POLICY AND PROCEDURE

POLICY NAME: Care Management Program Description	**POLICY ID:** LA.CM.01
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA:** PHCO
EFFECTIVE DATE: 09/01/2011	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 09/12, 04/13, 11/13, 01/14, 9/14; 11/14, 9/15, 1/16, 10/16, 3/17, 3/18, 8/18, 2/19, 6/19, 10/19, 01/20, 11/20, 01/21, 03/21, 05/22, 09/22, 12/22, 03/23, 05/23, 12/24	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
This policy outlines the care management program description.

PURPOSE:
To describe LHCC's Care Management Program.

SCOPE:
Louisiana Healthcare Connections Medical Management (LHCC) and Quality Improvement Departments.

DEFINITIONS:

Basic Behavioral Health Services:~~-~~ Mental health and substance ~~ab~~use services which are provided to Enrollees with emotional, psychological, substance ~~ab~~use, psychiatric symptoms and/or disorders. Services are provided in the Enrollee's Primary Care Physicians (PCP) office by the Enrollee's PCP as part of primary care activities. ~~Mental health and substance abuse services which are provided to Enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders that are provided in the Enrollee's PCP office by the Enrollee's PCP as part of primary care service activities.~~ Basic Behavioral Health Services include, but are not limited to, screening, brief intervention and assessment, prevention, early intervention, medication management, treatment, and r~~R~~eferral s~~S~~ervices provided in the primary care setting and as defined in the Medicaid State Plan. Basic Behavioral Health Services may further be defined as those provided in the Enrollee's PCP or medical office by the Enrollee's (non-Specialist) physician (e.g., DO, MD, APRN, PA) as part of routine physician evaluation and management activities. These services shall be covered by the Plan for Enrollees with both physical ~~health~~ and behavioral health coverage.

Care Coordination: Deliberate organization of patient care activities by a person or entity formally designated as primarily responsible for coordinating services furnished by providers involved in the Enrollee's care to facilitate care within the network with services provided by non-network providers to ensure appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of Enrollee's care.

Care Management: The overall system of medical management, care coordination, continuity of care, care transition, chronic and complex case management, and independent review. LHCC will ensure that each enrollee has an ongoing source of primary and/or behavioral healthcare appropriate to ~~his or her~~their needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the enrollee. LHCC offers and encourages integrated Care Management (CM) for all Enrollees with co-occurring Physical Health (PH) and Behavioral Health (BH) conditions. We use a multi-disciplinary team-based structure designed to enhance access to all covered and non-covered services and meet the Enrollees' holistic needs. (RFP Response 2.6.15.1) LHCC's health equity model will be used to detect, assess, and aid in reducing health disparities. (RFP Response 2.6.15.1)

Case Management: Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an Enrollee's needs through communication and available resources to promote high quality, cost-effective outcomes. Case management services are defined as services provided by qualified staff to a targeted population, including those with acute and chronic conditions, to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Case Management services may include an individual needs assessment and diagnostic assessment, development of the Enrollees Plan of Care (POC), establishment of treatment objectives, and monitoring outcomes. Case Management consists of three levels of care and Transitional Case Management when moving across settings. The three levels include Case Management (Low/Tier 1), Case Management (Medium/Tier 2), Intensive Case Management (High/Tier 3) (Model Contract 2.7.1).

Complex condition: Enrollees who are classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; individuals that need more intensive programs or services; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life.

Chronic condition: Any ongoing physical, behavioral, or cognitive disorder, including chronic illnesses, impairments, and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is normally considered routine. Chronic conditions are persistent or frequently recurring conditions of significant duration that may limit an individual's activities and require ongoing medical care to optimize the individual's quality of life.

Specialized Behavioral Health Services (SBHS) – Mental health services and ~~substance abuse~~substance abuse services that include, but are not limited to, services specifically defined in LHCC's Health Plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider, licensed mental health professional (LMHP), social workers, licensed addiction counselors etc. in specialized behavioral health facility settings.[CG1][PL2]

Special Health Care Needs Population - An individual of any age with a mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care requirements.

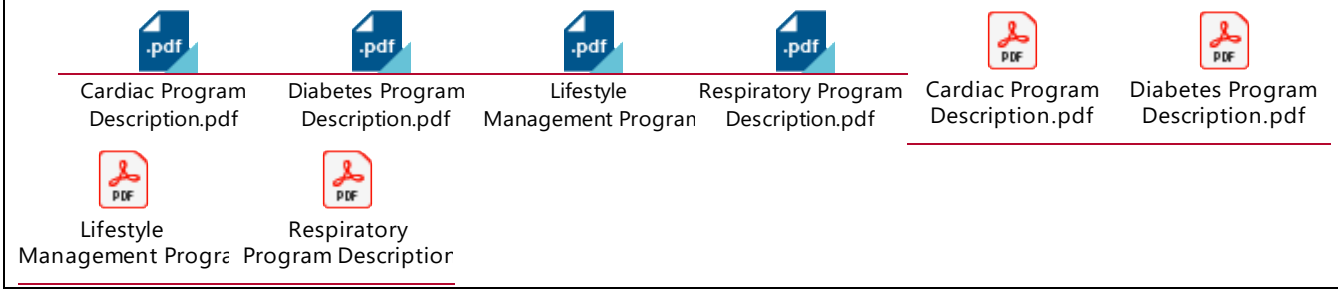
POLICY:
The Medical Management and Quality Improvement departments will maintain a Care Management Program Description which contains the goals and objectives of the program, identifies the target Care Management population, outlines the infrastructure of the program, and describes an overview of the methods and processes of identifying and assessing Enrollees, managing Enrollee's care, and measuring the impact of interventions.

