Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management**	**SUBJECT (Document Title)** **Non-Covered and Cost-Effective Alternative Services – LA**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
May 29, 2015	March 16, 2022	~~January 28, 2022~~December 02, 2022	~~March 16, 2022~~December 02, 2022

Department Approval/Signature:

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☐ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☒ Louisiana	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Missouri	☐ South Carolina	☐ West Virginia
	☐ Indiana	☐ Nebraska		

POLICY:

To establish the process permitting non-covered and cost-effective alternative services.

~~The Louisiana Medicaid Managed Care Organization (MCO) Contract provides a frame of refence for the development and implementation of In Lieu of Services as defined in the Code of Federal Regulation. The Healthy Plan shall examine these provsions in explit detail prior to developing an In Lieu of Serview for submission for State approval for its implamantaiont.~~

~~Furtherre, all In Lieu of Services proposals shall be reviewed and approvd by the Managing Medical Director before submission to the State.~~

The Louisiana Medicaid State Plan establishes the services covered as well as reimbursement methodologies for Medicaid fee-for-service (FFS). State Plan services are broad categories (e.g., physician services, hospital services), and the Medicaid FFS fee schedule operationalizes that coverage. In accordance with 42 CFR §438.210, Healthy Blue must provide for coverage of services that is no more restrictive in amount, scope, and duration than is covered in Medicaid FFS. Compared with Medicaid FFS, Healthy Blue has the flexibility to cover services in a greater amount, scope, or duration, or to an expanded patient group, if deemed medically necessary.

In addition to providing the full range of required and contracted core benefits and services, Healthy Blue may choose to provide value-added benefits (VABs) and cost-effective, in lieu of services. This provision allows use of medically appropriate services that are not covered under the state-specific benefit package on a case-by-case basis. The use of cost-effective alternative services allows flexibility to manage a member's care in a less costly manner while providing appropriate medically necessary services.

Service coverage is subject to benefit plan design and in accordance with applicable state and federal rules and regulations. Healthy Blue may approve coverage, at its discretion on a case-by-case basis, of services that are generally non-covered only if those services represent a medically appropriate and cost-effective alternative to covered services, and not indicated as "investigational and not medically necessary." Although non-covered, some medical care, procedures, or tests may be appropriate, reasonable, and/or medically necessary for a particular member. In that instance, the medically appropriate non-covered service may be reviewed to determine if it is also cost-effective, and if deemed so, may be approved despite the non-covered status. The medical necessity of a service, equipment, or supply does not guarantee approval. A service may be medically necessary, but is considered non-covered when the benefit limitation is exceeded. Benefit plans define those services, equipment, and supplies that are:

- Covered;
- Excluded; or
- Subject to limits (e.g., dollar caps or visit limitations).

The Health Care Management (HCM) associate working with the member receiving the service is responsible for ensuring the member receives adequate information explaining that this particular service is considered a non-covered service and is not part of the normal benefit plan.

In the event that Healthy Blue authorizes a non-covered alternative treatment or service and the member receiving the service develops a complication requiring additional care, the plan shall cover treatment of medically necessary services resulting from the complication of the non-covered service.

DEFINITIONS:

** Denotes terms for which Healthy Blue must use the State-developed definition.*

Benefits or Covered Services – Those Managed Care Organization (MCO) covered health care services to which an eligible Medicaid recipient is entitled under the Louisiana Medicaid State Plan.

Excluded Services* – Those services that enrollees~~which members~~ may obtain under the ~~Louisiana Medicaid~~ State Plan or applicable waivers and for which Healthy Blue is not financially responsible.

Experimental Procedure or ~~/~~Service – A procedure or service that requires additional research to determine safety, effectiveness, and benefit compared to standard practices and characteristics of patients most likely to benefit. The available clinical scientific date may be

relatively weak or inconclusive. The term applies only to the determination of eligibility for coverage or payment.

Fee-for-Service (FFS) – A method of provider reimbursement based on payments for specific services rendered. The Louisiana Medicaid State Plan establishes the services covered as well as reimbursement methodologies for Medicaid FFS.

In Lieu of Service (ILOS) – A medically-appropriate service outside of ~~Managed Care Organization (~~MCO~~)~~ covered services or settings, or beyond service limits established by the Louisiana Department of Health (LDH) for MCO covered services, that are provided to enrollees~~members~~ by Healthy Blue, at their option, as a cost-effective alternative to an MCO covered service or setting. Approved in lieu of services are authorized and identified in *Attachment ~~CD~~, In Lieu of Services~~Rate Certification~~*.

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~~not more~~ costly course of treatment is available or suitable for the beneficiary. ~~than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.~~ Any such services must be ~~clinically appropriate,~~ 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~~recipient~~ 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-Food and Drug Administration (FDA) approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." ~~The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis.~~

~~**Non-Covered Services –** Services not covered under the Title XIX Louisiana State Medicaid Plan.~~

Value-Added Benefit (VAB) – The additional benefits outside of MCO covered services~~the core benefits and services included in the Contract~~ that are delivered at Healthy Blue's discretion and are not included in capitation rate calculations. ~~Value-added benefit~~VABs seek to improve

quality and health outcomes, and/or reduce costs by reducing the need for more expensive care. VABs do not include in lieu of services.

PROCEDURE:

Non-Covered Service Authorization Process

1) The provider, member, or an associate may initiate a request for non-covered services. T~~Either way, t~~he Medicaid Prior Authorization (MPA) team ~~National Customer Care (NCC)~~ or Healthy Blue HCM associate must obtain clinical records and supporting documentation from the provider to substantiate the need for the service.
2) Once all necessary supporting documentation is received, the request is forwarded to the appropriate Healthy Blue Medical Director for review and determination within contracted timing of service authorization decision and notification standards.
3) The Medical Director reviews the request and supporting documentation and makes a determination based on the member's needs, medical necessity guidelines, and a cost~~-~~benefit analysis.
   a) If the Medical Director indicates an approval of the non-covered service, the provider and member are notified of the approval of the non-covered service per contractual and accreditation guidelines. The request is routed for a provider network single case agreement (SCA) when applicable.
   b) If the Medical Director determines a denial of the non-covered service, the provider and member are notified of the denial of the non-covered service per contractual and accreditation guidelines.

In Lieu of Service (ILOS)

1) ILOS are alternative services or settings covered by Healthy Blue as a substitute or alternative to services or settings covered under the Louisiana Medicaid State Plan. In accordance with 42 CFR § 438.3(e)(2), ILOS are medically appropriate and cost-effective substitute services that are offered voluntarily. If offered, Healthy Blue may not require enrollees to use any ILOS and reserves the right to cap or limit the number of enrollees receiving the ILOS at any time and for any reason.

