If a TGH fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a TGH for a period of two years.

H. Once the TGH has ceased doing business, the TGH shall not provide services until the provider has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:407 (February 2012), amended LR 41:

#### **§6227. Denial of License, Revocation of License, or Denial of License Renewal**

A. - C.3. ...

D. Revocation of License or Denial of License Renewal. A TGH license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. - 15. ...

16. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment;

17. failure to timely pay outstanding fees, fines, sanctions, or other debts owed to the department; or

18. failure to maintain accreditation, or for a new TGH that has applied for accreditation, the failure to obtain accreditation.

19. Repealed.

E. If a TGH license is revoked or renewal is denied or the license is surrendered in lieu of an adverse action, any owner, officer, member, director, manager, or administrator of such TGH may be prohibited from opening, managing, directing, operating, or owning another TGH for a period of two years from the date of the final disposition of the revocation, denial action, or surrender.

F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:408 (February 2012), amended LR 41:

#### **§6229. Notice and Appeal of License Denial, License Revocation, License Non-Renewal, and Appeal of Provisional License**

A. - B. ...

1. The TGH provider shall request the informal reconsideration within 15 calendar days of the receipt of the

notice of the license denial, license revocation, or license non-renewal. The request for informal reconsideration must be in writing and shall be forwarded to the Health Standards Section.

B.2. - D. ...

E. If a timely administrative appeal has been filed by the provider on a license denial, license non-renewal, or license revocation, the DAL or its successor shall conduct the hearing pursuant to the Louisiana Administrative Procedure Act.

E.1. - G.2. ...

3. The provider shall request the informal reconsideration in writing, which shall be received by the HSS within five days of receipt of the notice of the results of the follow-up survey from the department.

a. Repealed.

4. The provider shall request the administrative appeal within 15 days of receipt of the notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law, or its successor.

a. Repealed.

H. - H.1....

I. If a timely administrative appeal has been filed by a provider with a provisional initial license that has expired or by an existing provider whose provisional license has expired under the provisions of this Chapter, the DAL or its successor shall conduct the hearing pursuant to the Louisiana Administrative Procedure Act.

1. - 2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:409 (February 2012), amended LR 41:

#### **Subchapter D. Provider Responsibilities**

##### **§6247. Staffing Requirements**

A. - C.2. ...

3. A ratio of not less than one staff to five clients is maintained at all times; however, two staff must be on duty at all times with at least one being direct care staff when there is a client present.

D. - D.3....

4. Therapist. Each therapist shall be available at least three hours per week for individual and group therapy and two hours per month for family therapy.

5. Direct Care Staff. The ratio of direct care staff to clients served shall be 1:5 with a minimum of two staff on duty per shift for a 10 bed capacity. This ratio may need to be increased based on the assessed level of acuity of the youth or if treatment interventions are delivered in the community and offsite.

E. - G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:413 (February 2012), amended LR 41:

##### **§6249. Personnel Qualifications and Responsibilities**

A. - 1.a.ii.(c). ...

b. A supervising practitioner's responsibilities shall include, but are not limited to:

i. reviewing the referral PTA and completing an initial diagnostic assessment at admission or within 72 hours of admission and prior to service delivery;

ii. - iv. ...

v. at least every 28 days or more often as necessary, providing:

1.b.v.(a). - 6.b.viii. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:414 (February 2012), amended LR 41:

#### **Subchapter F. Services**

##### **§6267. Comprehensive Treatment Plan**

A. Within seven days of admission, a comprehensive treatment plan shall be developed by the established multidisciplinary team of staff providing services for the client. Each treatment team member shall sign and indicate their attendance and involvement in the treatment team meeting. The treatment team review shall be directed and supervised by the supervising practitioner at a minimum of every 28 days.

B. - G5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:418 (February 2012), amended LR 41:

##### **§6269. Client Services**

A. - A.4. ...

B. The TGH is required to provide at least 16 hours of active treatment per week to each client. This treatment shall be provided and/or monitored by qualified staff.

C. The TGH shall have a written plan for insuring that a range of daily indoor and outdoor recreational and leisure opportunities are provided for clients. Such opportunities shall be based on both the individual interests and needs of the client and the composition of the living group.

C.1. - G4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:419 (February 2012), amended LR 41:

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

Interested persons may submit written comments to Cecile Castello, Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821 or by email to MedicaidPolicy@la.gov. Ms. Castello is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert  
Secretary

1502#065

## **DECLARATION OF EMERGENCY**

### **Department of Health and Hospitals Office for Citizens with Developmental Disabilities**

#### **Certification of Medication Attendants (LAC 48:IX.Chapter 9)**

The Office for Citizens with Developmental Disabilities (OCDD) adopts LAC 48:IX.Chapter 9, Guidelines for Certification of Medication Attendants (CMA). R.S. 37:1021-1025 authorizes the establishment of "a medication administration course for the purpose of training and certifying unlicensed personnel to administer certain medication to residents of intermediate care facilities for the mentally retarded (ICFs/MR) and community homes for the mentally retarded either operated by the Office for Citizens with Developmental Disabilities (OCDD) or funded through the Department of Health and Hospitals (DHH); and to individuals in programs/agencies contracting for services with DHH except as prohibited in §911.B.5."

Based on an opinion given by the Louisiana State Board of Medical Examiners, the Department of Health and Hospitals has discontinued the use of physician delegation forms in intermediate care facilities and home and community-based settings. Unlicensed personnel must now complete minimum training requirements in order to administer medication to individuals with intellectual and developmental disabilities. The termination of physician delegation has resulted in a large influx of individuals seeking CMA training and certification. This has created an administrative burden to providers as well as OCDD to timely process a steadily increasing number of certifications. This is also an unfunded training mandate, which incurs significant costs to provider agencies and requires annual continuing education for re-certification. Due to limited funding, provider agencies who cannot afford to maintain the certification will experience a reduction in unlicensed personnel who are qualified to give medication to clients, thus increasing the risk for medication errors, critical incidents, and mortality for medically compromised and vulnerable clients. The Office for Citizens with Developmental Disabilities seeks to extend the certification period for certified medication attendants to two years, effective February 27, 2015. Provider agencies must determine CMA competency annually during the two-year period.

Also effective February 27, 2015, OCDD will allow CMAs who have not worked directly with medication administration for 12 months or more to be administered the statewide exam and a competency evaluation rather than requiring that they repeat the training. The opportunity for this will also decrease administrative burden and allow qualified individuals to more quickly re-enter the work force which will in turn, help assure client health and safety. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.