

IN LIEU OF SERVICES

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

The following principles must be reflected in each ILOS in order to receive LDH and CMS approval:

- ❖ ILOS must advance the objectives of the Medicaid program;
 - The ILOS must not violate any applicable federal requirements.
- ❖ ILOS must be cost effective;
 - Since ILOS are substitutes for state-plan services and settings, there should be a limit on the amount of expenditures for ILOS to reduce inequities for enrollees across delivery systems.
 - The ILOS cost percentage per program should not exceed 5%.
- ❖ ILOS must be medically appropriate;
 - LDH shall determine reasonable medical appropriateness and reserves the authority to deny approval of any ILOS it determines is not a medically appropriate substitute.
- ❖ ILOS must be provided in a manner that preserves enrollee rights and protections;
 - ILOS may not be used to reduce, discourage, or jeopardize enrollee access to state-plan covered services or settings. If an enrollee chooses not to receive an ILOS, they always retain their right to receive the state-plan service or setting on the same terms as would apply if an ILOS were not an option. MCOs may not deny an enrollee a medically appropriate state-plan service or setting on the basis that an enrollee has been offered an ILOS, is currently receiving an ILOS, or has received an ILOS in the past.
- ❖ ILOS must be subject to appropriate monitoring and oversight; and
 - LDH may rescind its approval or require corrective action to address deficiencies for any ILOS if it is no longer medically appropriate or cost effective or if there are other issues of non-compliance.
- ❖ ILOS must be subject to retrospective evaluation when applicable.

LDH may, at its discretion, conduct a retrospective evaluation of any ILOS to determine its adherence to the above listed requirements.

[LDH will provide an ILOS application form for MCO use. This application is to be used when proposing a new ILOS that is not in the MCO contract. Any MCO wishing to offer an ILOS that is in the MCO contract will notify LDH of their intent to offer the ILOS as well as the effective date.](#)

This section lists all approved ILOS that may be offered by the MCO.

Physical Health Services

MCOs must notify LDH of their intent to offer any of the authorized ILOS within this section and provide their policies for prior approval. Authorized physical health ILOS include the following:

- ❖ Chiropractic services for adults age 21 and older

- ❖ [Doula services](#)
- ❖ Hospital-based care coordination for pregnant and postpartum individuals with substance use disorder and their newborns
- ❖ Outpatient lactation support
- ❖ Remote patient monitoring
- ❖ [Care At Home](#)
- ❖ [Home Delivered Meals](#)

Chiropractic Services for Adults Age 21 and Older

The purpose of this ILOS is to provide coverage of chiropractic care for enrollees age 21 and older. Chiropractic services to diagnose and treat neuromusculoskeletal conditions associated with the functional integrity of the spine are a medically appropriate and cost-effective substitute for services currently covered under the Louisiana Medicaid State Plan.

Provider Qualification

Qualified providers must be enrolled in Medicaid and meet the following requirements:

- ❖ Current, valid, and unrestricted Louisiana chiropractic license

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

Covered Services

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.

Evaluation and Management Services

The initial visit must include a treatment plan, including:

- ❖ Level of care (duration and frequency of visits);
- ❖ Treatment goals; and
- ❖ Measures to assess the effectiveness of treatment (qualitative and/or quantitative).

Follow-up visits must include information on the enrollee's progress in the treatment plan, along with the measures used to assess effectiveness.

The level of evaluation and management service shall be determined by using Current Procedural Terminology (CPT) guidelines.

X-Rays

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.

Spinal Manipulation

Spinal manipulation of up to five regions is covered and considered medically necessary when included in the documented treatment plan.

Other Treatments

Other treatments refer to chiropractic treatments other than spinal manipulation. On each date of service, a maximum of two other treatments are covered and must be tailored to the enrollee's condition and identified in the documented treatment plan.

- ❖ Mechanical traction
- ❖ Whirlpool therapy
- ❖ Ultrasound therapy
- ❖ Electrical stimulation
- ❖ Therapeutic exercises
- ❖ Neuromuscular reeducation
- ❖ Gait training
- ❖ Massage therapy
- ❖ Manual therapy
- ❖ Dry needling

Prior Authorization and Referral

Chiropractic ILOS are covered without the requirement of prior authorization for up to 18 treatment sessions annually. Additional treatment sessions may be reimbursed with authorization by the MCO. 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.

Reimbursement

Reimbursement for chiropractic services is only available to qualifying providers, as determined by the MCO.