~~1)~~2) Healthy Blue may, at its option, cover services or settings for enrollees~~members~~ that are in lieu of MCO covered~~core benefits and~~ services if the following conditions are met, as required in 42 CFR §438.3(e)(2)(i)-(iii):

   a) LDH determines that the alternative service or setting is medically appropriate and cost-effective substitute for the MCO covered service or setting under the State Plan;
   b) The enrollee~~member~~ is not required by Healthy Blue to use the alternative service or setting; and
   c) The approved ~~in lieu of services~~ILOS are authorized and identified in *Attachment ~~D~~C, In Lieu of Services~~, with additional guidance in the MCO Manual Rate Certification~~*.

~~2)~~3) The utilization and actual cost of ~~in lieu of services~~ILOS are taken into account in developing the component of the capitation rates that represents the ~~core benefits and~~ MCO covered services, unless a statute or regulation explicitly requires otherwise.

4) Healthy Blue shall~~may~~ submit ~~additional~~ all ~~in lieu of services~~ILOS for~~to~~ LDH ~~for prior~~ approval in accordance with the *MCO Manual*.

a) The Contract provides a frame of reference for the development and implementation of ILOS as defined in the CFR. Healthy Blue shall examine these provisions in explicit detail prior to developing an ILOS for State submission and approval for its implementation.

b) Further, all ILOS proposals shall be reviewed and approved by the Managing Medical Director before State submission.

5) Healthy Blue ~~The submission~~ shall have ~~include a~~ plan for identifying and reporting the utilization of ~~in lieu of services~~ILOS to LDH in accordance with the *MCO Manual*. The plan shall be submitted to LDH or its designee during Readiness Review and upon any subsequent approval of additional ILOS.

~~3)~~a) *Healthy Blue reports costs associated with ILOS to LDH in Schedule AA of its Financial Reporting Template on a YTD basis.*

~~3)~~ Effective July 16, 2019, Healthy Blue received LDH approval to provide mental health intensive outpatient services in lieu of inpatient behavioral health hospitalization.

6)

~~4) LDH supports utilization of in lieu of behavioral health services provided by Magellan prior to integration of specialized behavioral health services.~~

~~5)~~7) ~~Requirements and policies for in lieu of services are provided in the Contract and the *MCO Manual* (refer to *Managed Care Organization (MCO) Manual – LA* for additional physical health service requirements).~~ Healthy Blue may, at its option, cover the approved services or settings for enrollees in lieu of Medicaid State Plan services as provided in *Attachment C, In Lieu of Services*. Requirements and policies for ILOS are provided in the *Contract* and the *MCO Manual*. The following table lists all approved ILOS that may be offered by Healthy Blue~~LDH approved in lieu of services~~:

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management	**Non-Covered and Cost-Effective Alternative Services – LA**

Service Category	In Lieu of Service	State Plan Service(s)	Effective Date
Physical Health	Chiropractic services for adults age 21 and older	Inpatient hospitals, outpatient hospitals, physician services, nurse practitioner services, other licensed practitioners' services, laboratory and x-ray services, prescribed drugs	1/1/202~~2~~3
Physical Health	Hospital-based care coordination for pregnant and postpartum individuals with substance use disorder and their newborns	Inpatient hospitals, outpatient hospitals, physician services, nurse practitioner services, other licensed practitioners' services	1/1/202~~2~~3
Physical Health	Doula Services	Inpatient and outpatient hospital services	1/1/2023
Behavioral Health	23-hour observation bed services for adults age 21 and older	Inpatient psychiatric hospitals	1/1/2020
~~Behavioral Health~~	~~Crisis stabilization units for adults age 21 and older[1]~~	~~Emergency services, inpatient hospitals~~	~~1/1/2020~~
Behavioral Health	Freestanding psychiatric hospitals for adults ages 21-64	General hospital psychiatric units	1/1/2020
Behavioral Health	Injection services provided by licensed nurses to adults age 21 and older	Physician services	1/1/2020
Behavioral Health	Mental health intensive outpatient programs	Inpatient psychiatric hospitals	1/1/2020
~~Behavioral Health~~	~~Mobile crisis response[1]~~	~~Emergency services, inpatient hospitals~~	~~9/22/2021~~
~~Behavioral Health~~	~~Behavioral health crisis care[1]~~	~~Emergency services, inpatient hospitals~~	~~11/12/2021~~
~~Behavioral Health~~	~~Population health management programs~~	~~Emergency services, inpatient hospitals~~	~~1/5/2022~~

Physical Health ILOS

1) Healthy Blue must notify LDH of their intent to offer any of the authorized ILOS and provide their policies for prior approval. Authorized physical health ILOS include the following:
   a) Chiropractic services for adults age 21 and older;
   b) Hospital-based care coordination for pregnant and postpartum individuals with substance use disorder (SUD) and their newborns; and
   c) Doula services.
2) Chiropractic Services for Adults Age 21 and Older:
   a) Qualified providers must be enrolled in Medicaid and meet the following requirements – current, valid, and unrestricted Louisiana chiropractic license.
   b) Nothing herein shall be construed to require Healthy Blue to execute an agreement with any qualified and willing provider. Healthy Blue reserves the right to execute agreements with qualified providers only as needed to successfully provide services, if it elects to offer this ILOS.
   c) As part of this ILOS, chiropractic services for the purpose of diagnosing and treating neuromusculoskeletal conditions associated with the functional integrity of the spine are covered and considered medically necessary. The following requirements apply.
      i) The initial visit must include a treatment plan, including:
         (1) Level of care (duration and frequency of visits);
         (2) Treatment goals; and
         (3) Measures to assess the effectiveness of treatment (qualitative and/or quantitative).
      ii) Follow-up visits must include information on the enrollee's progress in the treatment plan, along with the measures used to assess effectiveness.
      iii) The level of evaluation and management (E&M) service shall be determined by using Current Procedural Terminology (CPT) guidelines.
      iv) X-rays may be used to assess the enrollee's condition. X-rays must be limited to the level(s) of suspected abnormality and the minimum number of views necessary to establish the diagnosis. Repeat X-rays are not considered medically necessary in the absence of a significant worsening of symptoms despite treatment, a change in the pattern of symptoms which may suggest an alternate diagnosis, or the development of new symptoms.
      v) Spinal manipulation of up to five (5) regions is covered and considered medically necessary when included in the documented treatment plan.
      vi) Other treatments refer to chiropractic treatments other than spinal manipulation. On each date of service, a maximum of two (2) other treatments are covered and must be tailored to the enrollee's condition and identified in the documented treatment plan.

