

Louisiana's Coordinated System of Care

Residential Facilities Transition

Technical Assistance Meeting

April 20, 2011

8:30 a.m. – 12:30 p.m.

9th Floor, Iberville Building

627 North 4th Street, Baton Rouge

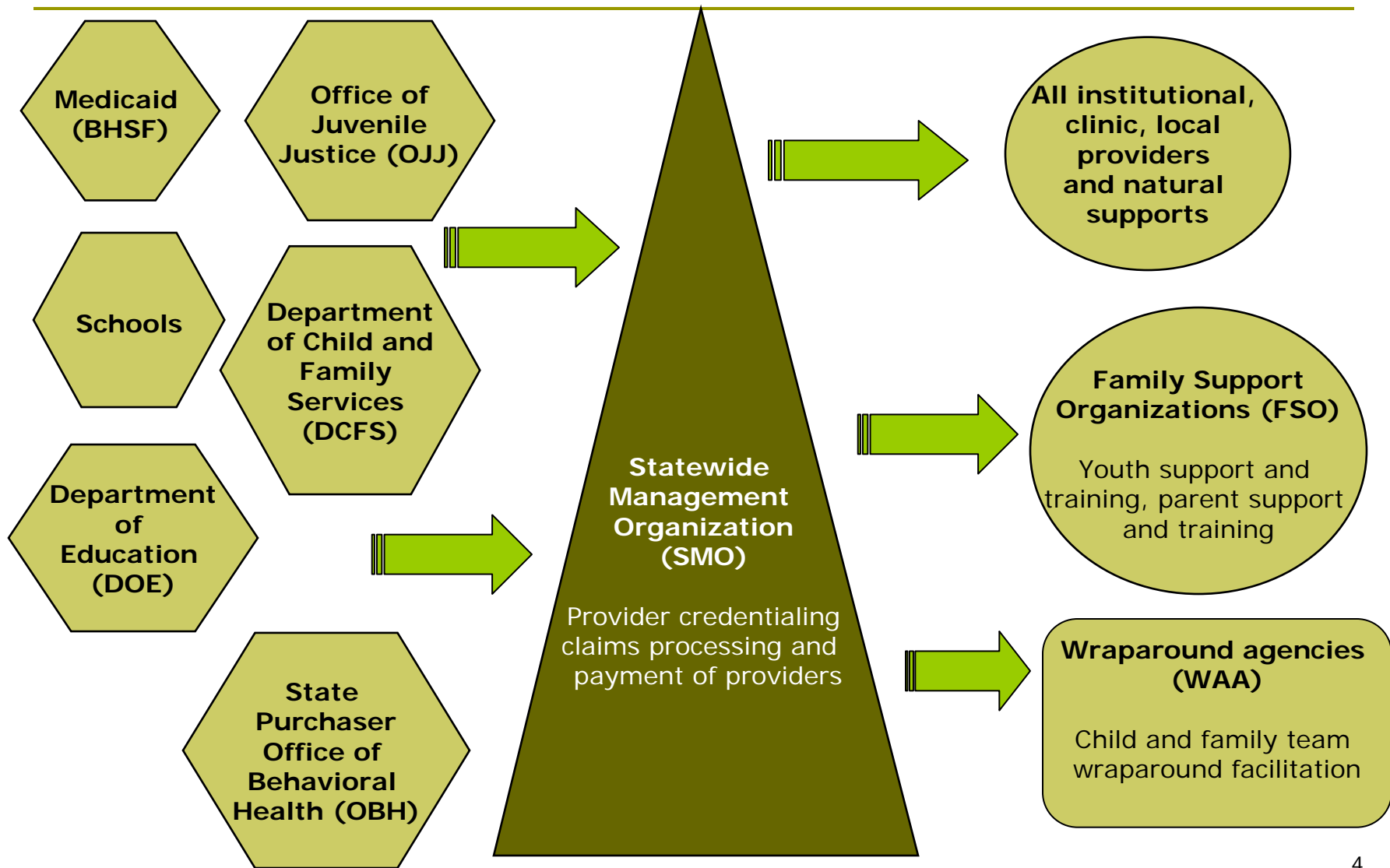
Agenda

- **Introductions and Welcome:**
 - **Department of Children and Family Services (DCFS), Karla Venkataraman – 15 minutes (Slides 1 - 2)**
- **Overview of new system:**
 - **Office of Behavioral Health (OBH), Ron Lampert – 10 minutes (Slides 3 - 4)**
- **Services and Timeline:**
 - **Medicaid, Dr. James Hussey – 10 minutes (Slides 5 - 7)**
- **IMDs, Options and Capacity:**
 - **Brenda Jackson, Mercer – 30 minutes (Slides 8 - 22)**
- **How will certifications and licensure occur? How will referrals and prior authorizations work?**
 - **DHH/OBH Galen Schum – 10 minutes (Slides 23-24)**
- **How will payments work under the new system?**
 - **Medicaid, LouAnn Owen – 10 minutes (Slides 25 - 29)**
- **Next steps:**
 - **Office of Behavioral Health (OBH), Ron Lampert – 5 minutes (Slide 31)**
- **Question and answers:**
 - **Joe Keegan – 60 minutes**
- **Addendum**

Overview of program approach

- ❑ The State of Louisiana (State) is undertaking the development of a Coordinated System of Care (CSoC) for Louisiana's at-risk children and youth with significant behavioral health (BH) challenges or co-occurring disorders in, or at imminent risk of, out-of-home placement.
- ❑ Louisiana leaders acknowledge that the needs of these children and families are currently being served through a fragmented service delivery model that is not well coordinated, is many times inadequate to meet their needs and is often difficult to navigate.
- ❑ This, too often, results in Louisiana's children with the highest level of risk detained in secure or residential settings due to lack of service options in the community.
- ❑ The mental health and substance abuse Statewide Management Organization (SMO) is:
 - At risk for adult services, including adults with limited mental health and substance abuse benefits
 - Non-risk for children's services and any individual with retroactive eligibility and spend-down

Proposed children's CSoC service payments



Services in children's CSoC system

Medically necessary services

- Pharmacy
- Licensed practitioner services, including licensed school employee services
- Unlicensed practitioner services, including certified school psychologist services
- Crisis intervention
- Substance abuse
- Treatment group home
- Psychiatric residential treatment facility
- Inpatient hospital

Services for children in CSoC

- Wraparound facilitation
- Case conference
- Independent living/skills building
- Short-term respite
- Youth support and training
- Parent support and training
- Crisis stabilization

