

**§3507. Benefits and Services**

A. Core benefits and 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 enrollees under Louisiana Medicaid state plan.

1. Core benefits and services shall be defined as those health care services and benefits required to be provided to Medicaid MCO members enrolled in the MCO as specified under the terms of the contract and department issued guides.

2. Covered services shall be defined as those health care services and benefits to which a Medicaid and LaCHIP eligible individual is entitled to under the Louisiana Medicaid state plan.

B. The MCO:

1. shall ensure that medically necessary services, defined in LAC 50:I.1101, are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are being furnished;

2. may not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member;

3. may place appropriate limits on a service:

a. on the basis of certain criteria, such as medical necessity; or

b. for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose;

4. shall provide core benefits and services as outlined and defined in the contract and shall provide medically necessary and appropriate care to Medicaid MCO Program members;

5. shall provide all of the core benefits and services consistent with, and in accordance with, the standards as defined in the Title XIX Louisiana Medicaid state plan:

a. the MCO may exceed the limits as specified in the minimum service requirements outlined in the contract;

b. no medical service limitation can be more restrictive than those that currently exist under the Title XIX Louisiana Medicaid State Plan;

6. 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/interconception care services for pregnant women in accordance with federal regulations; and

7. shall establish a pharmaceutical and therapeutics (P and T) committee or similar committee for the development of its formulary and the PDL.

C. If the MCO elects not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, the MCO must furnish information about the services it does not cover in accordance with §1932(b)(3)(B)(ii) of the Social Security Act and federal regulations by notifying:

1. the department in its response to the department's request for proposals (RFP) or whenever it adopts the policy during the term of the contract;

2. the potential enrollees before and during enrollment in the MCO;

3. enrollees within 90 days after adopting the policy with respect to any particular service; and

4. members through the inclusion of the information in the member handbook.

D. The following is a summary listing of the core benefits and services that an MCO is required to provide:

1. inpatient hospital services;
2. outpatient hospital services;
3. ancillary medical services;
4. organ transplant-related services;
5. family planning services as specified in 42 CFR §431.51(b)(2) (not applicable to an MCO operating under a moral and religious objection as specified in the contract);
6. EPSDT/well child visits, excluding applied behavior analysis (ABA) therapy services and dental services;
7. emergency medical services;

8. communicable disease services;
9. durable medical equipment and certain supplies;
10. prosthetics and orthotics;
11. emergency and non-emergency medical transportation;
12. home health services;
13. basic and specialized behavioral health services, excluding Coordinated System of Care services;
14. school-based health clinic services provided by the Office of Public Health certified school-based health clinics;
15. physician services;
16. maternity services;
17. chiropractic services;
18. rehabilitation therapy services (physical, occupational, and speech therapies);
19. pharmacy services (outpatient prescription medicines dispensed, with the exception of those who are enrolled in Bayou Health for behavioral health services only, or the contractual responsibility of another Medicaid managed care entity):
  - a. specialized behavioral health only members will receive pharmacy services through legacy Medicaid;
20. hospice services;
21. personal care services (age 0-20);
22. pediatric day healthcare services;
23. audiology services;
24. ambulatory surgical services;
25. laboratory and radiology services;
26. emergency and surgical dental services;
27. clinic services;
28. pregnancy-related services;
29. pediatric and family nurse practitioner services;
30. licensed mental health professional services, including advanced practice registered nurse (APRN) services;
31. federally qualified health center (FQHC)/rural health clinic (RHC) services;
32. early stage renal disease (ESRD) services;
33. optometry services;
34. podiatry services;
35. rehabilitative services, including crisis stabilization;
36. respiratory services; and
37. other services as required which incorporate the benefits and services covered under the Medicaid State Plan,

including the essential health benefits provided in 42 CFR 440.347.

NOTE: This overview is not all inclusive. The contract, policy transmittals, state plan amendments, regulations, provider bulletins, provider manuals, published fee schedules, and guides issued by the department are the final authority regarding services.