Non-Compliance, Recoupment, and Sanctions

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 the MCO.

Procedure Codes

The below table represents the procedure codes covered under this ILOS. The fees listed are calculated according to the methodology that would be employed by Medicaid FFS; however, the MCO has the discretion to execute agreements with providers for a different rate, when mutually agreeable. As specified above, a maximum of two other treatments, in addition to spinal manipulation, may be reimbursed per date of service.

| Service Category | Code | Description | Reference Fee |
|---|---|--|---------------|
| Evaluation and management – new patient | 99202 | Office or other outpatient visit for the evaluation and management of a new patient | \$42.77* |
| | 99203 | | \$62.18* |
| | 99204 | | \$96.56* |
| | 99205 | | \$122.19* |
| Evaluation and management – established patient | 99212 | Office or other outpatient visit for the evaluation and management of an established patient | \$24.83* |
| | 99213 | | \$41.53* |
| | 99214 | | \$62.65* |
| | 99215 | | \$84.93* |
| Spinal X-rays | 72020 | Radiologic examination, spine, single view, specify level | \$15.31* |
| | 72040 | Radiologic examination, spine, cervical; 2 or 3 views | \$23.32* |
| | 72050 | Radiologic examination, spine, cervical; 4 or 5 views | \$33.27* |
| | 72052 | Radiologic examination, spine, cervical; 6 or more views | \$41.69* |
| | 72070 | Radiologic examination, spine, thoracic, 2 views | \$22.60* |
| | 72072 | Radiologic examination, spine, thoracic, 3 views | \$24.99* |
| | 72074 | Radiologic examination, spine, thoracic, minimum of 4 views | \$29.46* |
| | 72080 | Radiologic examination, spine, thoracolumbar, 2 views | \$23.29* |
| | 72100 | Radiologic examination, spine, lumbosacral; 2 or 3 views | \$24.49* |
| | 72110 | Radiologic examination, spine, lumbosacral; minimum of 4 views | \$34.22* |
| | 72114 | Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views. | \$44.25* |
| | 72120 | Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views | \$30.63* |
| 72220 | Radiologic examination, sacrum and coccyx, minimum of 2 views | \$19.65* | |
| Spinal manipulation | 98940 | Spinal Manipulation 1-2 Regions | \$16.87* |
| | 98941 | Spinal Manipulation 3-4 Regions | \$23.40* |
| | 98942 | Spinal Manipulation 5 Regions | \$38.13† |
| Other treatments‡ | 97012 | Mechanical Traction | \$10.76† |
| | 97014 | Electrical Stimulation (unattended) | \$8.86† |
| | 97022 | Whirlpool Therapy | \$12.55† |
| | 97035 | Ultrasound Therapy | \$10.40† |
| | 97032 | Electrical Stimulation (attended) | \$11.01* |
| | 97110 | Therapeutic Exercises | \$19.15* |
| | 97112 | Neuromuscular Reeducation | \$19.59* |
| | 97116 | Gait Training | \$16.72* |
| | 97124 | Massage Therapy | \$15.20* |
| | 97140 | Manual Therapy | \$17.72* |
| 20560 | Needle insertion without injection 1-2 | \$19.10† | |
| 20561 | Needle insertion without injection 3 or more muscles | \$27.39† | |

*From the Medicaid FFS fee schedule, as applicable to adults age 21 and older.

†Reference fee calculated using the methodology that would be employed by Medicaid FFS.

‡A maximum of two (2) other treatments, in addition to spinal manipulation, are covered per day of service.

Note: These fees are provided for reference purposes only, and the MCO may establish different fees in its agreements with providers.

Hospital-Based Care Coordination for Pregnant and Postpartum Individuals with Substance Use Disorder and Their Newborns

The purpose of this ILOS is to provide coverage of a comprehensive pregnancy medical home model of care to enrollees with substance use disorder (SUD) who are 18 years of age and older and pregnant or up to 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 OB care, SUD treatment services). In addition, this ILOS is not duplicative of MCO case management services.

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 obstetrical 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.

Provider Qualifications

Eligible and qualified providers are hospitals that are enrolled in Medicaid and provide outpatient services with the following staffing specifications:

- ❖ At least one licensed mental health professional (LMHP), such as an LCSW or LPC with a current, valid, and unrestricted Louisiana license;
- ❖ Additional staff may include LMHPs, registered nurses, or advanced practice registered nurses with a current, valid, and unrestricted Louisiana license; and
- ❖ A staffing ratio of at least one LMHP or nurse for every 40 enrollees must be maintained.