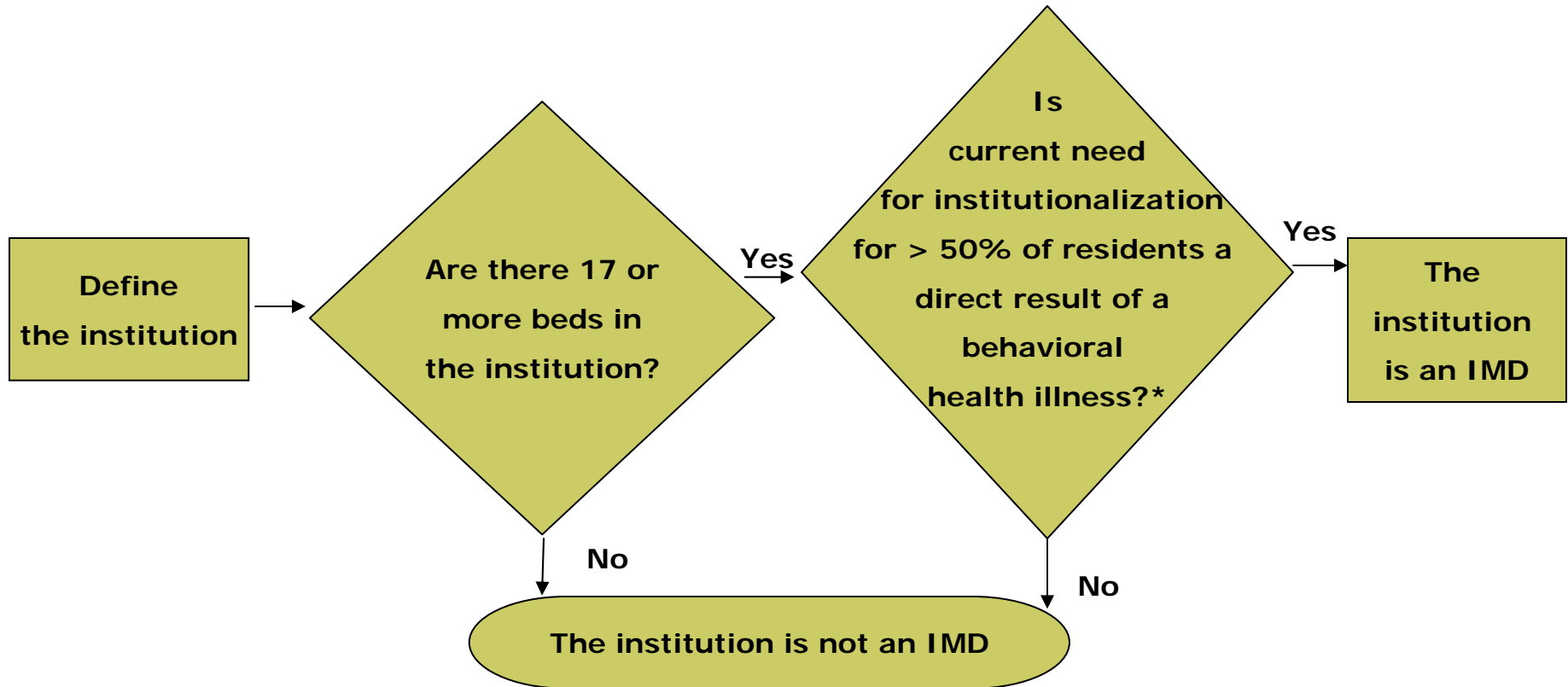
Timeline for children's CSoC

- January 1, 2012, children and adult statewide implementation of SMO, including the following services:
 - Hospital
 - Pharmacy
 - Child and adult (serious mental illness/major mental disorder (SMI/MMD)) licensed practitioner services, including school-based services
 - Child and adult (SMI/MMD) unlicensed practitioner services, including school-based services
 - Child and adult (SMI/MMD) crisis intervention
 - Child and adult substance abuse
 - Child therapeutic group home (TGH)
 - Child psychiatric residential treatment facilities (PRTFs)
 - Treatment planning for special needs individuals

Timeline for children's CSoC (cont'd)

- January 1, 2012 phase-in CSoC by region:
 - Independent living/skills building
 - Short-term respite (in home and community)
 - Youth support and training
 - Family support and training
 - Crisis stabilization (facility-based)

Determining if a residential facility is an institute for mental disease (IMD)



*This is evidenced by:

1. The resident has current diagnosis or had a behavioral health diagnosis at the time of admission, if the patient was admitted within the past year.
2. A large proportion of the residents are receiving psychopharmacological drugs.

Payments if a child residential facility is an IMD

- In Louisiana, the SMO will be paid for services authorized and provided consistent with quality assurance guidelines on a fee for service (FFS) basis for children.
 - Inpatient psychiatric hospitals and PRTFs are the only IMDs eligible.

Payments if an adult residential facility is an IMD

- In Louisiana, the SMO will be paid an insurance premium (capitated) for adults:
 - Medicaid services provided in an IMD facility may be funded by a capitated program like the SMO.
 - The contract could include, in its list of services to be provided under the contract, such services as acute detox and American Society of Addiction Medicines (ASAM) III.5 services. The SMO may then purchase these services from an IMD facility (e.g., adult substance abuse programs in Louisiana). For enrollees over the age of 21 and under the age of 65, the contract may not explicitly require that the entity use IMD facilities (e.g., facilities with more than 16 beds and 50% of the individuals with a behavioral health diagnosis).
 - This will allow Louisiana adult substance abuse programs, which are high quality, to contract with the SMO, regardless of size.

Options – residential continuum of care

Principles of residential care

- ❑ Contract with the SMO
- ❑ Should provide a highly structured setting, with a focus on stabilization of the child
- ❑ Should follow a no reject/eject policy
- ❑ The principle of unconditional support is followed
- ❑ Serving the child at most appropriate level of care

Options – residential continuum of care

- ❑ Inpatient psychiatric hospital or general hospital psychiatric unit
- ❑ Psychiatric residential treatment facilities:
 - Child/youth residential 250 beds
 - Child/youth addiction disorder 150 beds
- ❑ Therapeutic group homes 275 beds
- ❑ Non-medical group homes (NMGH):
 - Basic group home 100 beds
 - Mother and child group home 8 beds
 - Diagnostic/step-down 106 beds
- ❑ Crisis stabilization:
 - 180 children get 14 days annually
- ❑ Short-term respite (outside facility):
 - 720 children get 216 hours annually
- ❑ Addiction disorder (adult) 390 beds

Options – inpatient psychiatric hospital or general hospital psych unit

- ❑ Must contract with SMO
- ❑ Must participate in Medicaid
- ❑ General hospital with psychiatric unit
- ❑ Inpatient psychiatric hospital eligible under Medicaid

