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PURPOSE

This Amendment is written to meet regulatory and legislative requirements under Louisiana law/regulation that impact AMA 7100.05 Prior Authorization policy. This amendment will be used in conjunction with AMA 7100.05 to comply with Louisiana requirements.

SCOPE

Applies to Department:	☐ Care Management	☐ Precertification (including NME, SCPU, Specialty Medical Precent)	☐ NME Case Management	☐ Aetna Maternity Program
	☐ SCPU Case Management	☐ 24-Hour Nurse Line	☐ DM	☐ BH
	☐ Medical Management – Concurrent Review	■ Medical Management – Prior Authorization	☐ Medical Management – Utilization Management	☐ Medical Management

Product:	☐ HMO	☐ EPO	☐ PPO	☐ MC/POS	☐ TC	☐ JV
	■ Medicaid					

These requirements apply when the Controlling State is Louisiana.

POLICY

Legislation	Policy/Procedure Language Change:

2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract, Sections:	
2.2.7.1 **The Contractor shall comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations. The Contractor shall comply with all requirements set forth in 42 CFR Part 438, Subpart K, for all Enrollees.**	**The health plan will comply with the Paul Welstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations. The health plan will comply with all state and federal requirements.**
2.2.7.2 The Contractor shall develop and maintain internal controls to ensure mental health parity. The Contractor's utilization practices such as Prior Authorization, standards for medical necessity determination, and network policy, procedures, and practices shall comply With the federal regulations referenced above.	The health plan will develop and maintain internal controls to ensure mental health parity. The health plan's utilization practices such as Prior Authorization, standards for medical necessity determination, and network policy, procedures, and practices will comply. with the federal regulations referenced above.
2.4.1.4.2.2 The services support members with ongoing or chronic conditions in a manner that reflects the member's ongoing need for such services and supports; or	The services support members with ongoing or chronic conditions in a manner that reflects the member's ongoing need for such services and supports; or
2.4.1.4.2.3 provided family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used.	provided family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used.
2.4.1.5 The Contractor shall provide MCO Covered Services in accordance with LDH's definition of medically necessary services (see *Glossary*), including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and the MCO Manual. [42 C.F.R. §438.210(a)(5)(i)]	

2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract, Section: **2.4.1.5** The Contractor shall provide MCO Covered Services in accordance with LDH's definition of medically necessary services (see *Glossary*), including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and the MCO Manual. [42 C.F.R. §438.210(a)(5)(i)] **2.4.1.5.1** A public health quarantine or isolation order or recommendation also establishes medical necessity of healthcare services.	The health plan will provide MCO Covered Services in accordance with the State's definition of medically necessary services (see *Glossary*), including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and the MCO Manual. A public health quarantine or isolation order or recommendation also establishes medical necessity of healthcare services.

Exceptions to Service Authorizations

Legislation	Policy/Procedure Language Change:
2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract, Sections: **2.18.9.1.7**	

