AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	Act 421 – CMO Policy	Page:	1 of 11
Department:	Medical Management	Policy Number:	XXXXXX
Subsection:	Utilization Management	Effective Date:	01/01/2022
Applies to:	■ Medicaid		

PURPOSE:

The purpose of this policy is to describe and provide guidance regarding Aetna Better Health's process for prior authorization decision-making for Act 421-CMO Children's Medicaid Option (TEFRA/Katie Beckett) program. The program includes members 18 years or younger with severe disabilities, defined as a medically determinable physical or mental impairment that results in marked and severe limitations and has lasted or is expected to last at least one year, or to result in death. Eligibility will be determined by the Louisiana Department of Health.

STATEMENT OF OBJECTIVE:

The objectives of the policy are to assure appropriate authorization of services for Aetna Better Health members of the Act 421 Children's Medicaid Option including but not limited to:

- **Documentation requirements**
- **Certification period**
- **Parental/guardian consent**
- **Utilization Management**
- **Care Management**
- **Transportation**
- **Quality**

DEFINITIONS:

Act 421-CMO Children's Medicaid Option (TEFRA/Katie Beckett) program.	**Group of individuals 18 years old and younger with special healthcare needs due to medically determinable physical or mental impairment that resulted in marked and severe limitations and has lasted or is expected to last at least one year or to result in death. This requires individualized healthcare approach These members require the level of care given at an Intermediate Care Facility, a nursing home or hospital but with support can be safely cared for at home. Members qualify with resources under $2,000 excluding parental resources.**
Administrative	**Denial of requests for coverage of services or supplies that are not**

Denial	**covered based on federal or state law, a contractual or benefit exclusion, limitation or exhaustion and do not require a clinician to interpret the contractual limitation or apply clinical judgment to the limitation.**
Aetna Medicaid Medical Management (MM) Chief Medical Officer	**A full-time physician who is board certified with an active unencumbered license and who serves as the lead for the Aetna Medicaid MM unit.**
Aetna Clinical Policy Bulletins (CPBs)	**Statements of Aetna's policy regarding the experimental and investigational status and medical necessity of medical technologies that may be eligible for coverage under Aetna medical plans. CPBs also state what medical technologies Aetna considers cosmetic. CPBs apply to all Aetna medical benefit plans and are used in conjunction with the terms of the member's benefit plan and other Aetna-recognized criteria to determine health care coverage for Aetna's members.** **Aetna CPBs are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of health care providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies.**
Aetna Clinical Policy Council	**Evaluates the safety, effectiveness and appropriateness of medical technologies (i.e., drugs, devices, medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided) that are covered under Aetna medical plans, or that may be eligible for coverage under Aetna medical plans. In making this determination, the Clinical Policy Council will review and evaluate evidence in the peer-reviewed published medical literature, information from the U.S. Food and Drug Administration and other Federal public health agencies, evidence-based guidelines from national**

	medical professional organizations, and evidence-based evaluations by consensus panels and technology evaluation bodies.
Aetna Clinical Policy Review Unit	**The Aetna policy and procedure unit that reviews and updates Aetna CPBs on a yearly and prn basis.**
Child and Adolescent Level of Care Utilization System (CALOCUS©), Version 20	**A nationally recognized clinical guideline for making decisions regarding medical necessity for behavioral health treatment. CALOCUS was developed for children and adolescents by the American Association of Community Psychiatrists (AACP).**
Clinical Personnel	**Clinical personnel are defined as nurses, social workers, counselors, therapists, psychologists, chiropractors, pharmacists, dentists (DDS and DMD), and physicians, including temporary employees, who make clinical determinations as part of the benefit determination process, or who participate in the medical management process.**
Concurrent Review	**A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if Aetna Better Health did not previously approve the earlier care. All inpatient concurrent requests are considered urgent. Concurrent reviews are typically associated with inpatient care, residential behavioral care, intensive outpatient behavioral health care and ongoing ambulatory care.**
Denial, Reduction, or Termination of Financial Responsibility	**The non-authorization of care or service at the level requested based on either medical appropriateness or benefit coverage. Partial approvals (modifications) and decisions to discontinue authorization when the practitioner or member does not agree are also denials.**
MCG®	**MCG, including Chronic Care Guidelines, are evidence-based clinical guidelines that are updated annually. They support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives.**