Options – PRTFs

- ❑ Must contract with SMO and meet LAC 48:I.Chapter 90
- ❑ Must be accredited by The Joint Commission (TJC), The Council on Accreditation (COA) or The Commission on Accreditation of Rehabilitation Facilities (CARF)
- ❑ Facilities may be IMDs
- ❑ Must comply with pre-certification and utilization review requirements
- ❑ Must comply with active treatment plan requirements
- ❑ Must be physician-directed
- ❑ Must comply with seclusion and restraint requirements
- ❑ Number of beds needed statewide:
 - PRTF – 250 beds
 - PRTF addiction disorder – 150 beds
- ❑ Includes ASAM levels III.5 and III.7

Options – Therapeutic group homes

- ❑ Must contract with SMO and have eight beds or less.
- ❑ SMO will reimburse the facility:
 - Medicaid will pay SMO for behavioral health treatment
 - Child may have Medicaid card for physical health treatment
 - Non-Medicaid funds (OJJ, DCFS, OBH or family) pay SMO for room and board
- ❑ Children attend school in public school system.
- ❑ May not be provided in an IMD.
- ❑ Therapeutic group homes 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 State Plan definition on website: www.dhh.gov and promising practice on website.
- ❑ Approximately 275 beds needed statewide.

Options – Non-medical group homes

- ❑ Must contract with SMO as a group home and be licensed by DCFS.
- ❑ SMO will reimburse the enrolled facility for room and board (OJJ, DCFS or family will reimburse SMO) using non-Medicaid funds.
- ❑ SMO will reimburse individual practitioners enrolled with the SMO for behavioral health treatment of residents. Child may have Medicaid card for physical health treatment.
- ❑ Must have 16 beds or less.
- ❑ May have children that need behavioral health care (BH diagnosis or psychotropic medications).
- ❑ Children attend school in public school system.
- ❑ To the extent that the child is eligible for a TGH or PRTF level of care as determined by the Child and Adolescent Needs and Strengths (CANS), the child should be placed in that level of care.
- ❑ All group homes must meet and abide by federal IMD limitations on payment.
- ❑ Includes three types: Basic, Diagnostic, and Mother and Infant.

Options – Non-medical group homes

Basic group home requirements

- ❑ Services provided in a basic group home setting must be provided by a community practitioner certified and credentialed by the SMO to provide those services.
- ❑ The facility has 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.
- ❑ Staff should have special training in working with at-risk children and in crisis intervention strategies. The trained staff provides 24-hour supervision.
- ❑ Shall manage and maintain a waiting list, as necessary, when children are referred but for whom there are no openings.
- ❑ Step-down from other medical congregate living.
- ❑ Approximately 100 beds needed statewide.

Options – Non-medical group homes

Diagnostic centers requirements

- ❑ Provide intensive, short term, initial placement for children while being assessed.
- ❑ During placement, these children must receive the full array of services that are required, and the SMO will be expected to assess and meet the child's needs.
- ❑ The SMO is responsible for making professional recommendations regarding preferred services, supports and placement type options based on the child's treatment needs, as translated by the completed assessments, as soon as possible, but within the first 30 days of placement.
- ❑ Sixty day maximum placement.
- ❑ The SMO ensures that discharge planning begins at admission to ensure that transition of the child occurs prior to the 60-day timeline. The SMO ensures that a discharge summary is completed within 14 days for planned discharges or immediately for unplanned discharges.
- ❑ Approximately 106 beds needed statewide.

Options – Non-medical group homes

Mothers with infant level requirements

- ❑ Group homes – Mothers with infant level requirements:
 - 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 SMO.
- ❑ 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.
- ❑ The mother must be screened by CANs to require this level of care.
- ❑ Approximately 8 beds needed statewide.

Options – Crisis stabilization

- ❑ Must contract with SMO and be provided in a facility.
- ❑ Only for children enrolled in CSoC. Maximum of seven days per episode. Only budgeted for 180 children to get 14 days each in first year.
- ❑ 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.
- ❑ Provider qualifications
 - Respite care services agency
 - Center-based respite
 - Crisis receiving center
 - Crisis stabilization services provided by or in an IMD are non-covered

Options – Short term respite

- ❑ Must contract with SMO. Only for children enrolled in CSoC. Maximum of 72 hours per episode. Only budgeted for 720 children to get 216 hours each in first year.
- ❑ 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 serious emotional disturbance or relief of the child.
- ❑ Provider qualifications:
 - Short term respite care may not be provided simultaneously with crisis stabilization services.
 - Direct support worker
 - Respite care services agency
 - Agency-personal care attendant
 - Center-based respite
 - Crisis receiving center
 - Respite services provided by or in an IMD are non-covered

Options – addiction disorder (adult)

- ❑ Must contract with SMO
- ❑ Must provide an ASAM level of care
- ❑ Must be licensed by DHH as an addiction disorder facility and compliant with the residential module (LAC 48:I.Chapter 74)

Licensure of residential facilities

- Licensed/Certified by DHH health standards:
 - Psychiatric residential treatment facilities
 - Therapeutic group homes
 - Crisis stabilization
 - Short term respite (not in a facility)
 - Addiction disorder (adult)

- Licensed by DCFS:
 - Non-medical group homes:
 - Basic group homes
 - Diagnostic centers
 - Mothers with infant level

Referrals and prior authorization process

- ❑ The SMO will prior authorize all institutional and residential care.
- ❑ Referrals to the SMO may be made by any agency or provider.
- ❑ Training for judges and probation officers will be held this fall, prior to the program implementation.

Payments

- ❑ All providers will need to contract with the SMO.
- ❑ All payments to residential and non-residential behavioral health providers will be through the SMO.
- ❑ SMO is expected to contract with the State between July and September 2011, with a January 1, 2011 start date.

Program goals for reimbursement

- ❑ To provide the necessary resources and funding to address the core needs of at-risk Louisiana youths
- ❑ To develop reimbursement rates that are sufficient to attract providers to these new programs, while also recognizing the economic pressures faced by the state of Louisiana
- ❑ To better leverage available federal Medicaid funding within the behavioral health services arena
- ❑ To transition, when practical, from the initial program reimbursement rates to reimbursement rates that reflect Louisiana-specific provider cost experiences under these programs

Reimbursement methodology

Service Setting	Medicaid	DCFS, OJJ, OBH or Family
PRTF	Per diem set by Medicaid	N/A
TGH	Per diem (therapeutic services) set by Medicaid	Per diem (room and board)
Non-medical group home	Medicaid fee schedule for eligible services set by Medicaid	TBD
Crisis stabilization	Per diem (therapeutic services) set by Medicaid	Per diem (room and board)
Short-term respite	Medicaid fee schedule set by Medicaid	N/A
Addiction disorder	Negotiated with SMO (therapeutic services)	Per diem (room and board)

Initial payment rate development for PRTFs/TGHs

- ❑ A series of workgroup meetings will be held, with industry representatives, to solicit input for the initial program reimbursement rates.
- ❑ Initial rates will consider the expected cost of services required to be provided (modeled rate).
- ❑ Initial rates may also consider other states' cost experiences with similar behavioral health care programs.