Prior Authorization – The system shall determine whether a Managed Care Organization (MCO) Covered Service required Prior Authorization and if so, whether the Contractor granted such authorization; **2.12.8.7** The contractor shall not require Service authorization for: **2.12.8.7.2** Non-emergency inpatient hospital admissions for normal newborn deliveries; and **2.12.8.7.3** EPSDT screening services. **2.12.7.1.1** The contractor shall not require Service Authorization for the continuation of medically necessary MCO Covered Services of a new Enrollee transitioning into the Contractor, regardless of whether such services are provided by an in-network or out-of-Network Provider, however, the Contractor may require prior authorization of services beyond thirty (30) Calendar days.	Prior Authorization – The system will determine whether a health plan Covered Service required Prior Authorization and if so, whether the Contractor granted such authorization; The health plan will not require Service authorizations for: • Non-emergency inpatient admissions for normal newborn deliveries • Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening services The health plan will not require Service Authorization for the continuation of medically necessary MCO Covered Services of a new member transitioning into the health plan, regardless of whether such services are provided by an in-network or out-of-Network Provider, however, the health plan may require prior authorization of services beyond thirty (30) Calendar days.
2023 Louisiana Medicaid Managed Care Organization Model Contract Section: **6.1.5** The contractor shall comply with all settlement agreements, orders and/or judgements rendered by a court of competent jurisdiction, including, but not limited to, those that arise from A.J. v. LDH (Case 3:19-CV-00324), Chisholm v. Phillips (Case 2:97-cv-03274), and United States v. State of Louisiana (DOJ Agreement, Case-3:18-cv-00608), and subsequent implementation plans in accordance with the Contract, the MCO Manual, and as directed by LDH. LDH reserves the right to assess Monetary Penalties for failure to meet this requirement.	The health plan will comply with all settlement agreements, orders and/or judgements rendered by a court of competent jurisdiction, including, but not limited to, those that arise from A.J. v. LDH, Chisholm v. Phillips, and United States v. State of Louisiana (DOJ Agreement, and subsequent implementation plans in accordance with the Contract, the MCO Manual, and as directed by the State. The State reserves the right to assess Monetary Penalties for failure to meet this requirement.

2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract, Sections: **2.2.5.3** The Contractor shall follow all LDH directives regarding access to care and relaxation of authorization requirements during an emergency. Corresponding system edits for all services shall be implementable at the parish level during an emergency. **2.2.5.3.1** The Contractor must have a method for ensuring that Prior Authorizations are extended and transferred to new providers during a pandemic, natural disaster, man-made emergency, or other event if directed by LDH.	The health plan will follow all State directives regarding access to care and relaxation of authorization requirements during an emergency. Corresponding system edits for all services will be implementable at the parish level during an emergency. The health plan will make sure that Prior Authorizations are extended and transferred to new providers during a pandemic, natural disaster, man-made emergency, or other event if directed by the State.
2023 Louisiana Medicaid Managed Care Organization Model Contract, Sections: **2.12.1.2** The Contractor shall submit written policies and procedures to LDH or its designee for approval as part of Readiness Review and prior to any substantive changes. Policies and procedures shall include, but not be limited to: **2.12.1.2.1** The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services; **2.12.1.2.2** Provisions for ensuring confidentiality of clinical information; **2.12.1.2.4** Policies and procedures to maintain, or require providers and contractors to maintain, an individual health record for each Enrollee, in accordance with the MCO Manual. The Contractor shall collect and provide health records to LDH upon request. **2.12.1.2.5**	The health plan will submit written policies and procedures to the State or its designee for approval as part of Readiness Review and prior to any substantive changes. Policies and procedures will include, but not be limited to: The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services; Provisions for ensuring confidentiality of clinical information; Policies and procedures to maintain, or require providers and contractors to maintain, an individual health record for each member, in accordance with the MCO Manual. The health plan will collect and provide health records to the State upon request.

Where applicable, the requirement that each Enrollee's record includes information needed to perform utilization reviews. This information must include, at least, the following: **2.12.1.2.5.4** The Plan of Care (POC) required under 42 C.F.R. §456.80 and §456.180; **2.12.1.2.5.6** Date of operating room reservation, if applicable; and **2.12.1.2.5.7** Justification of emergency admission, if applicable.	Where applicable, the requirement that each Member's record includes information needed to perform utilization reviews. This information must include, at least, the following: The POC required; Date of operating room reservation, if applicable; and Justification of emergency admission, if applicable.
2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract, Section: **2.16.1.3.2** Up to date evidence-based practice guidelines consisting of explicit criteria developed by professional societies or, where evidence-based practice guidelines do not exist, consensus of professionals in the field; **2.12.2.1** The UM program shall include a UM Committee that integrates with other functional units of the Contractor as appropriate and supports the quality assessment and performance improvement program (QAPI) Program as defined in the *Quality Management and Quality Improvement* section.	The health plan will use up to date evidence-based practice guidelines consisting of explicit criteria developed by professional societies or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;. The UM program will include a UM Committee that integrates with other functional units of the health plan as appropriate and supports the quality assessment and performance improvement program (QAPI) Program as defined in the Quality Management and Quality Improvement section.
2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract, Sections:	

