LA.CLI.006 Covered Benefits and Services

Effective Date:	January 1, 2023	Accountable Dept.:	LA Medicaid ~~Care Management~~Utilization Management
Last Reviewed Date:	October 1, 2024~~3~~		

Summary of Changes:

10/28/2024: Annual Review, minor grammatical changes and updated references to the most recent edition reviewed
~~**No changes; reviewed due to an annual review**~~

Scope:

This policy applies to all Humana Healthy Horizons® in Louisiana (Plan) associates who administer, review, or communicate covered physical and behavioral health benefits and services to eligible enrolled members.

Policy:

The Plan will cover and make available all covered benefits and services to our membership as outlined by the Louisiana Department of Health (LDH) program, including the coordination and delivery of these services for both physical and behavioral health needs. ~~**These services will be coordinated with LDH to promote service integration and the delivery of holistic, person- and family-centered care.**~~ Benefits are covered in accordance with all state statutes, regulations, plan **requirements**, and any other policies and procedures ~~**in which**~~**that** allow~~s~~ members to have the ability to achieve age-appropriate growth and development as well as attain, maintain, or regain functional capacity. Information on ~~**Humana Healthy Horizons**~~**the** Plan ~~**in Louisiana's**~~ benefits, services**,** and programs are provided to members and providers **through**~~**thorough**~~ the Member Handbook, Provider Handbook, and the Plan~~'s~~ website.

Procedure:

1. The Plan covers all benefits and services sufficient in amount, duration, and scope in accordance with those outlined by Louisiana Medicaid. Benefits and services furnished to members will not be more restrictive than those provided by Louisiana Medicaid.
2. The Plan~~'s~~ **U**~~**u**~~tilization **M**~~**m**~~anagement **(UM)** program adheres to the ~~**Louisiana Department of Health's**~~**LDH's** definition of medical necessity, including quantitative and non-quantitative treatment limits to evaluate the appropriateness of requested services.
3. The Plan will review applicable authorizations to determine if services are medically necessary following guidance in the Plan~~'s~~ adopted Prior Authorization List (PAL).
   - ~~3.~~a Any additions or removals to the PAL are submitted to LDH for approval at least sixty (60) days prior to any changes.
   - ~~4.~~b The PAL is created in compliance with requirements for Mental Health Parity in accordance to 42 CFR Part 438, Subpart K.
4. ~~5.~~4. All requests for pediatrics will be reviewed to ensure compliance with **Federal** EPSDT requirements.
5. The Plan will not arbitrarily deny or reduce the amount, duration, or scope of a required service because of the diagnosis, type of illness or condition of the member.

6. **The Plan will ensure s**~~S~~ervices provided are sufficient in an amount, duration, and scope that is reasonably expected to achieve the purpose for which the services are furnished.
7. All determinations made are based upon medical necessity review which evaluates the appropriateness of the services requested as well as the member's specific clinical presentation.
8. The assigned ~~**Utilization Management**~~**UM R**~~**r**~~eviewer will review for medical necessity using the appropriate criteria. If the service meets medical necessity, the UM R~~r~~eviewer will approve the service and complete all appropriate documentation within the utilization management system. They will notify the provider per the Timeliness of UM Determinations and Notifications process.
9. The UM Reviewers will not deny or partially deny services including the reduction of any requested service in the amount, duration, or scope. If the service does not meet medical necessity criteria, the ~~**nurse**~~ **UM Reviewer** will route the request to a Medical Director for review and decision.
10. The Medical Director reviews all information for medical necessity and makes a final determination. ~~**They**~~ **The Medical Director** will return the service authorization request to the UM **R**~~**r**~~eviewer to complete the required notifications per the Timeliness of Determinations and Notifications policy.
11. The Plan will not deny continuation of higher-level services such as inpatient hospital care for failure to meet medical necessity unless the Plan is able to provide the service through an in-network or out-of-network provider at a lower level of care.
12. For denials which may reduce or stop the amount of previously authorized services, additional outreach **by** the UM **Reviewer** ~~**clinician**~~ and/or **a** ~~**the**~~ Care Manager (CM) may be conducted in order to secure other appropriate lower levels of care (including In Lieu of Services~~**– ILOS or other cost-effective alternatives**~~) with goal of ensuring there is no interruption in services.
13. UM **Reviewers** ~~**staff**~~ have ability to make referrals to CM for further assistance and collaboration in helping members **coordinate services** ~~**to gain any excluded services**~~ that may be necessary to ensure that members have no interruptions in care. Automated referrals are made to CM on all inpatient admissions ensuring appropriate outreach is made for any discharge planning or other coordination of care needs for the member.
14. ~~**The Plan may offer additional services that may promote the wellness and health of the members including Value-Added Benefits (VAB) that may be cost effective and medically necessary. The Plan will submit all potential VAB it intends to offer to LDH for approval.**~~
15. ~~**Members may be assessed by CM to determine if they are eligible for any applicable VAB including any coordination and submission of referrals for these services.**~~

~~**Definitions:**~~

~~**Beneficiary – An individual who has been determined eligible, pursuant to Federal and State law to receive medical care, goods, or services under the Louisiana Medicaid Program.**~~

~~**Enrollee – Beneficiary who is currently enrolled in an MCO, either by choice or Automatic Assignment by the Enrollment Broker.**~~

~~**Medically Necessary Services – 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. 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; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the Beneficiary. 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 Beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Louisiana 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."~~

CONTRACT LANGUAGE:

