Government Business Division
Policies and Procedures

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

Effective Date	Date of Last Review	Date of Last Revision	Dept. Approval Date
~~January 1, 2008~~May 29, 2015[WJL1]	~~April 23, 2019~~February 19, 2021	~~April 23, 2019~~~~August 11, 2020~~February 19, 2021	~~April 23, 2019~~February 19, 2021
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 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 ~~alternative~~ 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 ~~the plan the~~ 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 ~~in the Precertification Lookup Tool (PLUTO)~~ as "investigational." 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

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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~~ it will be~~ approval~~ed~~. 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:

~~1)~~• Covered;
~~2)~~• Excluded; or
~~3)~~• 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 health care services to which an eligible Medicaid recipient is entitled under Louisiana Medicaid State Plan.

~~**Cost-Effective Alternate Services** – Consideration for coverage as an exception to benefit exclusions including devices or services deemed medically necessary, that provide cost-effective alternatives to treatment challenges, environmental disease triggers, or that improve the health or safety of members. Examples include the following:~~

~~1) Rehabilitation centers as a cost-effective alternative to expedite discharge of patients from acute hospitals when appropriate;~~
~~2) Short-term continuous care for acute episodic conditions to stabilize the condition rather than admit to the hospital;~~
~~3) Hotel accommodations for patients receiving outpatient radiation therapy in order to avoid the rigors of daily transportation;~~
~~4) Hotel accommodations for patients receiving outpatient intravenous (IV) antibiotic therapy and whose unsanitary home conditions could compromise treatment; or~~
~~5) Sitters and housekeeping services, in addition to home health, when a member needs and qualifies for home care rather than institutional care.~~[TFB2][MN3][WJL4]

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Excluded Services – Those services which members may obtain under the Louisiana Medicaid State Plan and for which Healthy Blue is not financially responsible.

Experimental Procedure/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 – 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), that are provided to 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 D, 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) not more costly 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 recipient requires at that specific point in time. Services that are experimental, non-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 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 benefits seek to improve quality and health outcomes,

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and/or reduce costs by reducing the need for more expensive care.

PROCEDURE:

Non-Covered Service Authorization Process

~~**Non-Covered Service Authorization Process**~~

1) The provider, member, or an associate may initiate a request [TFB5][WJL6]for non-covered services. Either way, the National Customer Care (NCC) or Healthy Blue HCM associate must obtain ~~(from the provider)~~ 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~~ce~~ 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[TFB7][WJL8].
   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 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~~Cost-Effective Alternative Services~~

1) Healthy Blue may, at its option, cover services or settings for members that are in lieu of 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 service or setting under the State Plan;
   b) The member is not required by Healthy Blue to use the alternative service or setting; and
   c) The approved in lieu of services are authorized and identified in *Attachment D, Rate Certification*.
2) The utilization and actual cost of in lieu of services are taken into account in developing the component of the capitation rates that represents the core benefits and services, unless a statute or regulation explicitly requires otherwise.
3) Healthy Blue may submit additional in lieu of services to LDH for prior approval. The submission shall include a plan for identifying and reporting the utilization of in lieu of services.

HBL offers the following ~~LDH supports utilization of~~ in lieu of behavioral health services ~~provided by Magellan prior to integration of specialized behavioral health services.~~

4) ~~The following in lieu of behavioral health services have been approved by~~ for all Medicaid-eligible adults age twenty-one (21) and above:

   a) Residential Substance Use Treatment Facilities for Adults – ~~– As in the FFS Medicaid system, some residential substance use treatment facilities are considered Institutions for Mental Diseases (IMD) because of the number of beds and the population served. However, without use of these facilities, members will be treated in more costly acute detox settings, and members will remain in hospital emergency departments while awaiting available beds.~~ This service reduces emergency department consumption, increases substance use treatment bed capacity, and provides a less costly alternative to general bed placement;~~.~~

   b) Utilization of Freestanding Psychiatric Hospitals instead of General Hospital Psychiatric Units for Adults – ~~r~~Reduces emergency department consumption and provides a less costly alternative to general bed placement; ~~In FFS Medicaid, this population was treated in more expensive general hospital psychiatric units which created access issues as beds in this setting were limited. Members often remained in emergency departments while waiting for available beds, thereby increasing costs to the healthcare system as members utilized those medical resources while awaiting beds in general hospitals. Use of freestanding psych units reduces emergency department consumption, increases psychiatric bed capacity and provides a less costly alternative to general hospital beds.~~

   c) Twenty-Three (23) Hour Observation Bed Services for Adults;[KF9][WJL10] ~~Currently utilized by MCOs.~~