2.12.5.5 The contractor shall provide staff specifically assigned to: **2.12.5.5.1** Special Behavioral Health Services (SBHS); and **2.12.5.5.2** Permanent Supportive Housing (PSH) to ensure appropriate authorization of tenancy services.	The health plan will provide staff specifically assigned to: Special Behavioral Health Services (SBHS); and Permanent Supportive Housing (PSH) to ensure appropriate authorization of tenancy services.

Requirements for Initiating a Request for Authorization

Legislation	Policy/Procedure Language Change:
Louisiana Department of Health Informational Bulletin 22-38, entire document Beginning 7/1/23, authorizations for services will not be given if provider is not enrolled in Medicaid according to the Provider Portal Enrollment Lookup Tool. For ABHLA Medicaid to accept an authorization request for services or medical supplies resulting from a practitioner's order, prescription or referral, the Ordering, Prescribing or Referring Provider (OPR) must be enrolled. The Ordering, Prescribing or Referring Providers (OPR), those physicians, other practitioners and facilities who render services to Medicaid beneficiaries based on the order, prescription, or referral, will not be authorized services for such items or services, beginning July 1, 2023, unless you enroll in Medicaid prior to that date. Providers with multiple provider types must complete enrollment for each type. Providers who have not completed enrollment by June 30, 2023, will have their patients assigned to another primary care physician and will be terminated from the program.	Beginning 7/1/23, authorizations for services will not be given if provider is not enrolled in Medicaid according to the Provider Portal Enrollment Lookup Tool. For ABHLA Medicaid to accept an authorization request for services or medical supplies resulting from a practitioner's order, prescription or referral, the Ordering, Prescribing or Referring Provider(OPR) must be enrolled. The Ordering, Prescribing or Referring Providers (OPR), those physicians, other practitioners and facilities who render services to Medicaid beneficiaries based on the order, prescription, or referral, will not be authorized services for such items or services, beginning July 1, 2023, unless you enroll in Medicaid prior to that date. Providers with multiple provider types must complete enrollment for each type. Providers who have not completed enrollment by June 30, 2023, will have their patients assigned to

	another primary care physician and will be terminated from the program. The health plan will check provider status upon receipt of the authorization request. If the provider is not listed on the Medicaid provider site as registered with the state, the request will be administratively denied, and notification will be sent to the provider.

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Legislation	Policy/Procedure Language Change:
2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract Sections: **2.12.3.6** The Contractor shall maintain written procedures including, but not limited to, the following: **2.12.3.6.1** A process for submission and processing of requests for initial and continuing authorizations of services; **2.12.3.6.1.1** The Contractor is responsible for eliciting pertinent health record information from the treating health care provider(s), as needed and/or as requested by LDH, for purposes of making Service Authorization determinations.	The health plan will maintain written procedures including, but not limited to, the following: A process for submission and processing of requests for initial and continuing authorizations of services; The health plan is responsible for eliciting pertinent health record information from the treating health care provider(s), as needed and/or as requested by the State, for purposes of making Service Authorization determinations.
2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract Section: **2.12.3.6.1.2** The Contractor shall take appropriate action when a treating health care provider does not provide complete medical history information within the requested timeframe.	The health plan will take appropriate action when a treating health care provider does not provide complete medical history information within the requested timeframe.

2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract Section: **2.12.3.4** The Contractor shall not be required to pay for a particular item or service when the provider does not provide requested medical information for purposes of making a Service Authorization determination, for that particular item or service.	The health plan will not be required to pay for a particular item or service when the provider does not provide requested medical information for purposes of making a Service Authorization determination, for that particular item or service.

