RULE

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

Healthy Louisiana and Coordinated System of Care Waiver
Behavioral Health Directed Payments
(LAC 50:XXXIII.503 and 703)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have adopted LAC 50:XXXIII.503 and 703 in 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. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXXIII. Behavioral Health Services
Subpart 1. Healthy Louisiana and Coordinated System of Care Waiver

Chapter 5. Reimbursement

§503. Directed Payments

A. Provider Directed Payments

1. Subject to written approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), the Department of Health (hereafter referred to as "the department" and/or "LDH") shall provide directed payments to qualifying providers that participate in

the Healthy Louisiana Medicaid managed care program or Coordinated System of Care (CSoC) waiver, in accordance with the applicable section 438.6(c) preprint(s) approved by CMS, federal regulations, and departmental requirements. Each CMS approved directed payment arrangement is effective for one Healthy Louisiana Medicaid managed care or CSoC contract rating period, unless otherwise approved by CMS.

2. Qualifying Provider

a. High fidelity wraparound agencies (WAA) and wraparound facilitators (WF), WF supervisors, WAA coaches, and WAA administrators that meet the criteria specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements; or

b. Peer support specialists, supervisors, trainers, and administrators employed by the family support organization (FSO) that meet the criteria specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements; or

c. Licensed mental health practitioners (LMHPs) and psychiatrists that provide behavioral health outpatient services and that meet the criteria specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements.

3. The Healthy Louisiana Medicaid managed care organization (MCO) and CSoC contractor shall assign qualifying providers to provider classes based upon criteria specified in the applicable section 438.6(c) preprint(s) approved by CMS, in accordance with departmental requirements.

a. Qualifying providers shall have no right to an administrative appeal regarding the qualifying provider criteria or determination of which providers meet the qualifying provider criteria.

4. The MCO and CSoC contractor shall utilize a payment process, whereby directed payments will be calculated and paid out based on the data and methodology specified in the applicable section 438.6(c) preprint(s) approved by CMS, in accordance with departmental requirements.

a. Qualifying providers shall have no right to an administrative appeal regarding calculation of directed payments or measurement rates.

5. Based upon the methodology specified in the applicable section 438.6(c) preprint(s) approved by CMS, in accordance with departmental requirements, the department shall cause directed payments to be paid in a single upfront lump sum payment to the MCOs; and payments shall be paid to the CSoC contractor within 30 days of receipt of invoice(s), on a retrospective basis.

a. Funding for the directed payments is only available during the time period in the applicable section 438.6(c) preprint(s) approved by CMS or until payments are exhausted, whichever comes first.

6. In accordance with the applicable section 438.6(c) preprint(s) approved by CMS and departmental requirements, directed payments must be based on actual utilization and delivery of services during the applicable contract period.

a. Within six months of the end of the rating period, the MCOs and CSoC contractor shall perform a reconciliation as specified in the applicable section 438.6(c) preprint approved by CMS or as otherwise dictated in accordance with departmental requirements.

i. Qualifying providers shall have no right to an administrative appeal regarding any issue related to reconciliation, including, but not limited to, the timing, amount of the reconciliation, and process.

7. If a qualifying provider is subject to a reconciliation, the qualified provider shall pay all amounts owed to the MCO or CSoC contractor, in accordance with departmental requirements.

a. In addition to all other available remedies, the MCO and the CSoC contractor has the authority to offset all

amounts owed by a qualifying provider due to a reconciliation against any payment owed to the qualifying provider, including, but not limited to, any payment owed by the MCOs or CSoC contractor.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 49:

Chapter 7. Grievance and Appeals Process

§703. Provider Grievance and Appeal Process

A. If the provider is filing a grievance or appeal on behalf of the member, the provider shall adhere to the provisions outlined in §701 of this Chapter.

B. The MCO and CSoC contractor must have a grievance and appeals process for claims, medical necessity, and contract disputes for providers in accordance with the contract and department issued guidance.

1. The MCO and CSoC contractor shall establish and maintain a procedure for the receipt and prompt internal resolution of all provider initiated grievances and appeals as specified in the contract and department issued guidance.

2. The grievance and appeals procedures, and any changes thereto, must be approved in writing by the department prior to their implementation.

3. Notwithstanding any MCO, CSoC contractor, or department grievance and appeal process, nothing contained in any document, including, but not limited to Rule or contract, shall preclude a provider's right to pursue relief through a court of appropriate jurisdiction.

4. The MCO and CSoC contractor shall report on a monthly basis all grievance and appeals filed and resolutions in accordance with the terms of the contract and department issued guidance.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing, LR 49:

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.

Stephen R. Russo, JD

Secretary