Actual cost of services provided for PRTFs/TGHs

- ❑ Providers will be asked to file cost reports with the Medicaid program, so the initial program reimbursement rates can be evaluated.
- ❑ The specific cost report information required for submission will be determined by the State at a later date.
- ❑ The initial rates may be adjusted to reflect industry cost experiences under the new programs.

Next steps

- ❑ Now – PRTF DHH licensure may begin immediately for accredited children’s facilities, and adult addiction services facilities may be licensed by DHH if they meet the core addiction services licensing requirements, plus the residential module
- ❑ May – Face-to-face meetings
- ❑ June – Technical assistance visits to providers wanting to be PRTFs
- ❑ July – TGH regulations finalized and PRTF regulations modified
- ❑ August – TGH licensure may begin for accredited facilities
- ❑ July-September – SMO contract finalized and all residential providers may go through the credentialing process
- ❑ October – Conduct trainings for State employees, providers and judges in conjunction with the SMO
- ❑ January 1, 2012 – Contract with SMO begins, and residential providers receive referrals and payments from the SMO

Questions and Answers?

Addendum

What is an IMD?

Determine if each institution is an IMD

- ❑ IMDs are defined as “a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services” (§42 CFR 435.1009):
 - Does the institution have more than 16 beds?
 - Does the institution have more than 50% of residents with mental diseases?
- ❑ To not be considered an IMD, a group of facilities – with 16 or fewer beds in any one facility and a total number of beds of 17 or more in multiple facilities – must be geographically separate, as well as operationally separate, in such things as budgeting, clinical staffing (including the medical director), supplies and equipment, and upkeep of the building. The group of facilities may share the same ownership and the same executive director, if the other criteria are met.

IMD exclusion

- ❑ Federal financial participation (FFP) is not available for any medical assistance under title XIX for services provided to any individual who is under the age of 65, and who is a patient in an IMD.
- ❑ This payment exclusion was designed to ensure that states, rather than the federal government, continue to have principal responsibility for funding inpatient psychiatric services.
- ❑ Under this broad exclusion, no FFP is available for the cost of services provided, either inside or outside the IMD, while the individual is a patient in the facility.
- ❑ States cannot cover IMD services for individuals, under the age of 65, under Medicaid. This includes institutional and medical facilities, such as drug and alcohol treatment facilities with 16 or more beds.

Exception to IMD exclusion

- ❑ States may provide optional coverage for individuals under the age of 21, in psychiatric facilities that have been accredited by organizations recognized by the State, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 42 CFR 440.160.
- ❑ Individuals under the age of 21 may receive Medicaid State Plan services as inpatients in a psychiatric hospital or in a PRTF, even if these facilities meet the definition of an IMD.
- ❑ Psychiatric hospitals and PRTFs are the only IMDs in which children may be patients and whose care may be paid for by Title XIX.

Restrictions on children's payments

- ❑ Medicaid providers, including inpatient general hospitals, other than inpatient psychiatric hospitals and PRTFs, may not receive Medicaid funding for any child residents in a facility of 17 beds or more, with more than 50% of their children having mental health diagnoses, because it is considered an IMD.
- ❑ If a facility is an IMD over 17 beds, Medicaid will only pay for inpatient psychiatric care if the facility is a PRTF or qualified inpatient psychiatric hospital.

Determine if each institution is an IMD

Restrictions on federal funding

- ❑ Psychiatric hospitals and PRTFs are the only IMDs in which children may be patients and whose care may be paid for by Title XIX.
- ❑ Any services provided to the child IMD resident **by the IMD, in the IMD, as part of the active treatment plan of care**, are eligible for federal Medicaid match and are assumed to be covered under the rate paid to the facility.
- ❑ Services provided to the child IMD resident **by other providers and outside the IMD or services that are not on the active treatment plan of care** are not eligible for federal Medicaid match.

Determine if each institution is an IMD

Definition of IMD resident for under age 22

- ❑ Resident is defined in federal regulation to exclude a child on conditional release or convalescent leave, if he is under age 22 and receiving inpatient psychiatric care under this section of the State Plan, until he is unconditionally released or, if earlier, the date he reaches age 22.
- ❑ Separately billed services provided to individuals under the age of 22, who are residents of an IMD while on convalescent leave or conditional release, are not eligible for FFP.

Determine if each institution is an IMD

What is an institution?

- Centers for Medicare & Medicaid Services (CMS) requires the State to consider six criteria, in totality, to determine if separate “components” or facilities are, in fact, a single institution. The criteria for two facilities being considered as a single institution are the following:
 - Are all components controlled by one owner or one governing body?
 - Is the chief medical officer responsible for the medical staff activities in all components?
 - Does one chief executive officer (CEO) control all administrative activities in all components?
 - Are all components separately licensed?
 - Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?
 - If two or more of the components are participating under the same provider category (such as nursing facilities), can each component meet the conditions of participation independently?

40

Determine if each institution is an IMD

Principles for determining if multiple facilities are a single institution:

- ❑ States have solicited responses from CMS regarding on how to apply the institution criteria.
- ❑ The following are the principles expressed by CMS to apply to multiple facilities under a single ownership/governing body:
 - Shared medical staff means a single medical director for multiple facilities, a clinical staff person serving multiple facilities or direct care staff with responsibilities in multiple facilities.
 - Geographically separate means facilities that are not in close proximity or adjacent, and the facilities do not share operational responsibilities and staffing responsibilities between facilities.
 - A single institution with multiple facilities may provide treatment at a single facility that is part of the institution or at each facility.

Determine if each institution is an IMD (cont'd)

Principles for determining if multiple facilities are a single institution:

1. Do the facilities share an owner or governing body? If no, then the facilities are separate institutions. If yes, go to question #2.
2. Do the facilities share a CEO, who controls all administrative activities in multiple components? If no, then the facilities are separate institutions. If yes, go to question #3.
3. Do the facilities share a CEO, payroll and human resources divisions, but no other staff? If yes, then the facilities are separate institutions. If no, go to question #4.
4. Do the facilities share any administrative functions other than payroll, and human resources, such as lawn maintenance, laundry, facility maintenance or shared cafeteria and food service? If yes, the facilities are a single institution. If no, go to question #5.