~~[1] The authorization for this in lieu of service will be terminated when comparable service are implemented in the State Plan.~~

(1) Mechanical traction
(2) Whirlpool therapy
(3) Ultrasound therapy
(4) Electrical stimulation
(5) Therapeutic exercises
(6) Neuromuscular reeducation
(7) Gait training
(8) Massage therapy
(9) Manual therapy
(10) Dry needling

d) Chiropractic ILOS are covered without the requirement of prior authorization for up to eighteen (18) treatment sessions annually. Additional treatment sessions may be reimbursed with authorization by Healthy Blue. A treatment session is defined as all chiropractic services that occur on a single date of service. A referral from a primary care provider or any other provider is not required.
e) Reimbursement for chiropractic services is only available to qualifying providers, as determined by Healthy Blue.
f) Use of all procedure codes must be in accordance with CPT guidance. Non-compliance with CPT guidance, failure to maintain adequate medical documentation to substantiate services rendered, or non-compliance with any of the provisions described in this document may result in recoupment and/or other sanctions as determined by Healthy Blue.
g) The table below represents the procedures codes covered under this ILOS:

Service	**CPT Code(s)**
Evaluation and management – new patient	99202, 99203, 99204, 99205
Evaluation and management – established patient	99212, 99213, 99214, 99215
Spinal X-rays	72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, 72120, 72220
Spinal manipulation	98940, 98941, 98942
Other treatments – a maximum of two (2) other treatments, in addition to spinal manipulation, are covered per day of service	97012, 97022, 97032, 97035, 97110, 97112, 97116, 97124, 97140, 20560, 20561

3) Hospital-Based Care Coordination for Pregnant and Postpartum Individuals with SUD and Their Newborns:
i) The purpose of this ILOS is to provide coverage of a comprehensive pregnancy medical home model of care to enrollees with SUD who are eighteen (18) years of age and older and pregnant or up to twelve (12) months postpartum. The model includes care

coordination, health promotion, individual and family support, and linkages to community/support services, behavioral, and physical health services. The model does not include coverage of physical and behavioral health services otherwise covered under the Louisiana Medicaid State Plan (e.g., outpatient obstetrical (OB) care, SUD treatment services). In addition, this ILOS is not duplicative of MCO case management services.

ii) This ILOS is a medically appropriate substitute for acute care utilization (e.g., emergency department visits, inpatient hospitalizations) due to inadequately-treated SUD during the pregnancy and postpartum periods. The benefit will not serve as a substitute for medically necessary physical and behavioral health services such as OB care or SUD care. Rather, the ILOS will help to ensure that enrollees receive comprehensive physical and behavioral health care services that meet their needs, while avoiding preventable use of acute care.

iii) Eligible and qualified providers are hospitals that are enrolled in Medicaid and provide outpatient services with the following staffing specifications:
   (1) At least one (1) licensed mental health professional (LMHP), such as an LCSW or LPC with a current, valid, and unrestricted Louisiana license;
   (2) Additional staff may include LMHPs, registered nurses, or advanced practice registered nurses with a current, valid, and unrestricted Louisiana license; and
   (3) A staffing ratio of at least one (1) LMHP or nurse for every forty (40) enrollees must be maintained.

iv) Nothing herein shall be construed to require Healthy blue to execute an agreement with any qualified and willing provider. Healthy Blue reserves the right to execute agreements with qualified providers only as needed to successfully provide services, if Healthy Blue elects to offer this ILOS.

v) Services covered under the model are divided into three (3) categories:
   (1) Intake, assessment, and care plan development;
      (a) Time requirement – 2.5 hours total time (face-to-face and non-face-to-face time)
      (b) Intake:
         (i) Pregnancy confirmation; referral to OB if needed
         (ii) Explanation of services
         (iii) Obtaining informed consent for treatment
         (iv) Obtaining detailed medical and social history
         (v) Create a mapping tool of contacts
      (c) Needs assessment through screenings:
         (i) Initiate assessment of unmet care needs for physical (medical and nutritional), behavioral and psychosocial needs. At a minimum, these assessments are completed:
            1. 5 P's Screening tool
            2. DSM-5 Opioid Use Disorder Screening
            3. NIDA Substance Use Screen

4. PHQ9 Depression Screening
5. GAD-7 Generalized Anxiety Disorder Screening
6. SDOH Health Leads Screening

(ii) Additional screenings may be added, to include:

1. Columbia Suicide Severity Rating Scale
2. Perinatal Posttraumatic Stress Disorder Questionnaire
3. PCL-C PTSD Checklist – Civilian version
4. ACE Adverse Childhood Experience Questionnaire
5. MDQ Mood Disorder Questionnaire
6. HITS Intimate Partner Violence Screening

(d) Plan of care development:

(i) Review assessments to identify care needs and discussing results with patient;

(ii) Develop treatment plan of patient-centered goals, including referral to medication-assisted treatment (MAT) or SUD treatment;

(iii) Assessing urgency of identified goals, prioritizing referrals based on needs, including housing referrals;

(iv) Obtain plan of care developed by Healthy Blue case management, if applicable, for incorporation;

(v) Assessing care plan understanding through teach back to uncover any misunderstanding of the plan, the medical condition and objections. Adjusting plan and referrals as needed;

(vi) Providing warm handoff to referral sources; and

(vii) Notification to Healthy Blue case managers of enrollment.

(e) All activities shall be documented fully.

(2) Care coordination; and

(a) Time requirement – 10 hours per month of total time (face-to-face and non-face-to-face time). Non-face-to-face time can include, but is not limited to:

(i) Warm handoffs to other providers and community services;

(ii) Contacting and communicating with physical and behavioral health providers;

(iii) Following up on outcomes of referrals or visits; and

(iv) Updating the enrollee's care plan.