Special Healthcare Needs Population	**A group of members identified by the Louisiana Department of Health, who are medically fragile. The special needs population requires a close focus to meet contractual requirements to manage this population. Special Needs Population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized healthcare approaches.[1]**
Medical Necessity Determination	**A decision about coverage for a requested service based on whether the service is clinically appropriate and/or needed based on a member's circumstances. The National Committee for Quality Assurance (NCQA) requires a medical necessity review and appropriate practitioner review of "experimental" or investigational" requests, unless the requested services or procedures are specifically excluded from the benefits plan.**
Medically Necessary / Medical Necessity	**This term refers to services or supplies for diagnosing, evaluating, treating or preventing an injury, illness, condition or disease, based on evidence-based clinical standards of care. Medically necessary services are accepted health care services and supplies provided by health care entities, appropriate to evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Determination of medical necessity is based on specific criteria.** **Note: This definition is based on the Centers for Medicare & Medicaid Services (CMS) and American College of Medical Quality (ACMQ) definitions.**
Notice of Action (NOA)	**Written notification of decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, specific to the member's clinical condition, utilizing language that is easily understood by the member and practitioner/provider. The notification includes a reference to the criterion, rationale for the decision and member appeal rights.**

[1] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 6.19

Peer-to-Peer Consultation	**A discussion between a requesting practitioner and a medical director/physician reviewer concerning a denial of coverage based on medical necessity. The discussion may occur before or after the medical necessity decision. A peer-to-peer review is optional and is not part of or a prerequisite for an appeal.**
Primary Care Practitioner (PCP)	**An individual, such as a physician or other qualified practitioner, who provides primary care services and manages routine health care needs.**
Post-Service Decision	**Any review for care or services that have already been received (i.e., retrospective review).**
Post-Stabilization Care Services	**Covered services that are:** • **Related to an emergency physical and/or behavioral health condition** • **Provided after a member is stabilized, and** **Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member's condition**
Practitioner	**A licensed or certified professional who provides medical or behavioral healthcare services.**
Pre-Service Decision	**Any case or service that Aetna Better Health must approve, in whole or in part, in advance of the member obtaining medical care or services. Prior authorization is a pre-service or prospective decision.**
Prior Authorization	**Prior assessment that proposed services (such as hospitalization) are appropriate for a particular patient and will be covered by Aetna Better Health. Payment for services depends on whether the patient and the category of service are covered by the member's benefit plan.**
Provider	**An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.**
Urgent Request	**A request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations:** • **Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, *or***

	• **In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.**

LEGAL/CONTRACT REFERENCE:

The legal reason for this policy should be cited in this section. This should include:

- **2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 4.3.2; 4.3.8; 6.19.2; 6.38.7; 10.5.1; 11.11.4.1**
- **National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans**
- **2019 Legislative Act 421 – Children's Medical Option**
- **Louisiana Department of Health Medicaid Act 421 Children's Medicaid Option (TEFRA/Katie Beckett) at Idh.la.gov/page 3985[2]**

FOCUS/DISPOSITION:

Scope

The scope of this policy defines the validity of requests, authorization and provision for a population of disabled children (defined as a medically determinable physical or mental health impairment that results in marked and severe limitations and has lasted or is expected to last at least one year, or to result in death.) This population falls under the special-needs population and Aetna Better Health will meet the contractual requirements set forth to manage this population.[3] Utilization management should coordinate with case management to ensure a timely discharge plan and to prevent duplication.[4]

Eligibility Criteria[5]

[2] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 6.19.2; 6.38.7; 10.5.1
[3]; Louisiana Medicaid Provider Manual page 3985
[4] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 6.30.2.7
[5] Louisiana Department of Health Medicaid ACT Children's Medicaid Option (TEFRA/Katie Beckett) at LDH.LA.gov/page/3985