Determine if each institution is an IMD (cont'd)

5. Do the facilities share a single medical director over multiple facilities, a clinical staff person, such as a psychologist/psychiatrist shared with all facilities, or direct care treatment staffs (licensed and unlicensed) with responsibilities in multiple facilities? If yes, the facilities are a single institution. If no, go to question #6.
6. Are the facilities licensed separately and geographically separate and not contiguous to other shared ownership facilities, so that it is not feasible to operate as a single institution? Geographically separate means facilities that are not in close proximity or adjacent, and the facilities do not share operational responsibilities and staffing responsibilities between facilities. If yes, then the facilities are separate institutions. If no, go to question #7.
7. Discuss the facts of the facilities with the State Medicaid Agency.

Determine if each institution is an IMD (cont'd)

Scenarios for determining if multiple facilities are a single institution (cont'd):

- ❑ Facilities share an owner/governing body. No administrative or clinical staff are shared. The components are licensed separately and are organizationally and geographically separate.
 - Each facility is considered a separate institution.
- ❑ Facilities share an owner/governing body and a CEO for administrative operations. Medical staff are shared between two or more facilities.
 - The facilities are considered to be a single institution.
- ❑ Facilities share an owner/governing body and a CEO for administrative operations. No medical staff are shared. Facilities are licensed separately. Facilities are geographically separate and not contiguous to other shared ownership facilities.
 - Each facility is considered a separate institution.

Determine if each institution is an IMD

Children in residential facilities

- A general medical surgical hospital (which is not a IMD) may operate as a PRTF. The hospital becomes an IMD only if the number of mental health inpatient psychiatric hospital beds and the number of PRTF beds exceed 50% of the total bed numbers of the general hospital combined. The general medical surgical hospital may operate:
 - One or more therapeutic group homes of eight (8) beds or less for children.
 - A PRTF for children that follows or adheres to all of the conditions of a PRTF and is interested in receiving Medicaid funding for 24-hour per day treatment services. Note: If the PRTF is geographically and functionally separate, shares no staff and is greater than 16 beds, the PRTF may be considered an IMD.

Determine if each institution is an IMD

Children in residential facilities (cont'd)

- ❑ Any small community-based group home or therapeutic group home of eight (8) beds or less operated by an IMD must be operated as a separate institution and comply with all rules for separate operational and medical staff, separate licensure and be organizationally and geographically separate. This facility/facilities would be eligible for payment of treatment services, and the room and board becomes the responsibility of the legally responsible party.
- ❑ A facility or group of small facilities, who share operational services and clinical staff and whose bed numbers are 17 or more when combined, is considered an IMD and may choose to become a PRTF, if the facility can meet all of the principles of a PRTF and the facility wishes to receive 24-hour per day funding through Medicaid.

Determine if each institution is an IMD

Children in residential facilities (cont'd)

- A community-based facility of 16 beds or less may choose to be:
 - a PRTF for children, if the facility follows all of the principles of a PRTF and wishes to receive Medicaid payment for 24-hour per day of mental health and substance abuse (MHSA) services.
 - A TGH for children, with eight (8) beds or less, receiving Medicaid payment for MHSA treatment services. In a small group home, payment of room and board will be the responsibility of the legally responsible payer other than Medicaid.
 - A non-medical group home for children with fewer than 50% of residents with a behavioral health diagnosis or on psychotropic drugs.

Determine if each institution is an IMD

Children in residential facilities (cont'd)

- ❑ A community-based facility of 17 beds or more may be a PRTF for children, if the facility is interested in receiving Medicaid funding and adheres to all the PRTF requirements for 24-hour per day mental health and substance abuse (MHSA) services.
- ❑ An IMD hospital may receive Medicaid funding to operate a PRTF for children in a facility of 17 or more beds, if the facility adheres to all the PRTF rules and principles.

Option Details

Options – PRTFs

- ❑ Must contract with SMO and meet LAC 48:I.Chapter 90
- ❑ Must be accredited by The Joint Commission (TJC), The Council on Accreditation (COA) or The Commission on Accreditation of Rehabilitation Facilities (CARF)
- ❑ Facilities may be IMDs
- ❑ Must comply with pre-certification and utilization review requirements
- ❑ Must comply with active treatment plan requirements
- ❑ Must be physician-directed
- ❑ Must comply with seclusion and restraint requirements
- ❑ Number of beds needed statewide:
 - PRTF – 250 beds
 - PRTF addiction disorder – 150 beds
- ❑ Includes ASAM levels III.5 and III.7

Options – PRTFs

Pre-certification and utilization review

- ❑ Children admitted to PRTFs must be pre-certified by the SMO's independent team pre-certification process:
 - The SMO's independent team must include a physician, have competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and have knowledge of the individual child's situation.
- ❑ The SMO's independent team pre-certification process must certify 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.

Options – PRTFs

Reimbursement

- Medicaid funding for all services provided by the PRTF, in the PRTF and on the active treatment plan:
 - A per diem rate, with the exception of psychiatrist and pharmacy services, which may be billed separately.
 - Psychiatrist and pharmacy services on the treatment plan are paid through Medicaid management information systems (MMIS) with surveillance and utilization review systems (SURS) post-pay review to verify an active treatment plan.
 - No services billed by other providers, or provided outside of the facility, may be billed to the Medicaid, unless the facility is 16 beds or less.
 - State facilities will continue to be cost settled.
 - Services provided outside of the facility and/or not on the active treatment plan are the responsibility of DCFS, OJJ, OBH or the family.

Options – PRTFs

Physician direction

- Physician direction is defined generally for other Medicaid services in the State Medicaid Manual (SMM 4320):
 - The physician is not required to be an employee of the PRTF or be utilized on a full-time basis or be present in the facility during all the hours that services are provided.
 - Each patient's care must be under the supervision of a physician directly affiliated with the PRTF.
 - A physician must see the patient at least once, prescribe the type of care provided and, if the services are not limited by the prescription, periodically review the need for continued care.
 - Although the physician does not have to be on the premises when his/her patient is receiving covered services, the physician must assume professional responsibility for the services provided and ensure that the services are medically appropriate.