LHCC will submit Care Management Program policies and procedures to Louisiana Department of Health (LDH) for approval prior to readiness review, annually, and prior to any revisions. For any delegated Case Management services, LHCC will have a written plan in place for monitoring and oversight of performance under any such agreements, including provisions for assessing Provider compliance and corrective actions and/or termination as appropriate. (Model Contract 2.7.10-2.7.10.1) In addition, LHCC will submit Care Management reports monthly or as indicated by LDH.

PROCEDURE:
The program description begins after the revision log that follows below.

REFERENCES:
Current NCQA Health Plan Standards and Guidelines.
Current Healthy Louisiana Managed Care Organization (MCO) contract
LHCC Response to RFP
LA.UM.16 Continuity and Coordination of Services

ATTACHMENTS:



ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:
La R.S. 46:460.54 applies to material changes to this policy.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	Attachment A: Complex Case Management is the former LA.CM.01 and was replaced by this policy (Case Management Program Description) on 4/10/13.	04/10/13
Ad Hoc Review	Added “Children with special healthcare needs co-occurring medical and behavioral health conditions” to Case Management Criteria	11/25/13
Ad Hoc Review	Reviewed and revised with additions to reflect process for Plan and BH integrated rounds in place.	01/27/14
Ad Hoc Review	Removed attachment: Complex Case Management. It is now its own policy. Changed Director of Medical Management to Director of CM. Changed number of cases to 65	09/2014
Ad Hoc Review	LA Procurement 2015 Policy Update	11/2014
Ad Hoc Review	Added Case Management workflow	02/23/15
Ad Hoc Review	Changed Case to Care; Changed “The Plan” to “LHCC;” Changed “Complex Care” to “Chronic Care,” Revised Scope, Goals, Functions & Outcomes.	09/24/15
Ad Hoc Review	Reviewed and revised to include CCMP program additions Reviewed and revised to include BH contract language and BH related personnel additions (I.e., Behavioral Health Practitioner, etc.) Changed “Chronic Care Management” to “Complex Care Management”	01/25/16
Ad Hoc Review	Changed DHH to LDH	10/24/16
Ad Hoc Review	Updated dates, added Envolve People Care	03/24/17
Annual Review	Updated dates, functions, program segments, data sources Changed Care to Case Manager; CMD to SVPMA, MC to CHS Added DM, CHS, BHCM Added BH goal and Health Coaching criteria Removed LTSS Added Special Health Care Needs Added NAS to outcomes Updated goal of ED Removed Paramedicine Program Updated Sickle Cell, Anxiety, Depression and PSUD Changed Care Management to Case Management Changed Case Managers to Care Managers Changed “The Plan” to LHCC	03/23/18
Ad Hoc Review	Added Care managers will also collaborate with PMUR (Pharmacy Medication Utilization Review) staff in ICT Staffing Model Added Asthma and Depression assessments to condition-specific assessments Removed attachment: EPC (Nurtur) Program Description Added attachments: Nurtur Pediatric Obesity Program Description, Nurtur Asthma Program Description, Nurtur Back Pain Program Description, Nurtur Diabetes Program Description, Nurtur Heart Failure Program Description, Nurtur Hypertension Program Description, Nurtur Weight Management Program Description	08/24/18
Ad Hoc Review	Changed “Case Management Program” to “Care Management Program” Updated dates and metrics to reflect 2019 Removed LTSS services as a Care Coordination function Capitalized Registered Nurse Changed VPMM reports to COO to reporting to SVPCO Removed laboratory data as data source Added LaEDIE (ED Registry) as a data source Grammatical and format changes Removed Nurse Advice Line under “Other referral sources” due to duplication Removed risk stratification for outreach timeframe based on acuity levels (high, medium, low) Changed used of word “complex” regarding moderate/medium acuity to “chronic”	02/25/19