- **Enrollees must be 18 years old or younger**
- **Enrollees must be a Louisiana resident and a United States citizen**
- **Enrollees must have a disability that is recognized under the definition of disability utilized in the Supplemental Security Income program of the Social Security Administration, regardless of whether the child is eligible to receive benefits under the program.**
- **Enrollee must have, or have applied for a Social Security Number**
- **Enrollee child does not have total assets (resources) exceeding $2,000 in value, excluding parental income.**
- **Enrollee meets an institutional level of care provided in a hospital, skilled nursing facility, or intermediate care facility (ICF).**
- **Enrollees can be cared for safely at home**
- **Enrollees may have a Chisholm designation in addition to an ACT 421 enrollment.**

EXCLUSIONS:

- **Enrollees approved for an Office of Citizens for Developmental Disability waiver will no longer be eligible for the ACT 421 enrollment.[6]**

RESPONSIBILITIES:

Aetna Better Health will authorize needed health services for 421–CMO enrollees including services that will help prevent institutionalization and are not available or less available under private insurance plans. ACT 421 members will be referred to care management via email at AetnaBetterHealthofLA-CMReferral@AETNA.com.

Aetna Better Health will provide comprehensive and preventive health care services for 421-CMO enrollees by authorizing services for core benefits and services including but not limited to doctor visits; pharmacy medications; speech, occupational and physical therapy; applied behavioral analysis; hospital services; dental services; durable medical equipment;

[6] Louisiana Department of Health.LA.gov/assets/Medicaid/ACT_421_FAQ p.10

patient care services (PCS), skilled nursing, home health and extended home health nursing if medically necessary.

Provider contracts or single case agreements may need to be considered during the authorization process to prevent interruptions in care.[7]

Clinical reviewer's responsibilities include:[8]

- **Identifying service requests that may potentially be denied or reduced on the basis of medical necessity**
- **Forwarding potential denials or reductions to the designated medical director for review**
- **If services are to be denied or reduced:**
  - **Providing written notification of denials/reductions to members**
  - **Notifying the requesting practitioner/provider and member of the decision to deny, reduce or terminate reimbursement within NCQA and state required timeliness requirements.**
  - **Documenting, or informing data entry staff to document the denial decision in the business application system prior authorization module**

Authorizations for members transitioning into Aetna Better Health MCO, will be continued for up to ninety (90) calendar days or until the member may reasonably transfer to a preferred provider without disruption. Aetna Better Health will honor prior authorizations issued prior to the member transitioning to the Act 421-CMO Children's Medicaid Option TEFRA Katie Beckett program. [9]

Aetna Better Health will not require service authorization for the continuation of medically necessary covered services of a new transitioning member, regardless if provider is in or out of network, but may require a prior authorization of services beyond thirty (30) calendar days.[10]

[7] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 6.30.2.4-6
[8] NCQA HP 2020 UM4 A1-2A2
[9] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 6.37-6.38
[10] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 6.38.4.1

OPERATING PROTOCOL:

Systems

The business application system has the capacity to electronically store and report all service authorization requests, decisions made by Aetna Better Health regarding the service requests, clinical data to support the decision, and timeframes for notification to practitioners/providers and members of decisions. All electronically stored data is housed within Aetna's business applications and are not outsourced to external vendors.

Measurement

- **Number of authorization requests received**
- **Percentage of prior authorization requests approved**
- **Trend analysis of prior authorization requests approved**
- **Percentage of prior authorization requests denied**
- **Trend analysis of prior authorization requests denied**
- **Timeliness of decisions and notifications**

Reporting

- **Regulatory state reports**
- **Percentage of requests for 421-CMO approved**
- **Trend analysis of requests for 421-CMO approved**
- **Percentage of requests for 421-CMO denied**
- **Trend analysis of requests for 421-CMO denied**
- **Utilization tracking and trending is reviewed by the CMO monthly and is reported at a minimum of quarterly to the QM/UM Committee**
- **Annual report of inter-rater reliability assessment results**

INTER-/INTRADEPENDENCIES:

Internal

- **Care Management**
- **Utilization Management**
- **Enrollment department Chief executive officer**
- **Chief medical officer**
- **Claims**
- **Finance**
- **Information Technology**
- **Medical Director**
- **Medical Management**
- **Member Services**
- **Provider Services**
- **Quality Management**

Quality Management/Utilization Management Committee

External

- **Enrollees**
- **Practitioners and providers**
- **Regulatory bodies**

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