(b) Prenatal:

(i) General activities:

1. Confirmation of consent
2. Confirm and update birth plans
3. Confirm and update contact information
4. Assisting with benefit reinstatement, if indicated

(ii) Care Coordination:

1. Coordination of referrals identified from treatment plan, incorporating collaboration with Healthy Blue as needed to improve effectiveness and prevent duplication
2. Review and revision of care plan, as needed
3. Visit preparation, navigation, and follow up for key OB services
4. Coordination with Healthy Blue case managers to enhance care and prevent duplication
5. Multidisciplinary long-term postpartum follow-up includes referrals for medical, developmental, and social support for mother and infant

(iii) Risk Assessment:

1. Reviewing patient history from referral source (if applicable) and medical charts
2. Reassess physical, mental and social needs; identifying gaps
3. Providing assistance to close gaps for physical, mental and social needs
4. Review risks identified during assessment and addressing those risks
5. Assisting with development of peer support

(iv) Alcohol/SUD Treatment:

1. Interdisciplinary case conference with hospital care team during pregnancy, delivery and postpartum periods, including patient care plan.
2. Participation at SUD Treatment Case Conference, if indicated
3. Providing referral and/or education for Naloxone

(v) Health Education and Promotion:

1. Orientation to labor and delivery process, including pain management plan and discussion of post-partum family planning, education on the importance of post-partum care
2. Provide individualized education on pregnancy, childbirth, parenting, physical well-being, lactation support and information on Neonatal Abstinence Support and related topics

(c) Delivery Care:

(i) In-hospital, rooming in and assessment of neonatal opioid withdrawal syndrome (NOWS), if required staffing and space are available

(ii) Lactation support and follow up education

(iii) Assessing baby safety needs

(iv) Navigating and educating mother for potential NICU admission, as needed

(v) Assessment of care transition to home

(d) Postpartum Care:

(i) Care Coordination:

1. Identifying/connecting patient with peer support

2. Provide referrals for medical, developmental and social support, (Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Healthy Start, Early Steps)
3. Follow meconium drug screening and report to the Department of Children and Family Services (DCFS), if appropriate
4. Visit preparation and follow up for pediatric visits
5. Assist with/make referral to pediatrician
6. Identifying NOWS and neonatal abstinence syndrome (NAS) support by care partners

(ii) Health Education and Promotion:

1. Discussion of postpartum needs, including importance of postpartum care, red flag warnings for postpartum hygiene, signs and symptoms of illness for mother, sleep and nutritional needs.
2. Discussion of red flag warnings for signs and symptoms of newborn illness, feeding and lactation support, care of baby's skin, mouth, umbilical cord and circumcision

(iii) Risk Assessment:

1. Reassessment for depression and anxiety screening with on-site treatment or referral as indicated
2. Provide education and advocacy for DCFS reporting and the justice system
3. Documentation of activities and progress across all categories of care coordination activities

(3) Outreach for disengaged enrollees.

(a) Time requirement – 8 hours per month total time (face-to-face and non-face-to-face time).
(b) Maintaining and reviewing call log for potential disengagement
(c) Medical record review for missed physician or diagnostic appointments
(d) Checking with SUD treatment providers for missed appointments
(e) Contact attempts by preferred contact method at least three (3) times on different days and different times of day
(f) Escalating contact tracking to friends, family, employer, judicial, social services, etc., from contact mapping
(g) Documentation of efforts made for outreach attempts

vi) Services under this ILOS are covered without the requirement of prior authorization or referral. Healthy Blue may make referrals to providers of this service at its discretion.

vii) Reimbursement for these services is only available to qualifying providers, as determined by Healthy Blue. Providers are advised to contact the MCOs for specific additional guidance prior to rendering services.

viii) Use of all procedure codes must be in accordance with this terms and conditions described in this document. Failure to maintain adequate medical documentation to substantiate services rendered or non-compliance with any of the provisions described in this document may result in recoupment and/or other sanctions as determined by Healthy Blue.

ix) The table below represents the procedure codes covered under this ILOS. The primary diagnosis code on the claim should reflect the primary SUD experienced by the enrollee.

Service	CPT Code	Maximum Units Per Pregnancy and Postpartum Period
Intake, Assessment, Care Plan Development	H0002	1
Care Coordination	H0006	20
Outreach for Disengaged Enrollees	H0023	4

Behavioral Health ILOS

1) Healthy Blue must notify LDH of their intent to offer any of the authorized ILOS within this section and provide their proposed service definitions for prior approval. Authorized behavioral health ILOS include the following:
   a) 23-hour observation bed services for adults age 21 and older;
   b) Freestanding psychiatric hospitals for adults ages 21-64;
   c) Injection services provided by licensed nurses to adults age 21 and older; and
   ~~Mental health intensive outpatient programs.; and~~
   ~~Population health management programs.~~
2) 23-Hour Observation Bed Services for Adults Age 21 and Older:
   a) This ILOS is an inpatient hospital-based intervention designed to allow for the opportunity to hold and assess an enrollee without admitting them.

~~Behavioral Health Crisis Care:~~

~~This ILOS is an initial or emergent psychiatric crisis response intended to provide relief, resolution and intervention through crisis supports and services during the first phase of a crisis for adults in an outpatient setting.~~

~~The authorization for this ILOS will be terminated when comparable services are implemented in the Louisiana Medicaid State Plan.~~

3) Freestanding Psychiatric Hospitals for Adults Ages 21-64:
   a) The purpose of this ILOS is to assist adult enrollees with significant behavioral health challenges. This population is often treated in more expensive general hospital psychiatric units, which creates access issues as beds in this setting are limited. Individuals often remain in emergency departments while waiting for available beds, thereby increasing costs to the healthcare system as they utilize those medical resources while awaiting beds in general hospitals. Use of freestanding psychiatric units reduces

emergency department consumption, increases psychiatric bed capacity, and provides a less costly alternative to general hospital beds.

4) Injection Services Provided by Licensed Nurses to Adults Age 21 and Older:
   a) Many enrollees are unable or unwilling to take oral psychotropics, or their mental status indicates a need for injectable medication to ensure compliance and stability. Embedded in the cost of many E&M coded visits is the cost of providing injectable medications. Allowing licensed nurses instead of physicians to perform this service delivery results in the most cost efficient and least costly service delivery, and helps to ensure compliance. The goals are reducing subsequent office visits and reducing hospitalizations due to lack of compliance.
5) Mental Health Intensive Outpatient Programs:
   a) The purpose of this ILOS is to provide enrollees treatment via the least restrictive level of care, allowing an alternative to inpatient hospitalization or Assertive Community Treatment (ACT) and providing a step-down option from inpatient hospitalization for enrollees at high risk for readmission.