	Changed specialty assessments to only include Sickle-Cell and Depression Changed “mental health” to “behavioral health” Changed “psychosocial issues” to “social determinants of health” along with examples Changed definition of when initial assessment is required – no longer based on when enrollee agrees to CM. Assessment completion time based on date of identification for CM Added caregiver as an option to needing to be willing and able to participate in CM program Removed flu vaccine rate and NICU follow-up appointment from CM effectiveness measure section Added PASRR program to Population Management section Changed number of ED visits for Chronic Pain Management from 5 visits to 4 Added Perinatal Depression Program to Condition specific CM/DM program	
Ad Hoc Review	Added verbiage regarding CM reporting to LDH Removed specific CM goals and aligned goal verbiage to include goals to be determined by NCQA, LDH, etc. annually. Added Laboratory data back into the data source list Moved paragraph “After completing the assessment of the enrollee as a whole, stratification as low, moderate/medium, or high priority is determined in terms of frequency of contact and intensity of interventions, and assignment to Care Coordination, Case Management, or Complex Case Management.” to the end of the assessment and screening section. Removed timeframe for initial outreach for high risk Enrollees Removed two CM Effectiveness measures – Postpartum outreach for Enrollees in CM and Enrollees with Sickle Cell and receiving hydroxurea	06/24/19
Ad Hoc Review	Re-word reassessment verbiage to align with RFP reference 6.19.4.3	10/24/19
Ad Hoc Review	Revised definitions section to reflect RFP definitions Added 2020 EPC Disease Management Program Descriptions Updated dates to reflect 2020 CM Program Description Grammatical changes including Care Management vs Case Management and Care Manager vs Case Manager Removed CCMP is a referral source because referrals are for the CCMP program Added COPD, Heart Disease, and Hyperlipidemia to DM programs	01/24/20
Ad Hoc Review	Added verbiage from Corporate CM Program Description regarding Program Segments and the Care Management Enrollee Prioritization Report Added Behavioral Health specifications to Complex Case Management criteria Added Community Liaison role and description to Integrated Care Team section Added EPSDT Waiver Program information Added new criteria for Special Health Care Need based on Amendment 2 from the Emergency Contract Updated requirements of the care plan to be completed within 45 days of the completion of the assessment to reflect Amendment 3	11/20/20
Ad Hoc Review	Added information regarding new Special Healthcare Need population, Act 412 Children’s Medicaid Option (CMO) per Amendment 3	01/2021
Ad Hoc Review	Formatting and grammatical changes Added the following to meet Emergency Contract references: Within the care plan section: • Offering enrollee freedom of choice in finding new providers and/or obtaining services • For Enrollees with behavioral health related disorders and may experience crisis, a plan for addressing crisis, including resources and contact information, to prevent unnecessary hospitalizations or institutionalization	03/25/21

	Justice-Involved Pre-Release Program within Population Management section Annual review – updated outcomes section to remove effectiveness measures no longer included in CM Program Evaluation	
Ad Hoc Review	Change Medical Management to Population Health and Clinical Operations Grammatical Changes Updated DOJ population to reflect DOJ Agreement Compliance Guide Updated EPC Program Descriptions in attachment section	05/27/22
Ad Hoc Review	Updated to reflect IPRO Survey Findings	09/30/22
Ad Hoc Review	Changed “Members” to “Enrollees” Updated with Model Contract Language Updated with RFP Language Reformatted to latest Policy Template	12/05/22
Ad Hoc Review	Updated to reflect Model Contract Language 2.7.5.1-2.7.5.3 Updated “Population Management” DOJ Population with regards to the updated DOJ Compliance Guide verbiage Updated Program Description Attachments for Disease Management	03/14/23
Ad Hoc Review	Updated DOJ Target Population Addendum to DOJ-AR identification strategy	05/03/23
Ad Hoc Review	Updated Levels of Case Management Changed “enrollees” to “Enrollees” to reflect contract language	05/31/23
Ad Hoc Review	Updated the DOJ-At Risk Population Criteria Revised when POC is due with updated contract language	10/09/23
Annual Review	Grammatical and Format Changes Updated Disease Management Programs Updated Care Management Structure Updated verbiage from Model Contract Updated NCQA verbiage for “Exhausted Benefits” Updated verbiage from HNA Removed “REDI Team”	12/2024

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company’s P&P management software, is considered equivalent to a signature.

Care Management Program Description 2024~~3~~

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Purpose

The purpose of the Care Management Program Description is to define Case Management functions, determine methods and processes for enrollee identification and assessment, manage enrollee care, and measure outcomes.

Definition of Enrollee

For the purposes of this policy the term enrollee is an inclusive term referring to the covered individual and the family, guardian, designee, authorized representative, caregiver, supporter, or another significant person involved in a fiduciary or supportive role.

Definition of Case Management

Louisiana Healthcare Connections (LHCC) adheres to the Case Management Society of America's (CMSA) definition of Case Management: "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost effective outcomes". LHCC also abides by the principles of Case Management practice, as described in CMSA's Standards of Practice for Case Management.

The Care Management program and the tools utilized to manage care were built on evidence-based clinical practice guidelines and preventive health guidelines adopted by Louisiana Healthcare Connections Health Plan. The assessments utilize the ~~Case Managements Society of America's (~~CMSA~~A)~~ Standards of Practice for Case Management and other evidence-based tools including the PHQ2/9. ~~—~~Disease specific assessments include research of latest scientific sources, articles, and publications from national organizations. ~~–~~The program also includes adherence to HEDIS effectiveness of care measures and the associated technical specifications to ensure enrollee compliance.

LHCC trains care management staff in motivational interviewing. Motivational interviewing [CG3][PL4]should be used to~~and utilizes motivational interviewing techniques to~~ guide enrollee goal identification and actions.