   ~~Crisis Stabilization Units for Adults – Use of these units is a key component in the crisis continuum and serves those who can be diverted from an emergency department or inpatient hospitalization, or can be "stepped down" from current inpatient hospitalization.~~

   d) ~~Peer Support Services for Adults – This evidenced-based practice builds upon the continuum of care necessary to help each individual realize his or her own recovery and wellness pathways through mentoring, navigating, advocacy, sharing learning and life planning. Services are adjunct and complimentary to clinical services.; and~~Injection Services Provide by Licensed Nurses to Adults~~ –~~ [KF11][WJL12]~~Allowing licensed nurses instead of physicians to perform injectable medication 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~~; and~~.~~[TFB13]

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

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[KF14]Effective July 16, 2019, Healthy Blue received approval from LDH to provide mental health intensive outpatient services in lieu of inpatient behavioral health hospitalization [WJL15][KF16][WJL17]

1) Cost-effective alternative services are services or settings Healthy Blue proposes as cost-effective alternatives to core benefits and services and LDH, in consultation with its actuary, determines to be permissible "in lieu of" services or settings to those included in the State Plan. The utilization and costs of these services are included in the capitation rate.

2) When Healthy Blue chooses to adopt or discontinue a cost-effective alternative service, LDH shall be notified sixty (60) calendar days in advance of the change.

3) Healthy Blue may offer additional benefits that are outside the scope of core benefits and services to individual members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the member and/or member's family, the potential for improved health status of the member, and functional necessity.

4) Members are not entitled to receive these services. Cost-effective alternative services may be provided because they are either:

a) Alternatives to covered services that, in Healthy Blue's judgement, are cost-effective; or

b) Preventative in nature and offered to avoid the development of conditions that, in Healthy Blue's judgement, would require more costly treatment in the future.

5) Cost-effective alternative services are not required to be determined medically necessary except to the extent that they are provided as an alternative to covered services. Even if medically necessary, cost-effective alternative services are not covered services and are provided only at Healthy Blue's discretion. The member is not required to use the cost-effective alternative service.

6) LDH shall maintain a list of pre-approved, cost-effective alternative services that may include, for example, use of nursing facilities as step down alternatives to acute care hospitalization. Services not included on the list shall be approved in writing by LDH.

7) Healthy Blue may identify cost-effective alternative services in encounter data submissions as specified by LDH.

Value-Added Benefits (VAB)and Services

1) As permitted under 42 CFR §438.3(e), Healthy Blue may offer VABs value-added benefits and services to members in addition to the core benefits and services. Healthy Blue shall not portray core benefits or services as VABs.

2) Value-added benefitVABs and services are those optional benefits and services offered by Healthy Blue, including those proposed in Healthy Blue'sthe Request For Proposal (RFP) response that are not:

a) Core benefits and services as defined in the Contract; and

b) Cost-effective alternatives as defined in the Contract.