#### E. Transition Provisions

1. In the event a member transitions from an MCO included status to an MCO excluded status or MCO specialized behavioral health only status before being discharged from a hospital and/or rehabilitation facility, the cost of the entire admission will be the responsibility of the MCO. This is only one example and does not represent all situations in which the MCO is responsible for cost of services during a transition.

2. In the event a member is transitioning from one MCO to another and is hospitalized at 12:01 a.m. on the effective date of the transfer, the relinquishing MCO shall be responsible for both the inpatient hospital charges and the charges for professional services provided through the date of discharge. Services other than inpatient hospital will be the financial responsibility of the receiving MCO.

F. The core benefits and services provided to the members shall include, but are not limited to, those services specified in the contract.

1. Policy transmittals, State Plan amendments, regulations, provider bulletins, provider manuals, and fee schedules, issued by the department are the final authority regarding services.

#### G. Excluded Services

1. The following services will continue to be reimbursed by the Medicaid Program on a fee-for-service basis, with the exception of dental services which will be reimbursed through a dental benefits prepaid ambulatory health plan under the authority of a 1915(b) waiver. The MCO shall provide any appropriate referral that is medically necessary. The department shall have the right to incorporate these services at a later date if the member capitation rates have been adjusted to incorporate the cost of such service. Excluded services include:

- a. services provided through the Early-Steps Program (IDEA Part C Program services);
- b. intermediate care facility services for persons with intellectual disabilities;
- c. personal care services (age 21 and over);
- d. nursing facility services;
- e. individualized education plan services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures;
- f. ABA therapy services;
- g. targeted case management services; and

h. all OAAS/OCDD home and community-based §1915(c) waiver services.

#### H. Utilization Management

1. The MCO shall develop and maintain policies and procedures with defined structures and processes for a utilization management (UM) program that incorporates utilization review. The program shall include service authorization and medical necessity review and comply with the requirements set forth in this Section, the contract and department issued guides.

a. The MCO shall submit UM policies and procedures to the department for written approval annually and subsequent to any revisions.

2. The UM Program policies and procedures shall, at a minimum, include the following requirements:

a. the individual(s) who is responsible for determining medical necessity, appropriateness of care, level of care needed, and denying a service authorization request or authorizing a service in amount, duration or scope that is less than requested, must meet the following requirements. The individual shall:

i. be a licensed clinical professional with appropriate clinical expertise in the treatment of a member's condition or disease;

ii. have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions that have been taken or are pending such action by any hospital, governmental agency or unit, or regulatory body, that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character; and

iii. attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise;

b. the methodology utilized to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services;

c. the data sources and clinical review criteria used in decision making;

d. the appropriateness of clinical review shall be fully documented;

e. the process for conducting informal reconsiderations for adverse determinations;

f. mechanisms to ensure consistent application of review criteria and compatible decisions;

g. data collection processes and analytical methods used in assessing utilization of healthcare services; and

h. provisions for assuring confidentiality of clinical and proprietary information.

3. The UM Program's medical management and medical necessity review criteria and practice guidelines shall be reviewed annually and updated periodically as

appropriate. The MCO shall use the medical necessity definition as set forth in LAC 50:I.1101 for medical necessity determinations.

a. Medical management and medical necessity review criteria and practice guidelines shall:

i. be objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

ii. consider the needs of the members;

iii. be adopted in consultation with contracting health care professionals; and

iv. be disseminated to all affected providers, members, and potential members upon request.

b. The MCO must identify the source of the medical management criteria used for the review of medical necessity and for service authorization requests.

i. The vendor must be identified if the criteria are purchased.

ii. The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society.

iii. The guideline source must be identified if the criteria are based on national best practice guidelines.

iv. The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.

4. The MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

5. The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1585 (June 2011), amended LR 39:92 (January 2013), repromulgated LR 39:318 (February 2013), LR 41:936 (May 2015), LR 41:2367 (November 2015), LR 42:755 (May 2016).