Options – PRTFs

Active treatment plan

- An active plan of care compliant with all requirements:
 - Developed by a team with the required qualifications within 14 days of admission in conjunction with resident and family
 - Diagnostic evaluation includes medical, psychological, social, behavioral and developmental needs
 - Plan of care (POC) addresses all needs identified in evaluation
 - Treatment objectives are listed
 - POC reflects need for inpatient psychiatric care
 - POC is reviewed every 30 days by the team, with required qualifications
 - Prescribes an integrated program of therapies, activities and experiences designed to meet the objectives
 - Documents 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

Qualifications of team developing individual plan of care

- ❑ An interdisciplinary team of physicians and other personnel who are employed by, or provide services to, patients in the facility.
- ❑ The team must include, at a minimum:
 - A board-eligible or board-certified psychiatrist
 - A clinical psychologist (doctoral degree) and a licensed physician
 - A licensed physician with training/experience in treating mentally ill, and a psychologist who has a master's degree in clinical psychology or State certification
- ❑ The team must also include one of the following:
 - A psychiatric social worker
 - A registered nurse with training/experience in treating individuals with mental illness
 - A licensed occupational therapist with training/experience
 - A psychologist who has a master's degree in clinical psychology or State certification

Options – PRTFs

Seclusion and restraint

- ❑ Compliance with federal and State seclusion and restraint requirements:
 - Policy and procedure is compliant with requirements
 - Resident and family are notified of rules at admission
 - Seclusion and restraint are ordered by licensed practitioners permitted by State and facility
 - Interventions are documented
 - Treatment team physicians are consulted
 - Residents in interventions are monitored
 - Time-outs are applied, consistent with federal requirements
 - Post intervention debriefings occur, as required

Options – PRTFs

Seclusion and restraint (cont'd)

- Resident injuries sustained in interventions are treated promptly
- Resident injuries while in interventions are reported to Medicaid and the State Protection and Advocacy system
- Resident deaths are reported to the CMS, as well as agencies receiving injury reporting
- Staff training occurs and is properly documented

Options – Therapeutic group homes

- ❑ Must contract with SMO and have eight beds or less.
- ❑ SMO will reimburse the facility:
 - Medicaid will pay SMO for behavioral health treatment
 - Child may have Medicaid card for physical health treatment
 - Non-Medicaid funds (OJJ, DCFS, OBH or family) pay SMO for room and board
- ❑ Children attend school in public school system.
- ❑ May not be provided in an IMD.
- ❑ Therapeutic group homes 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 State Plan definition on website: www.dhh.gov and promising practice on website.
- ❑ Approximately 275 beds needed statewide.

Options – Therapeutic group homes

Requirements

- Treatment must:
 - Focus on reducing the behavior and symptoms of the psychiatric disorder
 - Decrease problem behavior and increase developmentally appropriate, normative and pro-social behavior in children and adolescents
 - Transition child or adolescent from TGH to home- or community-based living with outpatient treatment
 - Less intensive levels of treatment must have been determined to be 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 and is being provided on a 24-hour basis with direct supervision/oversight by professional behavioral health staff. The setting must be ideally situated to allow ongoing participation of the child's family. The child or adolescent must attend a school in the community.

Options – Therapeutic group homes

Requirements (cont'd)

- TGHs provide twenty-four hours/day, seven days/week structured and supportive living environment. 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

Options – Therapeutic group homes

Requirements (cont'd)

- 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, with the goal of transitioning the youth out of the program, as soon as is 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.

Options – Therapeutic group homes

Requirements (cont'd)

- ❑ For treatment planning, the program must use a standardized assessment and treatment planning tool, such as 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
 - The program must ensure that requirements for pretreatment assessment are met prior to treatment commencing

Options – Therapeutic group homes

Requirements (cont'd)

- ❑ Annually, facilities must submit documentation demonstrating compliance with fidelity monitoring for at least two evidence-based practices (EBPs) and/or one level of ASAM criteria. 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.
- ❑ 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.
- ❑ 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.

Options – Therapeutic group homes

Provider qualification requirements

- ❑ A TGH must be accredited and licensed as a residential treatment facility by the Louisiana DHH and may not exceed eight beds.
- ❑ TGH staff must be supervised by a psychiatrist or psychologist with experience in EBPs. Staff includes paraprofessional, master's and bachelor's level staff.
- ❑ Direct care staff:
 - Must be at least 18 years old and have a high school diploma or equivalent
 - Must be at least three years older than an individual under the age of 18
 - Must have certification in the State of Louisiana to provide the service, which includes criminal, abuse/neglect registry and professional background checks and must complete a State approved standardized basic training program

Options – Therapeutic group homes

Provider qualification requirements (cont'd)

- ❑ 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.
- ❑ Staffing schedules shall reflect overlap in shift hours.
- ❑ 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.

Options – Therapeutic group homes

Limitations

- ❑ Licensed psychologists and licensed mental health professionals (LMHPs) bill for their services separately.
 - 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 (by a psychiatrist) are required of TGH, but provided and billed separately by licensed practitioners for direct time spent.

Options – Therapeutic group homes

Limitations (cont'd)

- ❑ 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.
 - Medicaid does not reimburse for room and board.
- ❑ Unit of service: Reimbursement for the TGH is based on a daily rate for the skill building provided by unlicensed practitioners.

Options – Therapeutic group homes

Limitations (cont'd)

- ❑ Average length of stay (ALOS) ranges from 14 days to 120 days. TGH programs focusing on transition or short-term crisis are typically in the 14 to 30 day range.
- ❑ Discharge will be based on the child no longer making adequate improvement in this facility (and another facility is 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.

How will certifications and licensure occur?

Health standards section

- Who are we?:
 - A section of DHH, within the Medical Vendor Administration (MVA), commonly known as “Medicaid”
 - The regulatory division for licensing of healthcare providers:
 - License/certify over 30 different healthcare provider types in the State

Health standards section (cont'd)

- ❑ Ambulance services
- ❑ Non-emergency transportation
- ❑ Personal care attendant agencies
- ❑ Supervised independent living agencies
- ❑ Some of the provider types under the oversight of the Health Standards Section are:
 - Nursing homes
 - Hospitals
 - Home health agencies
 - Dialysis facilities

Health standards section (cont'd)

- ❑ **Licensure** – This is the process that determines whether a healthcare provider meets the minimum licensing standards to be licensed and approved to be open and operational to provide services in Louisiana.
- ❑ **Certification** – This is the process that determines whether a healthcare provider meets federal and/or State participation requirements, which enables them to enroll as a provider in the Medicare or Medicaid programs.

Health standards section (cont'd)

- To learn more about us:
 - Explore the HSS website:
 - <http://WWW.dhh.louisiana.gov/offices/?ID-112>
 - Listing of licensing regulations
 - Contact and program information:
 - Introductions to all provider types
 - Licensure information
 - How to file a complaint



We license health care facilities to operate in the state of Louisiana. Our agency certifies these facilities for participation in Medicare and Medicaid.

DHH/Health Standards Section
 P.O. Box 3767, Baton Rouge, LA 70821
 located at 500 Laurel St., Suite 100, Baton Rouge, LA 70801-1811
 Hours 8:00 a.m. - 4:30 p.m. (closed state holidays)
 Phone 225-342-0138, Fax 225-342-5292
 Email hss.mail@la.gov

News:

- Bureau of Appeals transferred to Division of Administrative Law effective 01/01/2011. See [Provider Memo](#) dated 12/28/10 for details.