~~Mobile Crisis Response:~~
- ~~This ILOS is an initial or emergent crisis response intended to provide relief, resolution, and intervention through crisis supports and services during the first phase of a crisis in the community.~~
- ~~The authorization for this ILOS will be terminated when comparable services are implemented in the Louisiana Medicaid State Plan.~~

~~Population Health Management Programs:~~
- ~~Mindoula Clinical Services' Population Health Management Program (PHMP) is a precision solution that targets, engages, and serves enrollees with SMI, SUD, and/or Sickle Cell Disease (SCD) and other comorbid medical conditions through team based, tech enabled, care extension services. This focused approach includes (1) identification of enrollees for the PHMP using proprietary algorithms and enrollee archetype data, (2) outreach and enrollment of enrollees using an intake process specific to SMI, SUD, and SCD populations, and (3) provision of tech enabled programmatic interventions that include content and methods tailored to reducing total costs of care by addressing behavioral, medical, and social needs specific to SMI, SUD, and SCD populations.~~
- ~~These interventions are designed to enhance participants' skills, strategies, and supports, which in turn help to prevent and reduce unnecessary and avoidable medical costs associated with SMI, SUD, SCD, and other comorbid medical conditions, during the program and even after its completion.~~

Value-Added Benefit (VAB)

1) As permitted under 42 CFR §438.3(e)(1), Healthy Blue may offer VABs which are not Medicaid covered services or prohibited services. VABs are provided at Healthy Blue's expense, are not included in the capitation rate, and shall be identified as VABs in encounter

data in accordance with the *MCO Manual* and *MCO System Companion Guide*. Healthy Blue shall also report VABs in financial data in accordance with the *Financial Reporting Guide*.~~and services to members in addition to the core benefits and services. Healthy Blue shall not portray core benefits or services as VABs.~~

~~1)~~2) Enrollee incentives may be offered as a form of VAB to promote healthy behavior. Examples of permissible incentives include healthcare items or services (e.g., blood sugar screenings, cholesterol tests, medic alert jewelry) and non-health care items or services (e.g., gift certificates, t-shirts, infant car seats). Cash or instruments convertible to cash are not permissible.

~~1)~~ At a minimum, Healthy Blue shall offer VABs ~~are those optional services offered by Healthy Blue, including those~~ proposed in its response to the ~~Healthy Blue's~~ Request For Proposal (RFP) and agreed upon by LDH, consistent with the Contract. Additional VABS may be offered, at Healthy Blue's option. All VABs shall be reported in accordance with the *MCO Manual* and the *MCO System Companion Guide*.~~*that* are not:~~

~~b) Core benefits and services as defined in the Contract; and~~

~~c)~~3) ~~Cost-effective alternatives as defined in the Contract.~~

~~2)~~4) At Healthy Blue's discretion, it may provide or assist enrollees with transportation to access a VAB. Encounters for transportation related to a VAB shall be identified as such.~~VABs are provided at Healthy Blue's expense, are not included in the capitation rate, and shall be identified as VABs in encounter data.~~

~~3) VABs may include health care services which are currently non-covered services by the Louisiana Medicaid State Plan and/or which are in excess of the amount, duration, and scope in the Louisiana Medicaid State Plan.~~

~~4) VABs shall be specifically defined by Healthy Blue in regard to amount, duration, and scope.~~

~~5) Transportation to a VAB or service is the responsibility of the member and/or at the discretion of the Healthy Blue.~~

~~6) Healthy Blue shall send the member a notification letter if a VAB or service is not approved.~~

~~7) VABs are not Medicaid-funded and, as such, are not subject to appeal and state fair hearing rights. A denial of these benefits will not be considered an adverse benefit determination for purposes of grievances and appeals.~~

5) Healthy may propose to add to or expand upon the VABs proposed in the RFP response as pre-approved in writing by LDH. Deletions or reductions to the VABs may be proposed on an annual basis and shall be submitted to LDH for approval at least six (6) months in advance of the effective date of enrollment resulting from the enrollment period. Healthy Blue shall submit requests in accordance with the *MCO Manual*.

6) Healthy Blue may amend VAB subject to the requirements and timeframes specified in the Contract. When requesting such revisions, Healthy Blue should provide the following information for each VAB to LDH:

a) Type of request (e.g., new, removal, revision);

b) VAB name;

c) VAB description – if a revision to an existing VAB, include a summary of the change;
d) Category or group of enrollees eligible to receive the VAB if it is not appropriate for all enrollees;
e) Any limitations or restrictions that apply;
f) Types of providers responsible for providing the benefit or service, including any limitations on provider capacity if applicable;
g) How and when providers and enrollees will be notified about the availability of such VAB;
h) How an enrollee may obtain or access the VAB – if a new financial incentive, include the mechanism itself (e.g., gift card, prepaid debit card) and confirmation that it is not convertible to cash;
i) How the VAB will be identified in administrative data or encounter data;
j) Per member, per month (PMPM) actuarial value; and
k) Effective date.

7) Each submission must include a written certification that the VAB does not violate the Anti-Kickback statute (42 U.S.C. § 1320a-7b[b]) and its implementing regulations, the Beneficiary Inducement statute (42 U.S.C. § 1320a-7a[a][5]) and its implementing regulations, and any other applicable provisions.
8) Healthy Blue shall also provide the PMPM actuarial value and statement of commitment on an annual basis in accordance with the Contract.
9) Annually, for the VABs proposed in the RFP response, and as amended, Healthy Blue shall:
   a) Indicate the PMPM actuarial value of the VABs, individually and in aggregate, based on enrollment projections for the plan, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information; and
   b) Include a statement of commitment to provide the VABs for the year.
10) Healthy Blue shall be directed by LDH in writing to revise its proposed PMPM based on any feedback from LDH, following an independent review of any statements of actuarial value provided by Healthy Blue.
~~8) Healthy Blue shall provide LDH a description of the VABs and services to be offered for approval. Additions, deletions, or modifications to VABs or services made during the Contract period shall be submitted to LDH for approval ninety (90) calendar days in advance of the proposed change.~~
11) The proposed monetary value of the~~se~~ VABs ~~and services~~ shall be considered a binding Contract deliverable. If for any reason, including, but not limited to, lack of enrollee participation, the aggregated annual PMPM proposed is not expended by Healthy Blue, LDH reserves the right to require Healthy Blue to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.
12) VABs are not subject to appeal and state fair hearing rights. A denial of these benefits is not considered an adverse benefit determination for purposes of enrollee grievances and

appeals. Healthy Blue shall send the enrollee a notification letter if a VAB or service is not approved.