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

Covered Services

Services covered under the model are divided into three categories:

- ❖ Intake, assessment, and care plan development;
- ❖ Care coordination; and
- ❖ Outreach for disengaged enrollees.

| Description | Services Provided |
|--|---|
| <p>Intake, Assessment, Care Plan Development</p> <p>Time requirement: 2.5 hours total time (face-to-face and non-face-to-face time)</p> | <p>Intake:</p> <ul style="list-style-type: none"> • Pregnancy confirmation; referral to OB if needed • Explanation of services • Obtaining informed consent for treatment • Obtaining detailed medical and social history • Create a mapping tool of contacts <p>Needs assessment through screenings:</p> <ul style="list-style-type: none"> • Initiate assessment of unmet care needs for physical (medical and nutritional), behavioral and psychosocial needs. At a minimum, these assessments are completed: <ul style="list-style-type: none"> ○ 5 P's Screening tool ○ DSM-5 Opioid Use Disorder Screening ○ NIDA Substance Use Screen ○ PHQ9 Depression Screening ○ GAD-7 Generalized Anxiety Disorder Screening ○ SDOH Health Leads Screening <p>Additional screenings may be added, to include:</p> <ul style="list-style-type: none"> ○ Columbia Suicide Severity Rating Scale ○ Perinatal Posttraumatic Stress Disorder Questionnaire ○ PCL-C PTSD Checklist – Civilian version ○ ACE Adverse Childhood Experience Questionnaire ○ MDQ Mood Disorder Questionnaire ○ HITS Intimate Partner Violence Screening <p>Plan of care development:</p> <ul style="list-style-type: none"> • Review assessments to identify care needs and discussing results with patient • Develop treatment plan of patient-centered goals, including referral to medication-assisted treatment (MAT) or SUD treatment • Assessing urgency of identified goals, prioritizing referrals based on needs, including housing referrals • Obtain plan of care developed by MCO case management, if applicable, for incorporation • 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. • Providing warm handoff to referral sources. • Notification to MCO case managers of enrollment <p>All activities shall be documented fully.</p> |
| <p>Care Coordination</p> <p>Time requirement: 10 hours per month of total time (face-to-</p> | <p>PRENATAL</p> <p>General Activities</p> <ul style="list-style-type: none"> • Confirmation of consent • Confirm and update birth plans |

face and non-face-to-face time). Non-face-to-face-time can include, but is not limited to:

- Warm handoffs to other providers and community services
- Contacting and communicating with physical and behavioral health providers
- Following up on outcomes of referrals or visits
- Updating the enrollee's care plan

- Confirm and update contact information
- Assisting with benefit reinstatement, if indicated

Care Coordination

- Coordination of referrals identified from treatment plan, incorporating collaboration with the MCOs as needed to improve effectiveness and prevent duplication
- Review and revision of care plan, as needed
- Visit preparation, navigation, and follow up for key OB services
- Coordination with MCO Case Manager to enhance care and prevent duplication
- Multidisciplinary long-term postpartum follow-up includes referrals for medical, developmental, and social support for mother and infant

Risk Assessment

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

Alcohol/Substance Use Disorder Treatment

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

Health Education and Promotion

- 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
- Provide individualized education on pregnancy, childbirth, parenting, physical well-being, lactation support and information on Neonatal Abstinence Support and related topics

DELIVERY CARE

- In-hospital, rooming in and assessment of neonatal opioid withdrawal syndrome (NOWS), if required staffing and space are available
- Lactation support and follow up education
- Assessing baby safety needs
- Navigating and educating mother for potential NICU admission, as needed
- Assessment of care transition to home