Featured Services

- [Emergency Preparedness](#)
- [OTIS - Online Tracking Incident System for Nursing Homes and ICF/DD Facilities](#)
- [Home and Community Based Services General Information](#)
- [Home & Community Based Service Licensure Applicants - Required Training](#)
- [Licensing - Change of Address, Ownership, Key Personnel Form & Fee Scale](#)
- [RODS - Provider Online Licensing System](#)

Toll Free Complaint Numbers:

Adult Day Care 877-343-5179
 ICF/DD 877-343-5179
 (Intermediate Care Facility for Developmentally Delayed)
 Home Health 800-327-3419
 Hospital 866-280-7737
 Nursing Home 888-810-1819
 Support Coordination (Case Management) 800-660-0488

Service Provider Agencies (Personal Care Attendant, Supervised Independent Living, Respite Care, Family Support Services, & Adult Day Health Care) 800-660-0488

How to File a Complaint

Report Medicaid Fraud:
 1-800-488-2917 - Program Integrity

Licensing standards

- The DHH is given statutory authority for the development and enforcement of statewide standards to ensure the health, safety and welfare of patients, residents, clients and/or consumers receiving care and services provided by licensed health care facilities or providers.

Facility need review

- ❑ A review conducted for a provider type to determine whether there is a need for additional beds to be licensed and/or enrolled in the Medicaid program.
- ❑ This facility need review (FNR) process for PRTFs and TGHs is under development and will be based on populations served and access to services.

Licensing process

- Any person, organization or corporation desiring to operate a PRTF or a TGH shall make application to DHH on forms prescribed by the department.

How to apply for a license

- Obtain initial application packet:
 - Complete order form requesting an application packet for FNR; then, if FNR is approved, an initial licensing packet for a PRTF or a TGH can be requested.
 - Health Standards Section: 225-342-0138
 P.O. Box 3767
 Baton Rouge, LA 70821
<http://www.dhh/louisiana.gov/offices/?ID-112>

State of Louisiana
Department Of Health and Hospitals
Health Standards Section
INFORMATION REQUEST/ORDER FORM

APPLICANT: _____
 ADDRESS: _____
 CITY/STATE/ZIP: _____
 CONTACT PERSON: _____ PHONE: _____
 EMAIL ADDRESS: _____

ORDER QUANTITY	LICENSING AND CERTIFICATION PACKETS	UNIT COST	TOTAL ORDER
	ADDICTIVE DISORDER FACILITY PACKET	\$25.00	
	ADULT BRAIN INJURY (Packet Pending)	\$25.00	
	ADULT DAY CARE	\$25.00	
	ADULT DAY HEALTHCARE	\$25.00	
	ADULT RESIDENTIAL CARE PROVIDER	\$25.00	
	AMBULATORY SURGERY CENTER PACKET	\$25.00	
	CASE MANAGEMENT	\$25.00	
	COMMUNITY MENTAL HEALTH CENTER PACKET	\$0	
	COMPREHENSIVE OUT-PATIENT REHABILITATION FACILITY PACKET	\$0	
	EMERGENCY MEDICAL TRANSPORTATION	\$50.00	
	END STAGE RENAL DISEASE PACKET	\$25.00	

How to apply for a license (cont'd)

- ❑ Obtain FNR approval.
- ❑ Obtain licensing application packet.
- ❑ Read and understand licensing regulations, Condition of Participation for the Use of Restraint or Seclusion in PRTFs, and standards for payment for either PRTFs or TGHs.
- ❑ Submit application, licensing fee and all other required documents.

The licensing application packet

- Contains:
 - Licensing regulations
 - Initial application
 - Initial provider memo:
 - Guides applicant on the process
 - Indicates the required fees
 - Refers to other agencies that need notification:
 - Fire Marshal
 - Office of Public Health
 - Plan Review
 - Forms requiring completion

Read and understand the licensing regulations

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Psychiatric Residential Treatment Facilities Licensure
(LAC 48:I.Chapter 90)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts LAC 48:I.Chapter 90 as authorized by R.S. 40:2181-2191. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 48

PUBLIC HEALTH• GENERAL

Part I. General Administration

Subpart 3. Licensing

Chapter 90. Psychiatric Residential Treatment Facilities (under 21)

Subchapter A. General Provisions

§9001. Purpose

A. The purpose of this Chapter 90 is to provide for the development, establishment and enforcement of statewide standards for the care of residents in Psychiatric Residential Treatment Facilities (PRTFs) participating in the Louisiana Medicaid Program, to ensure maintenance of these standards, and to regulate conditions in these facilities through a program of licensure which shall promote safe and

d. any other comparable nationally recognized accrediting organization.

Administrator• (see *chief executive officer*)

Behavior Management• techniques, measures, interventions and procedures applied in a systematic fashion to promote positive behavioral or functional change fostering the resident's self-control, and to prevent or interrupt a resident's behavior which threatens harm to the resident or others.

Cessation of Business• when a PRTF participating in the Louisiana Medicaid Program stops providing services to the community.

Change of Ownership (CHOW)• the sale or transfer whether by purchase, lease, gift or otherwise of a PRTF by a person/corporation of controlling interest that results in a change of ownership or control of 30 percent or greater of either the voting rights or assets of a PRTF or that results in the acquiring person/corporation holding a 50 percent or greater interest in the ownership or control of the PRTF.

Chief Executive Officer (CEO) or Administrator• the person responsible for the on-site, daily implementation and supervision of the overall facility's operation commensurate with the authority conferred by the governing body.

Clinical Director• the person who has responsibility for the psychiatric aspects of the program and who has to provide full-time coverage on an on-site or on-call basis.

CMS• the Centers for Medicare and Medicaid Services, Department of Health and Human Services.

Core Mental Health Disciplines• academic training programs in psychiatry, psychology, social work, and

Submit the application packet

- ❑ Complete application.
- ❑ Submit all required documents:
 - Including Office of State Fire Marshal (OSFM) and Office of Public Health (OPH) approvals for occupancy
- ❑ No application will be reviewed until payment of the application fee is received.

Wait for HSS packet review

- Health Standards Section (HSS) Program Manager will review the submitted packet.
- Contact will be made with applicant if any problems are identified with submitted information:
 - Applicant must complete all requirements of the application process within 90 days of initial submission of the application material.

Approval of packet

- ❑ Applicant will be notified by mail when application is approved.
- ❑ The notification instructs the applicant to call the appropriate HSS office to schedule a mutually agreed upon date for the initial licensing survey.
- ❑ This survey is generally conducted within 30 days of that call.

Prepare for an on-site initial licensing survey

- An initial licensing survey of the facility, by representatives of HSS, shall be scheduled when required application documentation is approved.
- This survey is conducted to ensure the facility meets the standards set forth in licensing regulations and standards for payment.