Medical Necessity Criteria (Physical and Behavioral Health)

Legislation	Policy/Procedure Language Change:
2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract Sections: **2.4.1.6** The Contractor shall cover medically necessary services that address: **2.4.1.6.1** The prevention, diagnosis and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability; **2.4.1.6.2** The ability for an Enrollee to achieve age-appropriate growth and development; and **2.4.1.6.3** The ability for an Enrollee to attain, maintain, or regain functional capacity.	The health plan will cover medically necessary services that address: • The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability; • The ability for a member to achieve age-appropriate growth and development; and • The ability for a member to attain, maintain, or regain functional capacity.
Louisiana Medicaid Managed Care Organization Model Contract Section: **2.2.7.1.2** All financial requirements or treatment limitations, including nonquantitative treatment limitations (NQTL), to mental	All financial requirements or treatment limitations, including nonquantitative treatment limitations (NQTL), to mental

health or substance use disorder benefits shall not be more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits, in accordance with 42 C.F.R. §438.910. Financial requirements cannot accumulate separately for medical/surgical benefits and mental health/SUD benefits.	health or substance use disorder benefits will not be more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits, financial requirements cannot accumulate separately for medical/surgical benefits and mental health/SUD (Substance Use Disorder) benefits.
2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract Sections: **2.12.8.1** The Medicaid Executive Director, in consultation with the Medicaid Medical Director, may require the Contractor to authorize services on a case-by-case basis. **2.12.8.2** The Contractor shall not deny continuation of higher-level services (e.g., inpatient hospital or PRTF) for failure to meet medical necessity unless the Contractor can provide the service through an in-network or out-of-Network Provider at a lower level of care. **2.12.8.4** The Contractor shall perform Prior Authorization and concurrent utilization review for admissions to inpatient general hospitals and concurrent utilization review for psychiatric admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals. **2023 Louisiana Medicaid Managed Care Organization Model Contract Sections:** **2.12.11.1.1** When a referring party requests PRTF for an Enrollee, the Contractor shall perform an initial screen upon receipt of referral	 The Medicaid Executive Director, in consultation with the Medicaid Medical Director, may require the health plan to authorize services on a case-by-case basis. The health plan will not deny continuation of higher-level services (e.g., inpatient hospital or residential services Psychiatric Residential Treatment Facility (PRTF) for failure to meet medical necessity unless the health plan can provide the service through an in-network or out-of-network provider for a lower level of care. The health plan will perform Prior Authorization and concurrent utilization review for admissions to inpatient general hospitals and concurrent utilization review for psychiatric admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals. When a referring party requests Psychiatric Residential Treatment Facility (PRTF) for member, the health plan will perform an