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3) ~~Value-added benefit~~VABs ~~and services~~ are provided at Healthy Blue's expense, are not included in the capitation rate, and shall be identified as ~~value-added benefit~~VABs ~~or services~~ in encounter data.
4) ~~Value-added benefit~~VABs ~~and services~~ 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.
5) ~~Value-added benefit~~VABs ~~and services~~ shall be specifically defined by Healthy Blue in regard to amount, duration, and scope.
6) Transportation to a~~the~~ VAB~~value-added benefit~~ or service is the responsibility of the member and/or at the discretion of the Healthy Blue.
7) Healthy Blue shall send the member a notification letter if a VAB or service is not approved.
8) ~~Value-added benefit~~VABs ~~and services~~ 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. ~~Healthy Blue shall send the member a notification letter if a value-added benefit or service is not approved.~~
9) Healthy Blue shall provide LDH a description of the ~~value-added benefit~~VABs and services to be offered for approval. Additions, deletions, or modifications to ~~value-added benefit~~VABs or services made during the ~~c~~Contract period shall be submitted to LDH for approval ninety (90) calendar days in advance of the proposed change.
10) The proposed monetary value of these ~~value-added benefit~~VABs and services shall be considered a binding ~~c~~Contract deliverable.
11) For each VAB~~value-added benefit or service~~ proposed, Healthy Blue shall:
    a) Define and describe the benefit or service;
    b) Identify the category or group of members eligible to receive the benefit or service if it is not appropriate for all members;
    c) Note any limitations or restrictions that apply to the benefit or service;
    d) Identify the types of providers responsible for providing the benefit or service, including any limitations on provider capacity if applicable;
    e) Propose how and when providers and members will be notified about the availability of such benefits or services;
    f) Describe how a member may obtain or access the benefit or service; and
    g) Describe how the benefit or service will be identified in administrative data or encounter data.
12) For the ~~thirty-six (36) month~~ term of the ~~initial~~ ~~c~~Contract, Healthy Blue shall:
    - ~~Indicate the per-member, per-month (PMPM) actuarial value of benefits or services assuming enrollment of 200,000 members, accompanied by a statement~~ Provide, within thirty (30) days from the date the Contract is signed, ~~preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information; and~~

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a) ~~Include~~ a statement of commitment to provide the benefits or services for the entire ~~thirty-six (36) month~~ term of the ~~initial c~~Contract.

~~For the twenty-three (23) month term of the contract extension, Healthy Blue shall:~~

b) ~~Include a statement of commitment to provide the benefits or services for the entire twenty-three (23) month term of the contract extension.~~ The value of the commitment for the ~~c~~Contract ~~extension~~ term shall be no less than the aggregated annual value of all the benefits or services on a per member, per month (PMPM) basis ~~included~~ in effect at the ~~statement~~termination of ~~commitment for~~ the previous Contract with LDH resulting from RFP #305PUT-DHHRFP-BH-MCO-2014-MVA~~initial contract term~~; and

c) Healthy Blue may honor each benefit or service commitment made during the ~~initial~~previous ~~c~~Contract ~~term~~ with LDH resulting from RFP #305PUR-DHHRFP-BH-MCO-2014-MVA. For the ~~c~~Contract ~~extension~~ 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.

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

13)

14) 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 ~~defined as those services that~~ members ~~may obtain~~ under the Louisiana State Plan or applicable waivers, ~~and for~~ 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 members on how to access excluded services, providing all required referrals and assisting in the coordination of scheduling such services.

3) ~~These services shall be paid for by the Louisiana Department of Health (LDH) on a fee-for-service basis or other basis.~~ Excluded ~~S~~services include the following:

~~1)~~a) Dental services with the exception of varnish provided in a primary care setting, surgical dental services, and emergency dental services;

~~2)~~b) Intermediate Care Facility for Individuals with ~~Developmental~~ Intellectual[TFB18][WJL19] Disabilities (ICF/~~D~~IID) services;

~~3)~~c) Personal care services (PCS) for those ages twenty-one (21) and older;

~~4)~~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;

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~~5)~~e) Individualized Education Plan (IEP) services 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);
~~6)~~f) Services provided under the Home and Community-Based Services (HCBS) Waiver;
~~7)~~g) Targeted Case Management services; and
~~8)~~h) Services provided through LDH's Early-Steps Program (Individuals with Disabilities Education Act (IDEA), Part C Program Services).

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."
2) The following non-exhaustive list of services are prohibited, limited, or not Medicaid covered services~~, and shall not be provided under the contract~~:
   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) Cosmetic drugs, devices, procedures, or equipment;
   ~~Any services for chronic pain management, including spinal injections to alleviate chronic, intractable pain;~~[TFB20][WJL21]
   ~~1)~~ Elective abortions (those not covered under contractual~~Louisiana Medicaid~~ limitations on abortions) and related services (refer to *Women's Health and Family Planning Services – LA*);
~~2)a) Experimental/investigational drugs, procedures or equipment, unless approved by the Secretary of LDH;~~
   ~~3)~~d) ~~Elective cosmetic surgery, and~~
   e) Assistive reproductive technology and ~~S~~services, including sterilization reversal procedure[TFB22][WJL23]s, for treatment of infertility~~, including sterilization reversal procedures~~;~~.~~
   f) Harvesting of organs when a Louisiana Medicaid enrollee is the donor of an organ to a non-Medicaid enrollee;
   g) Surgical procedures discontinued before completion, regardless of the reason; and
   h) Provider preventable conditions (refer to *Concurrent Review (Telephonic and Onsite) – LA*).
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.