POSTPARTUM CARE

Care Coordination

- Identifying/connecting patient with peer support

| | |
|---|--|
| | <ul style="list-style-type: none"> • Provide referrals for medical, developmental and social support, (WIC, Healthy Start, Early Steps) • Follow meconium drug screening and report to DCFS, if appropriate • Visit preparation and follow up for pediatric visits • Assist with/make referral to pediatrician • Identifying NOWS and neonatal abstinence syndrome (NAS) support by care partners <p><u>Health Education and Promotion</u></p> <ul style="list-style-type: none"> • 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. • 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 <p><u>Risk Assessment</u></p> <ul style="list-style-type: none"> • Reassessment for depression and anxiety screening with on-site treatment or referral as indicated • Provide education and advocacy for DCFS reporting and the justice system • Documentation of activities and progress across all categories of care coordination activities |
| <p>Outreach for Disengaged Enrollees</p> <p>Time requirement: 8 hours per month total time (face-to-face and non-face-to-face time).</p> | <ul style="list-style-type: none"> • Maintaining and reviewing call log for potential disengagement • Medical record review for missed physician or diagnostic appointments • Checking with SUD treatment providers for missed appointments • Contact attempts by preferred contact method at least three times on different days and different times of day • Escalating contact tracking to friends, family, employer, judicial, social services, etc., from contact mapping • Documentation of efforts made for outreach attempts |

Prior Authorization and Referral

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

Reimbursement

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

Non-Compliance, Recoupment, and Sanctions

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 the MCO.

Procedure Codes

The below table represents the procedure codes covered under this ILOS. The fees listed are estimated by Medicaid’s actuarial consultant based on a time study; however, the MCO has the discretion to execute agreements with provider for a different rate, when mutually agreeable.

| Service | Service Code | Maximum Units per Pregnancy and Postpartum Period | Estimated Fee |
|---|--------------|---|-------------------------------------|
| Intake, Assessment, Care Plan Development | H0002 | 1 | \$77.60/unit |
| Care Coordination | H0006 | 20 | \$221.06/unit (1 unit = 1 month) |
| Outreach for Disengaged Enrollees | H0023 | 4 | \$133.63/unit (1 unit = 1 month) |

The primary diagnosis code on the claim should reflect the primary substance use disorder experienced by the enrollee.

Outpatient Lactation Support

The purpose of this ILOS is to provide coverage of outpatient lactation support services for enrollees who are breastfeeding or exclusively pumping. Outpatient lactation support services for breastfeeding care and for the diagnosis and treatment of breastfeeding issues are a medically appropriate and cost-effective substitute for services currently covered under the Louisiana Medicaid State Plan, such as evaluation and treatment provided by an obstetric or pediatric provider in the outpatient hospital or office setting. This ILOS is not duplicative of MCO case management services or Doula ILOS.

Exclusive breastfeeding is recommended for the first six months of an infant’s life with continued breastfeeding after solid foods are introduced for as long as is desired. There are numerous health benefits to breastfeeding, for both the breastfeeding enrollee and their infant, which can reduce overall medical spending. Societal, medical, and workplace challenges that often hinder breastfeeding may be mitigated with lactation support and assessment in the outpatient setting. Interventions to support breastfeeding have been found to increase breastfeeding duration and are recommended by the U.S. Preventive Services Task Force.

Provider Qualification

Qualified lactation support providers must have achieved and maintain certification as a Breastfeeding Counselor or Lactation Consultant, as described by the United States Breastfeeding Committee [\[link\]](#). A Breastfeeding Counselor is qualified to provide breastfeeding counseling, address normal breastfeeding in healthy term infants, and to conduct maternal and infant assessments of anatomy, latch, and positioning, while providing support. A Lactation Consultant is qualified to provide the same services as a Breastfeeding Counselor and is additionally

certified by the International Board of Lactation Consultant Examiners to address the full range of breastfeeding care, particularly involving high acuity breastfeeding situations.

MCOs who enroll lactation support providers are responsible for verifying and maintaining documentation that qualification criteria are met.

Nothing herein shall be construed to require the MCO to execute an agreement with any qualified and willing lactation support provider. The MCO reserves the right to execute agreements with qualified lactation support providers only as needed to successfully provide services, if the MCO elects to offer this ILOS.

Covered Services

As part of this ILOS, outpatient lactation support services for the purpose of providing breastfeeding care and for the diagnosis and treatment of breastfeeding or pumping issues are covered and considered medically necessary for any enrollee who is pregnant, breastfeeding, or expressing breastmilk for the purposes of providing nutrition to an infant.

There is no restriction as to the site of service, which may include, but is not limited to, a healthcare facility, clinic setting, community setting, or the enrollee's home. Delivery of the service through a synchronous audio/video telehealth modality is also permissible. Telehealth services must adhere to the *Telemedicine/Telehealth* section of this Manual.