Levels of Case Management

LHCC has developed a tiered case management program that provides differing levels of case management based on an individual's needs. ~~LHCC engages members, their parent or legal guardian, as appropriate, based on the level of case management commensurate with their risk score as identified through predictive modeling combined with the care needs identified in the Enrollee's plan of care and comprehensive assessments, including a Health Needs Assessment (HNA).~~ LHCC engages Enrollees, their parent or legal guardian, as appropriate, based on the level of case management commensurate with their risk score. The risk score is identified through predictive modeling. Tier assignment takes into consideration the risk score as well as the care needs identified in the Enrollee's plan of care and comprehensive assessments,

including a Health Needs Assessment (HNA). Where the Enrollee's PCP or behavioral health provider offers case management, the Care Management team provides support to the provider as the lead case manager on the multi-disciplinary care team.

Case management tier assignments are made as expediently as possible and re-evaluated at every enrollee interaction [CG5][PL6]and upon any change in status or need. To ensure appropriate support, we validate and, as needed, modify case management tier assignment based on the individualized evaluation of the enrollee including their strengths, needs, preferences, and goals[CG7][PL8]. (RFP 2.6.6.4.a)

LHCC offers and encourages integrated Care Management (CM) for all Enrollees with cooccurring PH and BH conditions. We use a multi-disciplinary team-based structure designed to enhance access to all covered and non-covered services and meet the Enrollees' holistic needs. (RFP 2.16.15.1) Enrollees who are not enrolled in case management services (Tier 3, 2, or 1) will have access to care coordination services and population health programs designed to improve the health and wellness of our entire population. As part of our risk stratification and predictive modeling process, we continuously identify and outreach to individuals who would benefit from prevention and wellness and other population health programs and activities to ensure optimal health for all Enrollees. (RFP 2.6.6.2)

The enrollee will be assigned to an appropriate qualified healthcare professional within the CM team (Care Manager, Program Specialist, or Behavioral Health Care Manager) to complete an additional comprehensive assessment to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring, based on the following acuity level identified in the HNA (Model Contract 2.7.3.1):

- **Case Management (Low/Tier 1)** – Enrollees engaged in this level of case management are of the lowest level of risk within the case management program and typically require support in care coordination and in addressing social determinants of health (SDOH)~~SDOH.~~ (Model Contract 2.7.5.3) Care Coordination assistance may be needed for housing, financial, community resources, or assistance with accessing healthcare services. Care coordination typically involves non-clinical activities performed by non-clinical staff; clinical staff may aid if minor medical, or behavioral health concerns arise. Services at this level of coordination include outreach to enrollee, assistance scheduling appointments, and assistance securing authorizations and follow up to ensure compliance.

  A Plan of Care (POC) shall be completed in person within ninety (90) Calendar Days of identification and include assessment of the home environment and priority SDOH. Case Management meetings shall occur at least quarterly, or more as required within the Enrollee's POC, with

annual updates to the POC and formal in-person re-assessment annually. Attestations of annual updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed (Model Contract 2.7.5.3)

- **Case Management (Medium/ Tier 2)** – Enrollees engaged in the medium level of case management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. (RFP 2.6.6.2) Enrollees in case management may have a chronic condition or multiple co-morbidities that are generally well managed. Enrollees in case management typically have adequate family or other caregiver support and need moderate to minimal assistance from a Care Manager. Care managers serving Tier 2 members focus on implementation of the Enrollee's plan of care, preventing institutionalization and other adverse outcomes, and supporting the Enrollees in meeting his or her care goals including self-management. (Model Contract 2.7.5.2)

  A POC shall be completed in person within thirty (30) Calendar Days of identification and include assessment of the home environment and priority SDOH. Case Management meetings shall occur at least monthly, with quarterly updates to the POC and formal in-person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of quarterly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 2 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs (Model Contract 2.7.5.2).

- **Intensive Case Management/ (High/Tier 3) –**
- Enrollees engaged in intensive care management are of the highest need and require the most focused attention to support their clinical needs and to address SDOH. High Complex/Intensive Case Management is focused on addressing the needs of Enrollees with complex physical, BH, and/or SDOH needs that require a higher level of staff expertise, intensity, and interventions. (RFP Response 2.6.6.2) Complex/Intensive Case Management is performed by LHCC for members who have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure the member receives appropriate services and care. Care managers serving Tier 3 members focus on implementation of the member's plan of care, preventing institutionalization and other adverse outcomes, and supporting the member in meeting his or her care goals, including self-management. (Model Contract 2.7.5.1) Those included in the Complex/ Intensive Case Management Tier 3 may have complex needs, including Enrollees classified as children or adults with special health care

needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; individuals that are in need of more intensive programs or services; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life. Care Managers will monitor Enrollee's key indicators of disease progress, i.e., HgbA1c levels and medication adherence. Pregnant Enrollees are excluded from Complex Case Management unless co-morbidities occurred before or will continue after pregnancy.

A POC shall be completed in person within thirty (30) Calendar Days of identification and shall include assessment of the home environment and priority SDOH. Case Management meetings shall occur at least monthly, in person, in the Enrollee's preferred setting, or more as required within the Enrollee's POC, with monthly updates to the POC and formal in person re-assessment quarterly. Case Management may integrate community health worker support. Attestations of monthly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider shall be completed. Case managers serving Tier 3 Enrollees shall focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an Enrollee with primarily behavioral health needs (Model Contract 2.5.5.1).