~~9)~~

~~10) For each VAB proposed, Healthy Blue shall:~~

~~Define and describe the benefit or service;~~

~~a) Identify the category or group of members eligible to receive the benefit or service if it is not appropriate for all members;~~

~~a) Note any limitations or restrictions that apply to the benefit or service;~~

~~a) Identify the types of providers responsible for providing the benefit or service, including any limitations on provider capacity if applicable;~~

~~a) Propose how and when providers and members will be notified about the availability of such benefits or services;~~

~~a) Describe how a member may obtain or access the benefit or service; and~~

~~a) Describe how the benefit or service will be identified in administrative data or encounter data.~~

~~10) For the term of the Contract, Healthy Blue shall:~~

~~a) Provide, within thirty (30) days from the date the Contract is signed, a statement of commitment to provide the benefits or services for the entire term of the Contract.~~

~~a) The value of the commitment for the Contract term shall be no less than the aggregated annual value of all the benefits or services on a per member, per month (PMPM) basis in effect at the termination of the previous Contract with LDH resulting from RFP #305PUT-DHHRFP-BH-MCO-2014-MVA; and~~

~~a) Healthy Blue may honor each benefit or service commitment made during the previous Contract with LDH resulting from RFP #305PUR-DHHRFP-BH-MCO-2014-MVA. For the Contract term, Healthy Blue shall seek to align its benefits or services commitments with LDH priorities and Healthy Blue's Alternative Payment Model (APM) Strategic Plan.~~

~~10) LDH will work with its contract actuary to independently review any statements of actuarial value.~~

~~10) If for some reason, including but not limited to lack of member participation, the aggregated annual PMPM proposed is not expended, LDH reserves the right to require Healthy Blue to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.~~

Excluded Services

1) Excluded services are available to enrollees~~members~~ under the Louisiana State Plan or applicable waivers, which Healthy Blue is not financially responsible to provide. These services shall be paid for by LDH on a FFS or other basis.
2) However, Healthy Blue is responsible for informing enrollee~~member~~s on how to access excluded services, providing all required referrals and assisting in the coordination of

scheduling such services. Healthy Blue shall implement procedures to coordinate the services it provides to the enrollee with the services the enrollee receives in FFS.

3) Excluded services include the following:
   a) Adult ~~D~~dental services with the exception of ~~varnish provided in a primary care setting,~~ surgical dental services~~,~~ and emergency dental services;
   b) Services to individuals in Intermediate Care Facility for Individuals with Intellectual~~Developmental~~ Disabilities (ICF/II~~D~~D) services;
   c) Personal care services (PCS) for those ages twenty-one (21) and older;
   d) Nursing facility services, with the exception of post-acute rehabilitative care provided at the discretion of Healthy Blue as a cost-effective alternative service to continued inpatient care as an approved ~~i~~in ~~L~~lieu of ~~S~~service;~~.~~;
   e) Individualized Education Plan (IEP) services including physical therapy, occupational therapy, speech/language therapy, audiology and some psychological therapy, provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures (these services are not provided by OPH certified school-based health clinics);
   f) ~~Services provided under~~ All ~~the~~ ~~H~~home and ~~C~~community-~~B~~based ~~W~~waiver ~~S~~services ~~(HCBS) Waiver~~;
   g) Targeted ~~C~~case ~~M~~management services; and
   ~~h)~~ Services provided through LDH's Early-Steps Program; and ~~(Individuals with Disabilities Education Act (IDEA), Part C Program Services).~~
   h)
   ~~i)~~ The following excluded drugs:
   i)
   ~~i)~~ Select agents when used for symptomatic relief of cough and colds, not including prescription antihistamine and antihistamine/decongestant combination products;
      i)
      ~~)~~ Select agents when used for anorexia, weight loss, or weight gain, not including orlistat;
      ii)
      ~~ii)~~ Select agents when used to promote fertility, not including vaginal progesterone when used for high-risk pregnancy to prevent premature births;
      iii)
      ~~)~~ Drug Efficacy Study Implementation (DESI) drugs; and
      iv)
      ~~j)~~v) Select nonprescription drugs, not including over the counter (OTC) antihistamines, antihistamine/decongestant combinations, or polyethylene glycol.

Prohibited and Non-Covered Services

~~1) Services that are experimental, non-Food and Drug Administration (FDA) approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."~~

1) Healthy Blue shall ensure that physicians and all other professionals abide by the professional guidelines set forth by their certifying and licensing agencies in addition to complying with Louisiana Medicaid regulations.
2) Healthy Blue shall not pay claims or execute contracts with individuals or groups of providers who have been excluded from participation in federal health care programs under either 42 USC §1320a-7 or §1320a-7a [42 CFR §438.214(d)] or state funded health care programs. Healthy Blue may access a list of providers excluded from federally funded health care programs at using the following sources:
   a) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);
   b) The System of Award Management (SAM);
   c) Health Integrity and Protection Data Bank; and
   d) Louisiana Adverse Actions List Search (LAALS).
3) Healthy Blue shall not authorize or remit payment for services provided under the Contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any US territories (Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa).
4) In general, services that are not approved by the FDA or services that are experimental, investigational, or cosmetic are excluded from Medicaid coverage and will be deemed not medically necessary.

~~2)~~5) The following ~~non-exhaustive list of~~ non-exhaustive list of services are excluded from MCO covered services and/or limited by~~prohibited, limited, or not~~ Louisiana Medicaid (not Medicaid covered services) and shall not be provided to enrollees under the Contract~~members~~:

a) Any service (drug, device, procedure, or equipment) that is not medically necessary;
b) Experimental/investigational drugs, devices, procedures or equipment, unless approved by the Secretary of LDH;
c) Elective cosmetic surgery and ~~C~~cosmetic drugs, devices, procedures, or equipment;
~~d) Any services for chronic pain management, including spinal injections to alleviate chronic, intractable pain;~~
~~e)~~d) Elective abortions (those not covered in the Louisiana Medicaid State Plan and in *Attachment B, MCO Covered Services* and the *MCO Manual*~~under contractual limitations on abortions~~) and related services (refer to *Women's Health and Family Planning Services – LA*);
~~f)~~e) Assistive reproductive technology and services for treatment of infertility~~, including sterilization reversal procedures;~~
~~g)~~ Harvesting of organs when a Louisiana Medicaid enrollee is the donor of an organ to a non-Medicaid enrollee;

~~h)~~f) ~~Surgical procedures discontinued before completion, regardless of the reason;~~ and

g) Provider preventable conditions (PPCs), described below~~refer to *Concurrent Review (Telephonic and Onsite) – LA*~~.