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4) 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.
5) 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 [TFB24]
   d) [WJL25]Louisiana Adverse Actions List Search (LAALS).
6) 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).[TFB26][WJL27][WJL28]

4)

~~**Value-Added Benefits and Services**~~

~~1) As permitted under 42 CFR §438.3(e), Healthy Blue may offer value-added benefits and services to members in addition to the core benefits and services.~~

~~2) Value-added benefits and services are those optional benefits and services offered by Healthy Blue, including those proposed in the Request For Proposal (RFP) response that are not:~~

~~a) Core benefits and services; and~~

~~b) Cost-effective alternatives.~~

~~3) Value-added benefits and services are provided at Healthy Blue's expense, are not included in the capitation rate, and shall be identified as value-added benefits or services in encounter data.~~

~~4) Value-added benefits and services 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.~~

~~5) Value-added benefits and services shall be specifically defined by Healthy Blue in regard to amount, duration, and scope.~~

~~6) Transportation to the value-added benefit or service is the responsibility of the member and/or at the discretion of the Healthy Blue.~~

~~7) Value-added benefits and services 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. Healthy Blue shall send the member a notification letter if a value-added benefit or service is not approved.~~

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~~8) Healthy Blue shall provide LDH a description of the value-added benefits and services to be offered for approval. Additions, deletions, or modifications to value-added benefits or services made during the contract period shall be submitted to LDH for approval ninety (90) calendar days in advance of the proposed change.~~
~~9) The proposed monetary value of these value-added benefits and services shall be considered a binding contract deliverable.~~
~~a) For each value-added benefit or service proposed, Healthy Blue shall:~~
~~i) Define and describe the benefit or service;~~
~~ii) Identify the category or group of members eligible to receive the benefit or service if it is not appropriate for all members;~~
~~iii) Note any limitations or restrictions that apply to the benefit or service;~~
~~iv) Identify the types of providers responsible for providing the benefit or service, including any limitations on provider capacity if applicable;~~
~~v) Propose how and when providers and members will be notified about the availability of such benefits or services;~~
~~vi) Describe how a member may obtain or access the benefit or service; and~~
~~vii) Describe how the benefit or service will be identified in administrative data or encounter data.~~
~~b) For the thirty-six (36) month term of the initial contract, Healthy Blue shall:~~
~~i) Indicate the per-member, per-month (PMPM) actuarial value of benefits or services assuming enrollment of 200,000 members, 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~~
~~ii) Include a statement of commitment to provide the benefits or services for the entire thirty-six (36) month term of the initial contract.~~
~~c) For the twenty-three (23) month term of the contract extension, Healthy Blue shall:~~
~~i) Include a statement of commitment to provide the benefits or services for the entire twenty-three (23) month term of the contract extension. The value of the commitment for the contract extension term shall be no less than the aggregated annual value of all the benefits or services on a PMPM basis included in the statement of commitment for the initial contract term; and~~
~~ii) Healthy Blue may honor each benefit or service commitment made during the initial contract term. For the contract extension term, Healthy Blue shall seek to align its benefits or services commitments with LDH priorities and Healthy Blue's APM Strategic Plan.~~
~~d) LDH will work with its contract actuary to independently review any statements of actuarial value.~~
~~e) 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.~~

Other Considerations

1) ~~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 fee-for-service.~~ Healthy Blue shall cover medically necessary core benefits and services that address:
   a) The prevention, diagnosis and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability;
   b) The ability for a member to achieve age-appropriate growth and development; and
   c) The ability for member to attain, maintain, or regain functional capacity.
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.[TFB29][WJL30]
   a) 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.
   b) A public health quarantine, isolation order, or recommendation also establishes the medical necessity of healthcare services.
5) 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.

~~1)~~

6) 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.
7) ~~2)~~ Healthy Blue may cover, in addition to services covered under the ~~s~~State ~~p~~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.