- **Transitional Care Management** - Coordination of services for the enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 C.F.R. §438.208(b)(2)(i). CM Staff will provide transitional case management for members to support transitions between institutional and community care settings, including but not limited to, transitions to/from inpatient hospitals, nursing facilities ~~(not~~(not including members of the DOJ Target Population), psychiatric facilities, Psychiatric Residential Treatment Facility~~PRTFs~~, therapeutic group homes, permanent supportive housing, intermediate care facilities, residential substance use disorder settings, and transitions out of incarceration. (Model Contract 2.7.5.4)

- **Disease Management** - Health coaching provided by certified health coaches/disease managers for chronic medical conditions (diabetes, hypertension, Chronic Obstructive Pulmonary Disease (COPD), congestive heart failure, and asthma)~~,~~). Health coaching for behavioral health chronic conditions is provided by licensed mental health practitioners for attention deficit hyperactivity disorder (ADHD), anxiety, depression, and perinatal depression. The program objectives include the provision of telephonic outreach, education, and support services to promote enrollee adherence to treatment guidelines and facilitate enrollee self-management.

- **Community Health Services –** Certified ~~community health services representatives~~community resource coordinators who coordinate visits with Enrollees during provider appointments to connect Enrollee's to Case Management. This program also includes visits to Enrollees while hospitalized to engage in Case Management to reduce inappropriate re-admissions.

Mission of Care Management Program

- Assist Enrollees in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition.
- Assist Enrollees in determining and accessing available benefits and resources.
- Work collaboratively with Enrollees, family and significant others, providers, and community organizations to develop goals and assist Enrollees in achieving those goals.
- Assist Enrollees by facilitating timely receipt of appropriate services in the most appropriate setting.

Maximize benefits and resources through oversight and cost-effective utilization management. Goals of the Care Management Program

- Achieve enrollee experience with Case Management of >90% satisfaction annually.
- Collaborating within multidisciplinary teams to utilize resources to promote the health and well-being of Louisianans.
- Meeting HEDIS goals as designated by LDH and NCQA annually.
- Supporting LHCC Population Health Strategic Plan Goals annually.

Case Management Functions

Case Management functions include:

- Early identification of Enrollees who have special needs and/or other physical, behavioral, or social needs.
- Assessment of Enrollee's risk factors, current health status, current service utilization, gaps in care, and medication review.
- Obtain verbal, voluntary consent for participation in Case Management [CG9][PL10]
- Utilize an Integrated Care Management model to address physical and behavioral health needs of the enrollee.
- Development of an individualized plan of care in concert with the enrollee and/or Enrollee's family, primary care provider (PCP), and managing providers.
- Development of a comprehensive plan of care in concert with the enrollee and/or Enrollee's family, primary care provider (PCP), and managing providers, that includes identification of enrollee goals, barriers to meeting those goals, and appropriate Case Management interventions.

- Referrals and assistance to ensure timely access to providers, including person-centered medical homes, if applicable.
- Active coordination of care to link Enrollees to providers, medical services, residential, social, and other support services where needed.
- Ongoing monitoring and revision of the plan of care as required by the Enrollee's changing condition.
- Assistance with facilitation of continuity and coordination of care among the Enrollee's various providers.
- Ongoing monitoring, follow up and documentation of all care coordination/Case Management activities.
- Addressing the Enrollee's right to decline participation in Case Management or dis-enroll at any time.
- Accommodating the specific cultural and linguistic needs of all Enrollees
- Conducting all Case Management procedures in compliance with HIPAA and state law.

Program Segments

A defined set of care management population criteria is in place to create a consistent Care Management Program Description and a consistent measurement process of the care management program. The criteria below is not all inclusive; clinical judgment should be used to determine a Enrollee's appropriateness for each level of care management, considering such factors as: stability of the condition(s), available support system, current place of residence, etc. (Louisiana Healthcare Connections may make expansions on these core criteria as needed to meet regulatory requirements and changes in populations as discovered through annual assessment).

Case Management (Low/Tier 1)[CG11][PL12]
• Primarily psychosocial issues such as housing, financial, etc. with need for referrals to community resources • Need for assistance with accessing Healthcare services • Enrollees overusing and/or abusing services • Enrollees that are children with a serious emotional disturbance who are enrolled for the Coordinated Systems of Care (CSoC) program shall receive care coordination via the CSoC contractor. • Permanent Supportive Housing needs
Case Management Criteria (Medium/ Tier 2)
• Diagnostic categories typically associated with high intensity of services and/or high cost but are generally well managed in the individual. Diagnoses include, but are not limited to: o HIV/AIDS o Cancer o Asthma, with associated inpatient admission o Sickle cell o Diabetes o Congestive Heart Failure

- Hemophilia
- ADHD
- Depression
- Anxiety
- Perinatal Substance Use Disorder (SUD)
- Adults with a Serious and Persistent Mental Illness (SPMI)
- High Risk Pregnancy