~~i)~~

~~3) Providers shall not bill Healthy Blue, Medicaid, or the recipient for a missed appointment or any other services not actually provided. Services that have not been documented are considered services not rendered and are subject to recoupment.~~

~~Healthy Blue shall ensure that physicians and all other professionals abide by the professional guidelines set forth by their certifying and licensing agencies in addition to complying with Louisiana Medicaid regulations.~~

~~4) Healthy Blue shall not authorize services or execute contracts with individuals or groups of providers who have been excluded from participation in federal health care programs under Section 1128/1128A of the Social Security Act [42 CFR §438.214(d)] or state funded health care programs. Healthy Blue may access a list of providers excluded from federally funded health care programs at using the following sources:~~

~~a) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);~~

~~b) The System of Award Management (SAM);~~

~~c) Health Integrity and Protection Data Bank; and~~

~~c) Louisiana Adverse Actions List Search (LAALS).~~

~~4) Healthy Blue shall not authorize or remit payment for services provided under the Contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any US territories (Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa).~~

Provider Preventable Conditions (PPCs)

1) Louisiana Medicaid is mandated to meet the requirements of 42 CFR §447.26 with respect to non-payment for PPCs. Healthy Blue is required to implement procedures for non-payment for these events when applicable to its enrollees.
2) PPCs are defined into two (2) separate categories:
   h) Health care-acquired condition (HCAC), meaning a condition occurring in any inpatient hospital setting, identified as a hospital acquired condition (HAC) in accordance with 42 CFR §447.26; and
      i) Refer to the CMS website for a current listing of HCACs and associated diagnoses [link].
      ii) It is the responsibility of Healthy Blue to determine if the HCAC was the cause for any additional days added to the length of stay. Healthy Blue may not reimburse for services related to HCAC.
      iii) Medicaid will require the Present-on-Admission (POA) indicators as listed below with all reported diagnosis codes. POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient

encounter, including emergency department, observation or outpatient surgery, are considered as present on admission. Present on admission reporting options:
(1) Y – Present at the time of inpatient admission;
(2) N – Not present at the time of inpatient admission;
(3) U – Documentation is insufficient to determine if condition is present on admission; or
(4) W – Provider is unable to clinically determine whether condition was present on admission or not

iv) Refer to the CMS website for the current listing of diagnoses that are exempt from POA reporting requirements [link].

i) Other provider preventable condition (OPPC), meaning a condition occurring in any health care setting in accordance with 42 CFR §447.26.

i) Healthy Blue is prohibited from reimbursing providers for the following OPPCs in any setting:
(1) Wrong surgical or other invasive procedure performed on a patient;
(2) Surgical or other invasive procedure performed on the wrong body part; or
(3) Surgical or other invasive procedure performed on the wrong patient.

ii) Healthy Blue shall not reimburse for any days that are attributable to the OPPC. The diagnosis codes that are utilized for the three (3) OPPCs listed above are included below.
(1) Y65.51 – Performance of wrong operation (procedure) on correct patient (existing code);
(2) Y65.52 – Performance of operation (procedure) on patient not scheduled for surgery; and
(3) Y65.53 – Performance of correct operation (procedure) on wrong side/body part.

3) Healthy Blue shall not impose a reduction in reimbursement for a PPC when the condition defined as a PPC for a particular enrollee existed prior to the initiation of treatment for the enrollee by that provider.
4) Reductions in provider reimbursement may be limited to the extent that the following apply:
a) The identified PPCs would otherwise result in an increase in reimbursement.
b) It is practical to isolate for non-payment the portion of the reimbursement directly related to treatment for, and related to, the PPC.
5) Non-payment of PPCs shall not prevent access to services for Medicaid enrollees.
6) In the event an outpatient surgery is performed erroneously, as described below, the appropriate modifiers to all lines related to the erroneous surgery/procedure are:
a) PC – Wrong surgery on patient;
b) PB – Surgery wrong patient; or
c) PA – Surgery wrong body part.

7) In summary, it is the responsibility of the provider to identify and report (through the UB-04) any PPC and not seek reimbursement from Medicaid for any additional expenses incurred as a result of the PPC. Healthy Blue may disallow or reduce provider reimbursements based on a post-payment review of the medical record.
8) It is the responsibility of Healthy Blue to ensure that reimbursement is not made for any expense as a result of a PPC.

~~Other Considerations~~MCO Covered Services

1) Healthy Blue 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*. Healthy Blue shall possess the expertise and resources to ensure the delivery of quality healthcare services to its enrollees in accordance with the Contract and prevailing medical community and national standards.
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 CFR §440.230, and for enrollees under the age of twenty-one (21), as set forth in 42 CFR Part 441, Subpart B [42 CFR §438.210(a)(2)].
3) Healthy blue shall ensure that MCO covered services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. Healthy Blue 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 CFR §438.210(a)(3)].
4) In accordance with 42 CFR §438.210(a)(4), Healthy Blue may place appropriate limits on a service that are:
    a) On the basis of criteria applied under the State Plan, such as medical necessity; or
    b) For the purpose of utilization control, provided that:
        i) The services furnished can reasonably be expected to achieve their purpose;
        ii) 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
        iii) 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 CFR §441.20.
5) Healthy Blue shall provide MCO covered services in accordance with LDH's definition of medically necessary services, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and the *MCO Manual* [42 CFR §438.210(a)(5)(i)].
    a) A public health quarantine or isolation order or recommendation also establishes medical necessity of healthcare services.

~~1)~~6) Healthy Blue shall cover medically necessary ~~core benefits and~~ services that address:

a) The prevention, diagnosis and treatment of an enrollee ~~member~~'s disease, condition, and/or disorder that results in health impairments and/or disability;
b) The ability for an enrollee ~~member~~ to achieve age-appropriate growth and development; and
c) The ability for an enrollee~~member~~ to attain, maintain, or regain functional capacity.

7) Healthy Blue shall ensure that each enrollee has an ongoing source of care appropriate to their needs as required under 42 CFR §438.208(b)(1) and shall formally designate a primary care provider (PCP) as primarily responsible for coordinating services accessed by the enrollee.
8) Healthy Blue shall not avoid costs for services covered in its Contract by referring enrollees to publicly supported health care resources [42 CFR §457.1201(p)].
9) Healthy Blue 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.
10) Healthy Blue 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 CFR §438.3(j)(1) and (2); 42 CFR §489.102(a)(3)].
11) Healthy Blue 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 language(s) and sign language interpreters in accordance with 42 CFR §438.206(c).

~~2) Healthy Blue may exceed the service limits as specified in the Louisiana Medicaid State Plan provided those service limits can be exceeded, with authorization, in FFS.~~
~~3) No medically necessary service limitation can be more restrictive than those that currently exist under the Louisiana Medicaid State Plan including quantitative and non-quantitative treatment limits.~~
~~4) Healthy Blue may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care.~~
~~) Refer to the definition of "medically necessary services." The Medicaid Director in consultation with the Medicaid Medical Director and Medicaid Behavioral Health Medical Director will make the final interpretation of any disputes about the medical necessity and continuation of core benefits and services under the Contract based on whether or not the Medicaid FFS program would have provided the service.~~
~~) A public health quarantine, isolation order, or recommendation also establishes the medical necessity of healthcare services.~~
~~7) The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) mandates that all medically necessary services listed in Section 1905(a) of the Social Security Act be covered under Medicaid for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program provided for Medicaid eligible individuals under the age of twenty-one (21) (42 CFR Part~~

~~441, Subpart B). Healthy Blue is responsible to provide all medically necessary services whether specified in the core benefits and services and Louisiana Medicaid State Plan or not, except those services (carved out, excluded, or prohibited services) that have been identified in the Contract.~~