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3) ~~The MCO shall not portray core benefits or services as a value-added benefit or service.~~
4) ~~Non-Emergency Medical Transportation (NEMT) to non-Medicaid covered services is not a core benefit; it may be considered a cost-effective alternative service if so approved.~~
8) 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.
9) Non-emergency medical or ambulance transportation to non-Medicaid covered services is not a core benefit, but may be considered a value-added benefit~~cost-effective alternative service~~[TFB31][MN32][WJL33][TFB34][WJL35], if so approved by LDH~~ as an in lieu of service~~.
10) Healthy Blue shall not avoid costs for services covered in its Contract by referring enrollees to publicly supported health care resources.
~~5)~~11) In the event LDH determines that Healthy Blue failed to provide one (1) or more 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 service(s), LDH shall authorize the members to obtain the 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. 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 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 covered services.

6) ~~Opioid Treatment Programs (OTP) and coverage of Methadone to treat opiate addiction may be provided as an "in lieu of" service at the discretion of Healthy Blue.~~
7) ~~LDH supports utilization of "in lieu of" behavioral health services provided by Magellan prior to integration of specialized behavioral health services. LDH has approved the following "in lieu of" services and variances in Medicaid published fee schedules requested by Magellan:~~
    a) ~~Residential substance use treatment facilities for Medicaid eligible adults;~~
    b) ~~Utilization of freestanding psychiatric hospitals instead of general hospital psychiatric units for all Medicaid eligible adults;~~
    c) ~~Twenty-three (23) hour observation bed services for all Medicaid eligible adults;~~
    d) ~~Crisis stabilization units for all Medicaid eligible adults;~~
    e) ~~Peer support services for all Medicaid eligible adults; and~~
    f) ~~Injection services provide by licensed nurses to all Medicaid eligible adults.~~

Moral or Religious Objections

1) If Healthy Blue elects [TFB36][WJL37]not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, Healthy

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Blue must furnish information about the core benefits and services that it does not cover, in accordance with §1932(b)(3)(B)(ii) of the Social Security Act and 42 CFR §438.102(b)(1), by notifying:

a) LDH prior to Contract execution, or whenever it adopts the policy during the term of the Contract;
b) Potential enrollees before and during enrollment in Healthy Blue;
c) Enrollees at least thirty (30) days prior to the effective date of the policy with respect to any particular service; and
d) Members through the inclusion of the information in the Member's Manual.

2) If Healthy Blue elects to not provide, reimburse for, or provide coverage of a core benefit or service described in the Contract because of an objection on moral or religious grounds, it shall provide the following information to LDH:
   1) 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.
3) At the discretion of LDH, the monthly capitation payment may be adjusted accordingly.
4) At this time, Healthy Blue does not have any moral or religious objections.

~~**Non-Covered Service Authorization Process**~~

~~1) The provider, member, or an associate may initiate a request for non-covered services. Either way, the National Customer Care (NCC) or Healthy Blue HCM associate must obtain (from the provider) clinical records and supporting documentation to substantiate the need for the service.~~

~~2)~~1) ~~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 notice standards.~~

~~3)~~1) ~~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 single case agreement (SCA) when applicable.~~

~~b)~~a) ~~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.~~

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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.

REFERENCES:

CFR Title 42
Concurrent Review (Telephonic and Onsite) – LA
EPSDT Services – Core Policy
Health Plan Advisory 15-17
Managed Care Organization (MCO) Manual – LA
Louisiana Medicaid Managed Care Organization (MCO) Manual

Louisiana Medicaid Professional Services Manual
Louisiana State Contract
~~Non-Covered and Cost Effective Alternative Services~~
Out-of-Area – Out-of-Network Care – LA
Out of Network Authorization Process
Pre-certification of Requested Services – LA
Value Added Benefit Tracking and Notification – LA
Women's Health and Family Planning Services – LA

RESPONSIBLE DEPARTMENTS:

Primary Department – Health Care Management

Secondary Department – Behavioral Health, Claims, Marketing, National Customer Care Organization
~~Behavioral Health~~

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 • Definition section updated • Reference section updated • BH added as secondary department
08/11/2020	Annual review Edits to the policy, definitions, and procedure sections References updated • Marketing added as a secondary department
02/19/2021	• Annual review • Edits to the policy, definitions, and procedure sections • Exceptions added • References updated • Claims and Marketing added as secondary departments • Included[WJL38] new MCO Manual verbiage for prohibited and non-covered services References updated • Claims added as a secondary deparmentUpdating 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)