- Children with special healthcare needs co-occurring medical and behavioral health conditions
- Other State-mandated criteria

Intensive Case Management (High/Tier 3)[CG13][PL14]

- Impact Pro risk score of >7 for Supplemental Security Income (SSI) Enrollees; >4.65 for all other Enrollees [CG15][PL16]
- Three or more inpatient admissions within the last 6 months for same/similar diagnosis
- Three or more e~~E~~mergency room (ER)~~R~~ visits in the last 3 months
- Rare, High-Cost Conditions
- Pregnant
- Requiring Acute Behavioral Health intervention(s):
  - Inpatient Acute Psychiatric in the past 30 days
  - Inpatient Residential Treatment in the past 30 days
  - Enrollee has active acute symptoms evident by active psychosis, active Substance Use Disorder indicating enrollee is in immediate need of acute inpatient levels of care and symptomology cannot be de-escalated via a crisis prevention plan
  - Enrollee Observer-Reported Communication Ability (ORCA) score is 95-100 / HIGH
- Enrollees living with a developmental or intellectual disability eighteen (18) years of age or older
- Enrollees under eighteen (18) years of age and are receiving services under the 1915(c) Home & Community- Based Services (HCBS) waivers and any amendments[CG17][PL18]
- Complex cases/ multiple co-morbidities, including but not limited to:
  - Chronic or non-healing wounds / Stage 3 burns that require extensive wound care or skin grafts
  - Requires life sustaining device – ventilator, tracheostomy, oxygen, Continuous Positive Airway Pressure (CPAP)~~PAP~~ / Bi-level positive airway ~~BIPAP~~pressure (BIPAP), tracheostomy care or suctioning
  - Total Parental Nutrition (TPN) or continuous tube feedings
  - Recent functional decline within 90 days
  - Private Duty Nursing
  - Skilled Nursing Visits (SNF) > 3 visits / week
  - Institutional/SNF/Intermediate Care Facility (ICF)/ Individuals with Intellectual Disabilities (IDD).
  - Multiple co-morbidities that require 4 or more specialists

- Diabetes with Lower Extremity (LEX) episode or HgbA1c > 7
- Post-transplant within 6 months
- Post-discharge from Neonatal Intensive Care Unit (NICU) with a chronic/complex diagnoses
- Catastrophic illness or injury, e.g., transplants, HIV/AIDS, cancer, serious motor vehicle accidents, etc.
- End Stage Renal Disease (ESRD)
- Dual diagnosis – Enrollees with serious, chronic behavioral health and physical health diagnoses
- Congenital heart anomalies (i.e., tetralogy of fallot, hypoplastic left heart syndrome, coarctation of aorta, etc.)

Health Coaching Criteria[CG19][PL20]

- Physical Health Coaching for Enrollees who have one of the chronic big 5 conditions (Diabetes, Congestive Heart Failure (CHF)~~CHF~~, Asthma, COPD, and Hypertension)
- Behavioral Health Coaching for Enrollees who have one the chronic 4 behavioral health conditions (ADHD, Anxiety, Depression, Perinatal Depression)
- Enrollees who meet criteria for the Community ~~Health Service Representative~~ Resource Coordinator program for outreach in the community or during inpatient hospitalization

Infrastructure & Tools

Organizational Structure

Chief Medical Officer (CMO)

The Chief Medical Officer (CMO) has operational responsibility for and provides support to LHCC's Care Management Program. The CMO, Senior Vice President of Population Health (SVP), and/or any designee as assigned by the LHCC President and Chief Executive Officer (CEO) are the senior executives responsible for implementing the Care Management Program including cost containment, quality improvement, medical review activities, outcomes tracking, and reporting relevant to Case Management. A pharmacist oversees the implementation, monitoring, and directing of pharmacy-related services. In addition to the CMO, LHCC may have one or more Medical Director and/or Associate Medical Directors.

The CMO's responsibilities include, but are not limited to, coordination and oversight of the following activities:

- Assists in the development and revision of Case management policies and procedures as necessary to meet state statutes and regulations
- Monitors compliance with the Care Management Program
- Provides clinical support to the Case management staff in the performance of Case Management responsibilities
- Provides a point of contact for practitioners with questions about the Case Management process

- Communicates with practitioners as necessary to discuss Case Management issues
- Assures there is appropriate integration of physical and behavioral health services for all Enrollees in Case Management as needed
- Educates practitioners regarding Case Management issues, activities, reports, requirements, etc.
- Reports Case Management activities to the Quality Assessment and Performance Improvement Committee (QAPIC) and other relevant committees

Behavioral Health Practitioner

A behavioral health practitioner is involved in implementing, monitoring, and directing the behavioral health care aspects of LHCC's Care Management Program. A behavioral health practitioner may participate in Case Management rounds to assist in identifying behavioral health care needs and integrating behavioral and physical care. The behavioral health practitioner may be a clinical director, a LHCC network practitioner, or behavioral health delegate. A physician, appropriate behavioral health practitioner (i.e., doctoral-level clinical psychologist or certified addiction medicine specialist) or pharmacist, as appropriate, may be consulted on cases involving behavioral health issues.