Prior Authorization and Referral

Lactation support provider ILOS are covered without the requirement of prior authorization for up to six total treatment sessions that occur during pregnancy or while less than 24 months postpartum. Additional treatment sessions may be reimbursed with authorization by the MCO. A treatment session is defined as all lactation support services that occur on a single date of service. A referral from a primary care provider or any other provider is not required.

Reimbursement

Reimbursement for lactation support services is only available to qualifying providers, as verified by the MCO.

A lactation support provider who provides services to more than one enrollee at a time must bill appropriately using the approved code associated with lactation classes. This is limited to eight unique enrollees per session.

Non-Compliance, Recoupment, and Sanctions

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 the MCO.

Approved Procedure Codes

The below table represents the procedure codes covered under this ILOS. The MCO has the discretion to execute agreements with providers for rates based on complexity and provider training.

| Service Category | Procedure Code | Modifier | ICD-10 | Description |
|----------------------------------|----------------|----------|--------|---|
| Lactation Support Provider Visit | S9445 | 33 | Z39 .1 | Patient education, non-physician provider, individual session |
| Lactation Classes | S9443 | | Z39.1 | Lactation classes, non-physician provider; group sessions must be at least 60 minutes |

Provider Enrollment and MCO Registry Specifications

Qualified providers must possess a current certification as an International Board-Certified Lactation Consultant (IBCLC), Advanced Lactation Consultant (ALC), Advanced Nurse Lactation Consultant (ANLC), Certified Lactation Consultant (CLC), Certified Breast Feeding Specialist (CBS), or Certified Lactation Education (CLE) and enroll with a valid NPI and taxonomy code(s) identified in the following chart.

DRAFT

| Provider Type | Provider Type Description | Provider Specialty | Provider Specialty Description | Primary Taxonomy | Primary Taxonomy Description | Secondary Taxonomy | Subspecialty | Entity Type |
|---------------|----------------------------|--------------------|------------------------------------|------------------|---------------------------------------|--------------------|---------------|-------------|
| DL | Doula | BC | Certified Breastfeeding Consultant | 374J00000X | Doula | 174N00000X | CB, CL or CE | 1 |
| LS | Lactation Support Provider | BC | Certified Breastfeeding Consultant | 174N00000X | Breastfeeding Consultant | | CB, CL or CE | 1 |
| LS | Lactation Support Provider | LC | Certified Lactation Consultant | 163WL0100X | Registered Nurse Lactation Consultant | | AN, IB, or AL | 1 |
| LS | Lactation Support Provider | LC | Certified Lactation Consultant | 174N00000X | Lactation Consultant, Non-RN | | IB or AL | 1 |

Subspecialty Designations

| Subspecialty | Subspecialty Description |
|--------------|--|
| CB | Certified Breastfeeding Specialist (CBS) |
| CL | Certified Lactation Counselor (CLC) |
| CE | Certified Lactation Educator (CLE) |
| AN | Advanced Nurse Lactation Consultant (ANLC) |
| IB | International Board Certified Lactation Consultant (IBCLC) |
| AL | Advanced Lactation Consultant (ALC) |

Claims and Encounter Billing Requirements

Doula providers must meet outpatient lactation support policy requirements to receive reimbursement for lactation support visits (S9445, modifier 33).

The rendering provider NPI is required when different from the billing provider.

The taxonomy code is required when adjudication is known to be impacted by the provider taxonomy.

Claims and encounters must be billed on the CMS1500/837P.

Outpatient lactation consultant services provided using telemedicine must be identified on claims and encounters by appending the modifier "95" to the applicable procedure code and indicating place of service (POS) 02 or 10. The MCO shall deny claims that do not have both the correct POS and modifier present on the claim.

Remote Patient Monitoring

Remote patient monitoring (RPM) means digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment, recommendations, and interventions. RPM devices include (1) non-invasive remote monitoring devices that measure or detect common physiological parameters, and (2) non-invasive monitoring devices that wirelessly transmit the beneficiary's medical information to their health care provider or other monitoring entity. The device must be reliable and valid, and the beneficiary must be trained or sufficiently knowledgeable in the proper use/wearing of the device to ensure appropriate recording of medical information. Medical information may include, but is not limited to, blood pressure and heart rate and rhythm monitoring for members with hypertension and blood glucose control for members with diabetes. Members enrolled should have smart phone or tablet access and connectivity for data reporting.