including review of records and current clinical information to determine whether PRTF is an appropriate level of care, or if alternate community-based services could meet the referral needs. The screen shall be completed within twenty-four (24) hours of the Contractor's receipt of the referral and all clinical information needed and requested by the Contractor to make the determination.	initial screen upon receipt of referral including review of records and current clinical information to determine whether PRTF is an appropriate level of care, or if alternate community-based services could meet the referral needs. The screen will be completed within twenty-four (24) hours of the health plan's receipt of the referral and all clinical information needed and requested by the health plan to make the determination.
2.12.11.1.2 Upon completion of the screen, if the PRTF is approved, the Contractor shall immediately notify the Enrollee and/or guardian and, with consent, the referring party requesting PRTF services and, within forty-eight (48) hours, provide written notification of the approval. The Contractor shall also then generate a Prior Authorization for each PRTF admission within forty-eight (48) hours of completion of the screen. In consultation with the Enrollee's guardian and referring party, the Contractor shall locate a PRTF provider appropriate to meet the Enrollee's needs with availability to admit the Enrollee. Given the need to locate an appropriate PRTF provider with bed availability in a Timely manner, the Contractor shall maintain near real time bed utilization/availability for network PRTFs and out-of-network replacements. When the initial screen results in a determination that the Enrollee is in need of PRTF care, the Contractor shall secure admission to an appropriate PRTF for the Enrollee within the timeframe stated in Attachment F, Provider Network Standards, in compliance with access and availability standards for this level of care.	Upon completion of the screen, if the Psychiatric Residential Treatment Facility (PRTF) is approved, the health plan will immediately notify the member and/or guardian and, with consent, the referring party requesting PRTF services and, within forty-eight (48) hours, provide written notification of the approval. The health plan will also then generate a Prior Authorization for each PRTF admission within forty-eight (48) hours of completion of the screen. In consultation with the Enrollee's guardian and referring party, the health plan will locate a PRTF provider appropriate to meet the Enrollee's needs with availability to admit the Enrollee. Given the need to locate an appropriate PRTF provider with bed availability in a Timely manner, the Health plan will maintain near real time bed utilization/availability for network PRTFs and out-of-network replacements. When the initial screen results in a determination that the Enrollee is in need of PRTF care, the health plan will secure admission to an appropriate PRTF for the Enrollee within the timeframe stated in Attachment F, Provider Network Standards, in compliance with access and availability standards for this level of care**.**
2.12.11.1.3 If PRTF placement is denied, the Contractor shall immediately notify the Enrollee and/or guardian and, with consent, the referring party	If Psychiatric Residential Treatment Facility (PRTF) placement is denied, the health plan will immediately notify the Enrollee member

requesting PRTF services and, within forty-eight (48) hours, provide written notification of the denial. The notification of denial shall include information on alternative services that may meet the Enrollee's needs to ensure health and safety, including information on available providers of those services, the right of the Enrollee to Appeal the denial, and the process to do so.	and/or guardian and, with consent, the referring party requesting PRTF services and, within forty-eight (48) hours, provide written notification of the denial. The notification of denial will include information on alternative services that may meet the Enrollee's member's needs to ensure health and safety, including information on available providers of those services, the right of the Enrollee member to Appeal the denial, and the process to do so.
2.12.11.1.4 For youth pending release from a secure setting for whom a PRTF is being requested, the Contractor is required to complete the screen prior to the youth's release if it is anticipated that the youth will be re-linked to the Contractor following release.	For youth pending release from a secure setting for whom a PRTF is being requested, the health plan is required to complete the screen prior to the youth's release if it is anticipated that the youth will be re-linked to the health plan following release.
2.12.11.2.2 The Contractor shall ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to-face interview with the child/youth, in addition to the recommendations of the team specified at 42 C.F.R. §441.156.	The health plan will ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This will include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to-face interview with the child/youth, in addition to the recommendations of the team.
2.12.11.2.3 The Contractor may use an LMHP/team composed of Contractor staff or subcontracted LMHPs. To ensure the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the Contractor shall ensure that the team is assembled by a subcontract in the child's/youth's parish of residence or adjacent parish (if not in state custody) or the child's/youth's parish or adjacent parish of responsibility (if in state custody).	The health plan may use an LMHP/team composed of health plan staff or subcontracted LMHPs. To ensure the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the health plan will ensure that the team is assembled by a subcontract in the child's/youth's parish of residence or adjacent parish (if not in state custody) or the child's/youth's parish or adjacent parish of responsibility (if in state custody).