Vice President of Medical Management (VPMM)

The VPMM is a Registered Nurse with experience in Utilization Management and Case Management activities. The VPMM is responsible for overseeing the day-to-day operational activities of LHCC's Care Management Program. The VPMM reports to the Chief Operating Officer (COO). The VPMM, in collaboration with the CMO, assists with the development of the Care Management Program strategic vision in alignment with the corporate and LHCC objectives, policies, and procedures.

Case Management Senior Director/ Manager and/or Case Management Supervisor

The Director/Manager of Case Management is a Registered Nurse (RN) or other appropriately licensed healthcare professional with Case Management experience. The Case Management Director/Manager directs and coordinates the activities of the department including supervision of a Clinical Program Manager, Care Managers, ~~Program Specialists,~~Care Management Support Coordinators, Care Navigators-, Transition ~~Program Coordinators, and~~Specialist and Community ~~Health Services Representatives.~~Resource Coordinators. The Case Management Director/Manager reports to the Senior Vice President of Population Health. The Case Management Supervisor works in conjunction with the Director/Manager of Case Management and the Directors of Clinical Operations Utilization Management to execute the strategic vision in conjunction with Centene Corporate and LHCC objectives and attendant policies and procedures and state contractual responsibilities.

Multidisciplinary~~Integrated~~ Care Team (MI~~H~~CT) Staffing Model

LHCC has identified a multi-disciplinary care team to serve each member based on the individual need of all members enrolled in case management tiers 1, 2, 3, and transitional case management as mentioned above. Physical and Behavioral Care Managers are co-located and based in Louisiana to allow integration of case management and provide continuity of care for members with both physical and behavioral health care needs. (Model Contract 2.7.9.2) Lead Care Managers are assigned based on the enrollee's~~member's~~ priority needs, as identified through the individual plan of care. For members with behavioral health as the primary issue, the Lead/Primary Care Manager would be the Behavioral Health Care Manager. Care Managers with expertise in physical or behavioral health care will support the lead care manager with the enrollee's~~member's~~ secondary diagnoses. For enrollees~~members~~ under the age of six (6), the lead Care Manager shall have expertise in early childhood mental health or access to a consultant with an expertise in infant and early childhood mental health. (Model Contract 2.7.9.1)

The teams utilize a common clinical documentation system to maintain centralized health information for each enrollee that includes medical, behavioral health, and all other services the enrollee receives. The CM staff shall conduct case management rounds at least monthly, which includes the Behavioral Health Care Managers and Behavioral Health Medical Directors. In addition, CM staff participate in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of coordination and communication. The clinical staff consults with and/or seeks advice from the Medical Director as indicated. -MI~~H~~CT roles include, but not limited to:

Medical Director

- Physician who holds an unrestricted license to practice medicine in the State of Louisiana and is Board Certified with experience in direct patient care
- Serves as a clinical resource for Care Managers and Enrollees' treating providers
- Facilitates multi-disciplinary rounds on a regular basis to discuss, educate, and provide guidance on cases
- Provides a point of contact for providers with questions about the Case Management process
- Communicates with practitioners as necessary to discuss Case Management issues

Care Manager (CM)

- Licensed RN, ~~RN Nurse,~~ Social Worker, or ~~LMHP~~Licensed Mental Health Professional (LMHP). Certified Case Manager (~~(~~CCM) credential preferred~~)~~

- Responsible for oversight of non-clinical Enrollees of the integrated ~~CC/~~CM team
- Responsible for working with the enrollee and Enrollee's treating providers to identify needs and create a care plan to help the enrollee to achieve goals
- Participates in inpatient rounds with concurrent review nurses to assist with discharge planning and coordination with the Enrollee's treating providers
- Communicates and coordinates with the enrollee and caregivers, treating providers, behavioral health providers, Disease Management staff, and other Enrollees of the ICT to ensure that enrollee needs are addressed
- Responsible for identifying resources and providers of services to ensure the greatest degree of integration into the community and the best possible health outcomes and enrollee satisfaction
- Includes Registered Nurse remote staff who coordinate ~~face-to-face~~in-person visits with Enrollees during provider appointments to perform on-site case management at the provider office. They also visit Enrollees while hospitalized.
- ~~Care Managers goals are to maintain an average caseload of 75.~~ ~~[CG21][PL22]~~
-

Behavioral Health Care Manager (BH-CM)

- Licensed Mental Health Provider (LHMP)
- Works with Enrollees, providers, and an integrated team
- Primary care manager for Enrollees with predominantly Behavioral Health related needs, or as secondary team member~~enrollee~~ for complex case management cases
- Participates in integrated care team rounds to assist with coordination with the Enrollee's other care team ~~Enrollees~~members.
-

Disease Manager

Licensed clinicians ~~(RN, RT, RD, LMHP, etc.)~~ who provides health coaching for identified Enrollees related to specific disease management programs (diabetes, CHF, hypertension, asthma, chronic back pain, weight management, ADHD, anxiety, depression, perinatal depression, etc.)