~~8) Healthy Blue shall provide pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of being pregnant and includes but is not limited to prenatal care, delivery, postpartum care, and family planning services for pregnant women in accordance with 42 CFR Part 440, Subpart B.~~

~~9) Healthy Blue may cover, in addition to services covered under the State Plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR Part 438, Subpart K.~~

~~10) Healthy Blue shall design its provider network to increase the emerging use of peers as behavioral health providers. This includes peers providing services for youth, adults, and parents/families served in community and residential settings, peer services as approved by LDH as cost-effective alternative services, and peer support specialists with Office of Behavioral Health (OBH) approved credentials to serve as qualified providers.~~

~~11) Non-emergency medical or ambulance transportation to non-Medicaid covered services is not a core benefit, but may be considered a cost-effective alternative service, if so approved by LDH as an in lieu of service.~~

~~12) Healthy Blue shall not avoid costs for services covered in its Contract by referring enrollees to publicly supported health care resources.~~

12) In the event LDH determines that Healthy Blue failed to provide one (1) or more MCO covered~~core benefits and~~ services, LDH shall direct Healthy Blue to provide such service. If Healthy Blue continues to refuse to provide the~~ core benefit or~~ MCO covered service(s), LDH shall authorize the enrollees~~members~~ to obtain the MCO covered service from another source and shall notify Healthy Blue in writing that it shall be charged the actual amount of the cost of such service.

a) In such event, the charges shall be obtained by LDH in the form of deductions of that amount from the next monthly capitation payment or a future payment as determined by LDH. With such deductions, LDH shall provide a list of the enrollees~~members~~ from whom payments were deducted, the nature of the services(s) denied, and payments LDH made or will make to provide the medically necessary MCO covered services.

~~13)~~b) In addition to the deduction, Healthy Blue may be assessed a monetary penalty per incident of non-compliance (see *Attachment G, Table of Monetary Penalties*).

Moral or Religious Objections

1) If Healthy Blue elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, Healthy Blue must furnish information about the core benefits and services that it does not cover, in

accordance with 42 USC §1396u-2(b)(3)(B)~~§1932(b)(3)(B)(ii) of the Social Security Act~~ and 42 CFR §438.102(b)(1), by notifying:

~~d)~~a) LDH with its proposal~~prior to Contract execution~~, or whenever it adopts the policy during the term of the Contract;

~~e)~~b) Potential enrollees before and during enrollment in Healthy Blue;

~~f)~~c) Enrollees at least thirty (30) calendar days prior to the effective date of the policy with respect to any particular service; and

~~g)~~d) ~~Members~~Enrollees through the inclusion of the information in the Member~~'s~~ Handbook~~Manual~~.

~~2)~~ If Healthy Blue elects to not provide, reimburse for, or provide coverage of a MCO covered~~core benefit or~~ service described in the Contract because of an objection on moral or religious grounds, Healthy Blue's ~~it shall provide the following information to LDH:~~

~~0) A statement of any moral and religious objections to providing any core benefits and services described in the Contract. The statement must describe, in as much detail as possible, all direct and related services that are objectionable. It must include a listing of the codes impacted including but not limited to Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding Systems (HCPCS) codes, diagnosis codes, revenue codes, modifier codes, etc., and if there are none, it must so state.~~

~~4)~~2) ~~At the discretion of LDH, the~~ monthly capitation payment will~~may~~ be adjusted accordingly.

~~5)~~3) At this time, Healthy Blue does not have any moral or religious objections.

REFERENCES:

- CFR Title 42
- Concurrent Review (Telephonic and Onsite) – LA
- ~~EPSDT Services – Core Policy~~
- ~~Health Plan Advisory 15-17~~
- Health Care Management Denial – LA
- Health Plan Advisory 15-17
- Louisiana Medicaid Managed Care Organization (MCO) Manual
- ~~Louisiana Medicaid Professional Services Manual~~
- Louisiana State Contract
- Managed Care Organization (MCO) Manual – LA
- Out-of-Area – Out-of-Network Care – LA
- Out of Network Authorization Process
- Precertification of Requested Services – LA
- Value Added Benefit Tracking and Notification – LA
- Women's Health and Family Planning Services – LA

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management	**Non-Covered and Cost-Effective Alternative Services – LA**

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management

Secondary Department(s):
Behavioral Health
Claims
Marketing
Medicaid Prior Authorization (MPA) Team
National Customer Care (NCC) Organization

EXCEPTIONS:

Federal law mandates that enrollees under twenty-one (21) years of age are entitled to receive all medically necessary health care, screening, diagnostic services, treatment, and other measures to correct or improve physical or mental conditions (Section 1905(r) of the Social Security Act). The EPSDT benefit is comprehensive in nature and includes coverage of all services described in federal Medicaid statutes and regulations including those that are not covered for adults, not explicitly described in the Contract, not included in the Medicaid FFS fee schedules, and not covered in the Louisiana Medicaid State Plan.

REVISION HISTORY:

Review Date	Changes
05/29/2015	• New. Created LA-specific version of corporate document.
05/19/2016	• Annual review • Minor grammatical edits
06/19/2017	• For annual review • Revision to procedure section • DHH changed to LDH • Bayou removed from reference section • References placed in alphabetical order
03/13/2018	• Off cycle review • Amendment 11 changes
05/19/2018	• For annual review • No changes
04/23/2019	• Annual review • Policy section updated with current contract language

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management	**Non-Covered and Cost-Effective Alternative Services – LA**

Review Date	Changes
	• Definition section updated • Reference section updated • BH added as secondary department
04/01/2021	• Annual review • Edits to the policy, definitions, and procedure sections • Exceptions added • References updated • Claims and Marketing added as secondary departments • Included new MCO Manual verbiage for prohibited and non-covered services • Updating the "Effective Date" from 01/01/2008 to 05/29/2015 as the LA plan went live in 2012 & this also reflects the original policy creation date noted in the Revision History (this is a LA-specific policy created from a corporate policy version)
01/28/2022	• Off-Cycle Review • Policy updated to include and reflect Amendment 10 and LDH MCO Manual changes to In Lieu of Services (Action Alert #38523 proposed retro-effective date 1/1/2022)
03/16/2022	• Annual Review; no changes
12/02/2022	• Off Cycle Review for LA Rebid 2023 Readiness Review • Updated policy, definitions, and procedure sections • Alphabetized and updated references • Added Medicaid Prior Authorization (MPA) Team as a secondary department • Policy updated to include and reflect Attachment C, —In Lieu of Services of MCO Contract effective 1/1/2023