2.12.11.2.4 For youth pending release from a secure setting for whom a PRTF is being requested, the Contractor is required to coordinate the completion of the CON prior to the youth's release if it is anticipated that the youth shall be re-linked to the Contractor following release**.**	For youth pending release from a secure setting for whom a PRTF is being requested, the health plan is required to coordinate the completion of the certificate of need (CON) prior to the youth's release if it is anticipated that the youth will be re-linked to the health plan following release.
2.12.11.2.5 Recertification of the stay shall occur every sixty (60) Calendar Days. For the PRTF screens to be complete, the team shall meet and rule out other community-based options. This does not apply to other inpatient screens.	Recertification of the stay will occur every sixty (60) Calendar Days. For the PRTF screens to be complete, the team will meet and rule out other community-based options. This does not apply to other inpatient screens.
2.12.11.3 In addition to the pre-screen and certifying the need, the Contractor shall:	In addition to the pre-screen and certifying the need, the health plan will:
2.12.11.3.1 Be responsible for tracking the Enrollee's authorization period for PRTF stays and providing notification to the Authorized Representative when a recertification is due.	Be responsible for tracking the member's authorization period for PRTF stays and providing notification to the Authorized Representative when a recertification is due;
2.12.11.3.2 Ensure that PRTF certification, including the independent certification, are forwarded to the admitting facility;	Ensure that PRTF certification, including the independent certification, are forwarded to the admitting facility;
2.12.11.3.3 Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions; and	Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions; and
2.12.11.3.4 Work with the FI to determine retroactive eligibility and assignment, when applicable.	Work with the Fiscal Intermediary (FI) to determine retroactive eligibility and assignment, when applicable.

2023 Louisiana Medicaid Managed Care Organization Model Contract Section: 2.9.25.25 The contractor shall report the number of out-of-state placements as specified by LDH. LDH may require the Contractor to take corrective action or employ other remedies for non-compliance as authorized in the Contract Non-Compliance section in the event LDH determines the Contractor's rate of out-of-state placements to be excessive.	The health plan will report the number of out-of-state placements as specified by the State. The State may require the health plan to take corrective action or employ other remedies for non-compliance as authorized in the Contract Non-Compliance section in the event the State determines the health plan's rate of out-of-state placements to be excessive.

Post Service (Retrospective) Review

Legislation	Policy/Procedure Language Change:
2023 Louisiana Medicaid Managed Care Organization Model Contract Section: 2.12.6.3.2 The contractor shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous Service Authorization approval, unless the approval was based upon a material omission or misrepresentation about the Enrollee's health condition made by the provider	The health plan will not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous Service Authorization approval unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.
2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract Section: 2.12.3.1 The Contractor shall have clearly delineated Service Authorization procedures for Prior Authorization, concurrent authorization, and post authorization that comply with 42 C.F.R. §438.210 and any court-ordered requirements of LDH. For pharmacy Service Authorizations, see the MCO Manual.	The health plan will have clearly delineated Service Authorization procedures for Prior Authorization, concurrent authorization, and post authorization and any court-ordered requirements of the State.

PROCEDURE
N/A

DEFINITIONS

Legislation	Policy/Procedure Language Change:
2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract Section **2.12.4.2** The Contractor shall use LDH's definition of medically necessary services. **Medically Necessary Services* –** Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the Beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the Beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Louisiana Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."	The health plan uses the State's definition of medically necessary services. **Medically Necessary Services*** – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the Beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the Beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it does not mean the service will be covered under the Louisiana Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