Receive survey compliance determination

- ❑ A substantial compliance determination, based on initial licensing survey, allows the issuance of a full license to operate.
- ❑ The full license shall be issued for a period of not more than 12 months for the premises named in the application.
- ❑ A license must be renewed annually.

Survey non-compliance

- ❑ The department may issue a provisional license, up to a period of six months, if there is no immediate and serious threat to the health and safety of the residents.

Licenses

- ❑ The current license shall be displayed in a conspicuous place within the facility at all times.
- ❑ The license is not assignable or transferable and shall be immediately void if the facility ceases to operate or if there is an ownership change.
- ❑ There is a separate license renewal process and annual licensing fee.

License denial, revocation or non-renewal

- When a facility is unable or unwilling to comply with requirements, or has failed to adequately protect the health, safety and welfare of patients, residents, clients and/or consumers, a license may be denied, revoked or refused.

**The initial DCFS licensing
process
DCFS Division of Programs
Licensing Section**

DCFS licensing section

- ❑ A section of DCFS within the Division of Programs.
- ❑ The regulatory section for licensing of child care facilities, child placing agencies and maternity homes.
- ❑ Provide licensure and regulatory oversight of 1,934 child care, child placing agencies and maternity homes:
 - 1,834 Day care centers
 - 44 Child placing agencies
 - 50 Child residential facilities
 - 6 Maternity homes

DCFS licensing section

Purpose and mission

- ❑ To fulfill the legislative mandate to protect the health, safety and well-being of the children of the state, who are in out-of-home care on a regular or consistent basis.
- ❑ To ensure development and maintenance of licensing standards, and to regulate conditions in these facilities through a program of licensing.
- ❑ To ensure protection of all individuals under care in child care facilities and placement agencies, and to encourage and assist in the improvement of programs.

DCFS licensing section

- To learn more about us:
 - Visit the DCFS website:
 - <http://www.dcfs.la.gov>
 - Listing of licensing standards and regulations
 - Contact and program information:
 - Introductions to all provider types
 - Licensure information
 - Licensure application
 - Licensing updates for current providers

What is a DCFS license?

- ❑ License – any license issued by the DCFS to operate any child care facility, maternity home or child-placing agency, as defined in R.S. 46:1403.
- ❑ Licensed programs:
 - Child care facility – day care centers
 - Child care facility – child residential facilities
 - Child care facility – maternity homes
 - Child placing agency – foster care, adoption and independent living

Licensing standards

- ❑ Provides for the development, establishment and enforcement of statewide standards for the care of children receiving services in out-of-home care settings.
- ❑ Regulate conditions in child care, child placing and maternity homes through a program of licensure, which promotes safe and adequate treatment of children.

Licensing process

- ❑ An initial application for licensing as a child care facility provider shall be obtained from the Department. (www.dcfsl.a.gov)
- ❑ A completed initial license application packet from an applicant shall be submitted to and approved by the Department prior to an applicant providing child care services.

How to apply for a child care facility license

- Obtain initial application:
 - DCFS Licensing Section - 225-342-9905
P.O. Box 3078
Baton Rouge, LA 70821
www.dcfsls.la.gov

- For initial applications, a fee of \$25.00 is required with the application form. This non-refundable fee will be applied toward the license fee when the facility is licensed. All fees are to be paid by certified check or money order made payable to the Department of Children & Family Services.

The initial application packet

- The completed initial licensing packet shall include:
 - Application and non-refundable fee
 - Office of Fire Marshal Services approval for occupancy
 - Office of Public Health, Sanitarian Services approval
 - City fire department approval, if applicable
 - City or parish building permit office approval, if applicable
 - Local zoning approval, if applicable
 - Copy of proof of current general liability and property insurance for facility
 - Copy of proof of insurance for vehicle(s)
 - Organizational chart or equivalent list of staff titles and supervisory chain of command
 - Program director résumé and proof of educational requirement

The initial application packet (cont'd)

- Service plan manager résumé and proof of educational requirement
- List of consultant/contract staff to include name, contact info and responsibilities
- Copy of program plan
- Copy of table of contents of all policy and procedure manuals
- Copy of evacuation plan
- Copy of house rules and regulations
- Copy of grievance process
- A floor sketch or drawing of the premises to be licensed
- Any other documentation or information required by the department for licensure

Read and understand the licensing standards

- Louisiana Administrative Code (Child Residential Standards)
 - TITLE 67
 - Part V
 - Subpart VIII
 - Chapter 71
 - Sections 7101 - 7123

Submit the application packet

- ❑ Completed application and fee.
- ❑ Submit all required documents.
- ❑ If the initial licensing packet is incomplete, the applicant will be notified of the missing information and will have ten (10) working days to submit the additional requested information. If the department does not receive the additional requested information within the ten (10) working days, the application will be closed.

Application packet received by DCFS

- Once the Department has determined the application is complete, the applicant will be notified to contact the Department to schedule an initial survey. If an applicant fails to contact the Department and coordinate the initial survey within 45 days of the notification, the initial licensing application shall be closed.
- After an initial licensing application is closed, an applicant who is still interested in becoming a child residential facility provider shall submit a new initial licensing packet with a new initial licensing fee to restart the initial licensing process.

On-site licensing inspection

- ❑ Prior to the initial license being issued to the child care facility, an initial licensing inspection shall be conducted to ensure compliance with all licensing standards.
- ❑ The initial licensing survey shall be an announced/scheduled inspection.
- ❑ No child shall be provided services by the child care facility until the initial licensing survey has been performed and the Department has issued an initial license.

License

- ❑ In the event the initial licensing survey finds the child care facility is compliant with all licensing laws and standards, and is compliant with all other required statutes, laws, ordinances, rules, regulations and fees, the Department may issue a full license to the provider. The license shall be valid until the expiration date shown on the license, unless the license is extended or revoked.
- ❑ In the event the initial licensing survey finds the child care facility is noncompliant with any licensing laws or standards, or any other required statutes, laws, ordinances, rules or regulations that present a potential threat to the health, safety or welfare of the participants, the Department shall deny the initial license.

License (cont'd)

- ❑ The license must be conspicuously displayed at the facility. The most recent annual inspection report, and any follow-up inspection reports, must be made available for inspection to any person requesting them.
- ❑ The license is not assignable or transferable and shall be immediately void if the facility ceases to operate or if its ownership changes.
- ❑ There is a separate license renewal process and annual licensing fee.

License denial, revocation or non-renewal

- When a child care facility is unable or unwilling to comply with licensing requirements, or has failed to adequately protect the health and safety of children receiving services, a license can be denied, revoked or not renewed.