Care at Home

The purpose of this ILOS is to provide ordered treatment, at home, for enrollees with chronic disease who are experiencing an acute exacerbation of their illness. This is not intended as emergency care, but urgent care for enrollees who are physically unable to reach their provider and may otherwise necessitate emergency transport for care. Providers refer their patient for an at home scheduled visit when a virtual care or an in-office visit is not appropriate to address the enrollee's acute chronic health needs. An in-home care provider, either an EMT or paramedic, depending on need, is sent to the member's residence within 24 hours to facilitate treatment and symptom management, reducing unnecessary ED use and hospitalizations. Communication and coordination of care is arranged with the referring Provider.

Home Delivered Meals

Members aged 18 and older with food insecurity who are being discharged from inpatient settings, exhibiting evidence of malnourishment, and/or members with complex medical needs and unable to prepare meals will be identified for inclusion in the program. This includes members with primary behavioral health diagnoses and pregnant women. All members are screened for their desire to participate in the program and ability to receive food delivery. Meals will be medically tailored to members' needs. Food providers will provide delivery to identified members. Nutritional counseling will be available to participating members. Available for eight months with ability to reauthorize.

Behavioral Health Services

MCOs 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:

- ❖ 23-Hour observation bed services for adults age 21 and older
- ❖ Freestanding psychiatric hospitals for adults ages 21-64
- ❖ Injection services provided by licensed nurses to adults age 21 and older
- ❖ Mental Health Intensive Outpatient Programs
- ❖ Population health management programs
- ❖ Therapeutic Day Center for ages 5-20
- ❖ Integrated Behavioral Health Homes
- ❖ Visions of Hope Community Services

23-Hour Observation Bed Services for Adults Age 21 and Older

This ILOS is an inpatient hospital-based intervention designed to allow for the opportunity to hold and assess an enrollee without admitting them.

Freestanding Psychiatric Hospitals for Adults Ages 21-64

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.

Injection Services Provided by Licensed Nurses to Adults Age 21 and Older

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.

Mental Health Intensive Outpatient Programs

Mental Health Intensive Outpatient Programs (MH IOPs) provide enrollees treatment via the least restrictive level of care, allowing an alternative to inpatient hospitalization or Assertive Community Treatment and providing a step-down option from inpatient hospitalization for enrollees at high risk for readmission.

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.

Therapeutic Day Center for Ages 5-20

The Center for Resilience is a therapeutic day center which provides educational and intensive mental health supports in an innovative partnership with the Tulane University Medical School Department of Child and Adolescent Psychiatry to ensure the emotional well-being and academic readiness of children with behavioral health needs. Children receive instructional, medical, and therapeutic services at the day program site with the goal of building the skills necessary to successfully transition back to the traditional school setting. Center for Resilience provides a caring, non-punitive, therapeutic milieu with positive behavioral supports, trauma-informed approaches, evidence-based mental health practices, small-group classroom instruction, and therapeutic recreation activities. The leadership team is comprised of clinicians, educators, and medical doctors, and the therapeutic milieu is a result of this intentionally interdisciplinary collaboration. The goal of this ILOS is to reduce incidents of crisis hospitalization and residential psychiatric care.

Integrated Behavioral Health Homes

Integrated Behavioral Health Homes (IBHH) is a value-based program that furthers alternative payment methodologies and integration by improving medical, behavioral, and social healthcare outcomes for participants while decreasing the overall total cost of care. MCOs who offer this ILOS will contract with qualified providers to deliver the six core services that are central to Medicaid health homes, as outlined by the ACA and endorsed by CMS, Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Council for Mental Wellbeing:

- ❖ Comprehensive care management;
- ❖ Care coordination;
- ❖ Health promotion;
- ❖ Comprehensive transitional care and follow-up;
- ❖ Patient and family support; and
- ❖ Referrals to community and social support services.

The eligible population will be identified by the MCO and assigned to the participating providers within the eligible population's geographical area. This is an opt-in model and does not require enrollees to change or adjust any of their existing provider relationships.

Visions of Hope Community Services

The Visions of Hope Community Services (VOH-CS) program is a comprehensive and intensive service bundling for high-risk, low-functioning individuals with severe and persistent mental illness. This model addresses whole person care that combines behavioral health while addressing social determinants of health and providing physical health coordination and support. The VOH-CS program serves individuals who would have difficulty navigating services across multiple, disconnected providers and thus are at greater risk of hospitalization, homelessness, substance use, victimization and incarceration. This model offers daily socialization opportunities for this population who might not interact socially with their peers in other settings.