Behavioral Health Services Provider Manual, Issued 08/17/2022, Chapter 2 Behavioral Health Services, Sect. 2.0, pg. 2 Specialized behavioral health services (SBHS) are mental health services and substance use/addiction disorder services, specifically defined in the Medicaid State Plan and/or applicable waivers. All mental health services must be medically necessary in accordance with LAC 50:I.1101. **2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract, Glossary page 26** **Specialized Behavioral Health Services (SBHS) –** Mental health services and substance use services that are provided outside of primary care, unless furnished in an integrated care setting, and include, but are not limited to, services provided by a psychiatrist, LMHP, and/or mental health rehabilitation provider.	Specialized behavioral health services (SBHS) are mental health services and substance use/addiction disorder services, specifically defined in the Medicaid State Plan and/or applicable waivers. All mental health services must be medically necessary in accordance with LAC 50:I.1101. **Specialized Behavioral Health Services (SBHS) – Specialized** Mental health services and substance use services that are provided outside of primary care, unless furnished in an integrated care setting, and include, but are not limited to, services provided by a psychiatrist, LMHP, and/or mental health rehabilitation provider.
2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract, Section: Definitions, p. 21 **Permanent Supportive Housing (PSH) Program –** A cross-disability program that provides rental subsidies for affordable housing units statewide to low-income Enrollees with substantial, long-term disabilities. PSH services are reimbursed under several Home and Community Based Services (HCBS) programs, and under Specialized Behavioral Health Services where it is billed as a component of Community Psychiatric Supportive Treatment (CPST) and Psychosocial Rehab (PSR). To be eligible for PSH, Enrollees must meet PSH Program eligibility criteria and medical necessity	**Permanent Supportive Housing (PSH) Program –** A cross-disability program that provides rental subsidies for affordable housing units statewide to low-income members with substantial, long-term disabilities. PSH services are reimbursed under several HCBS programs, and under Specialized Behavioral Health Services where it is billed as a component of CPST and PSR. To be eligible for PSH, members must meet PSH Program eligibility criteria and medical necessity criteria for services. Overall management of the PSH Program is centralized within the State and final approval

criteria for services. Overall management of the PSH Program is centralized within Louisiana Department of Health (LDH) and final approval for Enrollees to participate in the PSH is made by the LDH PSH Program staff.	for members to participate in the PSH is made by the State PSH Program staff
2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract, Section: **6.1.5** The contractor shall comply with all settlement agreements, orders, and/or judgements rendered by a court of competent jurisdiction, including, but not limited to, those that arise from A.J. v. LDH (Case 3:19CV-0324), Chisholm v. Phillips (Case 2:97-cv-03274, and United States v. State of Louisiana (DOJ Agreement, Case-3:18-cv-00608), and subsequent implementation plans in accordance with the Contract, the MCO Manual and as directed by LDH. LDH reserves the right to assess Monetary Penalties for failure to meet this requirement.	The health plan will comply with all settlement agreements, orders, and/or judgements rendered by a court of competent jurisdiction, including, but not limited to, those that arise from A.J. v. LDH (Case 3:19CV-0324), Chisholm v. Phillips (Case 2:97-cv-03274, and United States v. State of Louisiana (DOJ Agreement, Case-3:18-cv-00608), and subsequent implementation plans in accordance with the Contract, the MCO Manual and as directed by LDH. LDH reserves the right to assess Monetary Penalties for failure to meet this requirement. **Chisholm** directives can also be found in the MCO manual.
Louisiana Medicaid Managed Care Organization (MCO) Manual 3.0 page 30 Class members in Chisholm v. LDH (Case 2:97-cv-03274) are defined as follows: All current and future beneficiaries of Medicaid in the state of Louisiana under age twenty-one who are now on or will in the future be placed on the Developmental Disabilities Request for Services Registry. The MCO shall comply with all court-ordered requirements as directed by LDH, including, but not limited to, guidance provided in the Chisholm	Class members in Chisholm v. LDH (Case 2:97-cv-03274) are defined as follows: All current and future beneficiaries of Medicaid in the state of Louisiana under age twenty-one who are now on or will in the future be placed on the Developmental Disabilities Request for Services Registry. The health plan will comply with all court-ordered requirements as directed by LDH, including, but not limited to, guidance provided in the Chisholm Compliance Guide