~~2.4 Services-LDH Model Contract, pp. 84~~

~~2.4.1 MCO Covered Services-LDH Model Contract, pp. 84~~

~~2.4.1.1 The Contractor shall provide Enrollees all medically necessary MCO Covered Services specified in Attachment B, MCO Covered Services, as those services are defined in the State Plan and the MCO Manual. The Contractor shall possess the expertise and resources to ensure the delivery of quality healthcare services to its Enrollees in accordance with this Contract and prevailing medical community and national standards. – LDH Model Contract, pp. 84~~

~~2.4.1.2 MCO Covered Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Beneficiaries under FFS, as set forth in 42~~

~~C.F.R. §440.230, and for Enrollees under the age of twenty-one (21), as set forth in 42 C.F.R. Part 441, Subpart B. [42 C.F.R. §438.210(a)(2)] -LDH Model Contract, pp. 84~~

~~2.4.1.3 The Contractor shall ensure that MCO Covered Services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the Enrollee. [42 C.F.R. §438.210(a)(3)] -LDH Model Contract, pp. 85~~

~~2.4.1.4 In accordance with 42 C.F.R. §438.210(a)(4), the Contractor may place appropriate limits on a service that are: -LDH Model Contract, pp. 85~~

~~2.4.1.4.1 On the basis of criteria applied under the State Plan, such as medical necessity; or -LDH Model Contract, pp. 85~~

~~2.4.1.4.2 For the purpose of utilization control, provided that: -LDH Model Contract, pp. 85~~

~~2.4.1.4.2.1 The services furnished can reasonably be expected to achieve their purpose; -LDH Model Contract, pp. 85~~

~~2.4.1.4.2.2 The services support Enrollees with ongoing or chronic conditions and are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports; and -LDH Model Contract, pp. 85~~

~~2.4.1.4.2.3 Family planning services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning to be used consistent with 42 C.F.R. §441.20. -LDH Model Contract, pp. 85~~

~~2.4.1.5 The Contractor shall provide MCO Covered Services in accordance with LDH's definition of medically~~

~~necessary services (see Glossary), including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and the MCO Manual. [42 C.F.R.§438.210(a)(5)(i)] -LDH Model Contract, pp. 85~~

~~2.4.1.5.1 A public health quarantine or isolation order or recommendation also establishes medical necessity of healthcare services. -LDH Model Contract pp. 85~~

~~2.4.1.6 The Contractor shall cover medically necessary services that address: -LDH Model Contract, pp. 85~~

~~2.4.1.6.1 The prevention, diagnosis and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability; -LDH Model Contract, pp. 85~~

~~2.4.1.6.2 The ability for an Enrollee to achieve age-appropriate growth and development; and -LDH Model Contract, pp. 85~~

~~2.4.1.6.3 The ability for an Enrollee to attain, maintain, or regain functional capacity. -LDH Model Contract, pp. 86~~

~~2.4.1.7 The Contractor shall ensure that each Enrollee has an ongoing source of care appropriate to their needs as required under 42 C.F.R. §438.208(b)(1) and shall formally designate a PCP as primarily responsible for coordinating services accessed by the Enrollee, as further described in the Provider Network, Contracts, and Related Responsibilities section. -LDH Model Contract, pp. 86~~

~~2.4.1.8 The Contractor shall not avoid costs for services covered in its Contract by referring Enrollees to publicly supported health care resources. [42 C.F.R. §457.1201(p)] -LDH Model Contract, pp. 86~~

~~2.4.1.9 The Contractor shall provide a mechanism to reduce inappropriate and duplicative use of healthcare services, including, but not limited to, potentially preventable hospital emergency department (ED) visits and inpatient readmissions. -LDH Model Contract, pp. 86~~

~~2.4.1.10 The Contractor shall not condition the provision of care or otherwise discriminate against an Enrollee based on whether or not the Enrollee has executed an Advance Directive. [42 C.F.R. §438.3(j)(1) and (2); 42 C.F.R. §489.102(a)(3).] -LDH Model Contract, pp. 86~~

~~2.4.1.11 The Contractor and its providers shall deliver services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the Enrollee prevalent -LDH Model Contract, pp. 86~~

References:

Code of Federal Regulations- 42 CFR Public Health, Volumes 2-4 Centers for Medicare & Medicaid Services, Department of Health and Human Services

Louisiana Medicaid Managed Care Organization (MCO) Model Contract~~:~~ Attachment A, Part 2, Section 2.4**, 2.12.8.2** ~~**Services & Attachment B, MCO Covered Services**~~

Louisiana Medicaid Managed Care Organization (MCO) Model Contract, Attachment B: MCO Covered Services

Louisiana Medicaid Managed Care Organization (MCO) Model Contract, Attachment C: In Lieu of Services

~~**Louisiana Medicaid Managed Care Organization (MCO) Model Contract: Attachment A, Part 2, Section 2.4 Services & Attachment C, In Lieu of Services**~~

Louisiana Medicaid Managed Care Organization (MCO) Manual: Part 4~~**, Services Social Security Act, Section 1905(a)42 U.S.C.1396U-2(b)(3)(B)**~~

L**ouisiana** ~~**A MCD**~~ **Medicaid** Medical & Behavioral Services ~~**and Clinical Details**~~ **Chart**~~**Grid**~~

Version Control:

Policy creation-Approved by LDH for Readiness
5/15/23: Approved by LA UM Committee
10/30/23: Changed to new template for Annual Review Due by 5.15.24. KWise, MCD Clinical Delivery Experience

Owner:	Barbara McCarthy	Executive Team Member:	Dr. Gupta
Accountable VP / Director:	Nicole Thibodeaux		

Non-Compliance:

Failure to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services, or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules, and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Associate Support Center via Humana's secure intranet on Hi! (Workday & Apps/Associate Support Center).