Compliance Guide and accompanying MCO User Manual.	and accompanying MCO Chisholm Compliance MCE User Process Manual.
Chisholm Compliance Guide Page 3 The Managed Care Organization (MCO) shall have a **PAL** to assist the enrollee with the prior authorization process for all prior authorized services. The UM PAL shall communicate with Early Periodic Screening, Diagnostic and Treatment (EPSDT) case managers, providers and enrollees on prior authorization requests for prior authorized services.	The health plan will have a Prior Authorization Liaison **(PAL)** to assist the member with the prior authorization process for all prior authorized services. The UM PAL will communicate with Early Periodic Screening, Diagnostic and Treatment (EPSDT) case managers (support coordinators) , providers and members on prior authorization requests for prior authorized services. The PAL communicates with providers, members and support coordinator to facilitate obtaining missing information.
Chisholm Compliance Guide Page 4 The MCO's Prior Authorization Unit shall eliminate unnecessary bureaucratic barriers to obtaining prior authorization for all prior authorized services. They shall communicate with the EPSDT support coordinator if applicable.	The health plan's Prior Authorization Unit will eliminate unnecessary bureaucratic barriers to obtaining prior authorization for all prior authorized services. They will communicate with the EPSDT support coordinator if applicable
Chisholm Compliance Guide Page7 For requests involving hours of services, clearly indicate how many hours were requested and how many hours were approved. If there are multiple services, please be sure to list a breakdown of each service separately.	For requests involving hours of services, clearly indicate how many hours were requested and how many hours were approved. If there are multiple services, please be sure to list a breakdown of each service separately.
Chisholm Compliance Guide Page 7,10	

Reduction in Services: the MCO shall document the reasons for the change in services and notify the Department's Chisholm Compliance Team before denying the prior authorization request.	The health plan will document the reasons for a change in services and notify LDH Chisholm Compliance Team before denying any prior authorization request.
Chisholm Compliance Guide Page 8 **Non-covered Service** - If a service is denied because it is not covered by the MCO, but covered by Medicaid Fee For Service, the notice must direct the enrollee and provider to seek the services from DXC Medicaid Fee For Service.	If a service is denied because it is not covered by the health plan, but covered by Medicaid Fee For Service, the denial notice must direct the member and provider to seek the services from DXC Medicaid Fee For Service.
Chisholm Compliance Guide Page 11 For all Chisholm denials, partial denials and partial approvals, the notices must be sent to LDH Chisholm Compliance Staff (CCS) for review and approval prior to being sent to the member. Before sending the notice for review and approval, check the notice against the Chisholm Guide and fill out the Chisholm Notice Checklist to ensure that the notice being sent is in compliance and accurate	For all Chisholm denials, partial denials and partial approvals, the notices must be sent to LDH Chisholm Compliance Staff (CCS) for review and approval prior to being sent to the member Before sending the notice for review and approval, check the notice against the Chisholm Guide and fill out the Chisholm Notice Checklist to ensure that the notice being sent is in compliance and accurate
Chisholm Compliance Guide Page 3 The MCO's Prior Authorization Unit shall provide **notice of approval** or denial of prior authorization to EPSDT case managers, providers, and enrollees.	The health plan's Prior Authorization Unit will provide notice of approval or denial of prior authorization to EPSDT case managers, providers, and members.
Chisholm Compliance MCE User Process Manual page 4-7 Once Chisholm Compliance Staff (CCS) is satisfied with the denial notice and all necessary changes have been resubmitted,	Once Chisholm Compliance Staff (CCS) is satisfied with the denial notice and all necessary changes have been resubmitted,

then CCS will send a message via chatterbox stating that the notice is approved. Notices are not approved until message come across via the chatterbox from CCS staff stating that the notice is approved. A notice cannot be sent to the member until CCS has sent an approval message via Salesforce chatter.	then CCS will send a message via chatterbox stating that the notice is approved. Notices are not approved until message come across via the chatterbox from CCS staff stating that the notice is approved. A notice cannot be sent to the member until CCS has sent an approval message via Salesforce chatter.

REVIEW AND APPROVALS

Date

Sonya K. Nelson
Interim Chief Operating Officer

Antoinette K. Logarbo, MD
Chief Medical Officer

Date

EXHIBIT(S): N/A