~~Community Health Service Representative~~Community Resource Coordinator (CRC)

- Non-clinical personnel who are certified in health coaching
- Provides ~~face-to-face~~in-person location services in the community and with hospitalized Enrollees. In addition to these services, they will connect Enrollees to Case Management if applicable.

- Participates in Community Outreach Events.
-

~~Program Specialists (PS)~~Care Navigators

- ~~Program Specialists (PS)~~Care Navigators are college graduates with background in social services or other applicable health related field
- Has an assigned Care Coordination caseload and responsible for following all standards of Case Management practice~~?~~
- Performs enrollee outreach and care coordination
- Communicates and coordinates with the enrollee and their caregivers, physicians, behavioral health providers, Disease Management staff, and other members~~Enrollees~~ of the MI~~I~~CT to ensure that Enrollee's needs are addressed
- Responsible for identifying resources and providers of services to ensure the greatest degree of integration into the community and the best possible health outcomes and enrollee satisfaction

Care Management Support Coordinator (CMSC)~~Program Coordinator (PC) / Care Coordinator (CC)~~

- A highly trained non-clinical staff person working under the direction and oversight of a CM
- Provides administrative support to ~~CC/~~CM team
- Collects data for Health Risk Screening/Assessment
- Provides educational promotion, enrollee follow up, arranges PCP visits, and performs care coordination under direction of Care Manager
- Works both in the office and in the community, sometimes with ~~face-to-face~~ in-person enrollee interaction
- Performs enrollee outreach, education, and home safety assessments
- Assists with community outreach events such as: Health Check days, Healthy Lifestyle events, Baby Showers, Diaper Days, Reading Events, etc.
- Assists with Connections Plus cell phone program, pod cast programs, etc.
-

Pharmacy Personnel

- Licensed Clinical Pharmacists and/or Pharmacy Technicians
- Assists with enrollee identification based on pharmacy utilization reports
- Collaborates with the integrated care team regarding medication appropriateness, medication utilization trends, and enrollee adherence to medication regiment
-

PCP, Specialist, and Behavioral Health Provider

- Collaborates with care plan development
- Assists with identification of additional needed services
- Communication of enrollee treatments plans, as needed
-

Community and Peer Liaison

- Maintains collaborative relationships with Health & Family Services, government agencies, community resource and advocacy groups, to build additional community support for current and potential enrollee.
- Coordinate with the court system and state child-serving agencies about court- and agency-involved youth, to ensure that appropriate services can be accessed which may include attending court proceedings at the request of LDH when there is a need to inform the court of available services and limitations and participating in cross-agency staffing.

Information Systems:

Referrals, assessments, care plans, and all Case Management activities are documented in a central clinical documentation system which facilitates automatic documentation of the individual user's name, along with date and time notations for all entries. The clinical documentation system utilizes evidence-based clinical guidelines or algorithms to conduct assessment and ongoing management and has automated prompts for follow up based on the care plan. Additionally, this system allows the Case Management team to generate reminder/task prompts for follow-up according to the timelines established in the Case Management care plan. Reminders/tasks can be sent to any team enrollee, e.g., allowing Care Managers to request that non-clinical staff arrange for referrals to community resources. (Model Contract 2.7.10.10)

The clinical documentation system contains additional clinical information, e.g., inpatient admissions, outpatient referral authorizations, reviews by Medical Directors, etc. related to the enrollee. It also houses documentation of other activities regarding the enrollee, such as letters sent, quality of care issues, etc. In addition, the clinical documentation system enables the Care Manager to add all providers and facilities associated with the Enrollee's case to a list which allows the information to be readily available without having to review authorization and referral data. These features permit the Case Management team to easily access all clinical information associated to an Enrollee's case in one central location.

The clinical documentation system has a biometric data reporting feature that can be utilized to manage Enrollees on a daily and ongoing basis. It contains modules that allow graphing of measures such as blood pressure, lab values, daily weights, etc. which can be used to track progress and measure effectiveness of Case Management interventions.

Our CM staff identify providers and State staff that are also providing case management support as part of the initial HNA and care planning process. When we identify other case managers involved in the Enrollee's care, our Case Manager documents this in our CM platform and initiates a process to coordinate with the other entity to prevent duplication or fragmentation of services. (RFP 2.6.6.5)

In addition, LHCC's Care Management Department shares information with providers to help facilitate integration and coordination of across all services, systems, and provider types. Providers can access assessments and plan of cares created with the enrollee and Care Management staff directly through a secure provider portal. Providers are educated on accessing LHCC's provider portal to promote coordinated and integrated care planning.

Enrollee Identification and Access to Case Management

A key objective of LHCC's Care Management Program is early identification of Enrollees who have the greatest need for Case Management services. This includes, but is not limited to, Enrollees who have specialty behavioral health needs; opt-in Enrollees receiving PCS, or waiver services; Enrollees with over and under-utilization factors of ERD usage, polypharmacy, inpatient admissions and/or other services; those classified as children or adults with special healthcare needs; Enrollees who have ongoing healthcare services; those with catastrophic, high-cost, high-risk or co-morbid conditions; who have been non-adherent in less intensive programs; or are frail, elderly, disabled, or at the end of life.

LHCC combines data from multiple sources to use in its population stratification and program eligibility process. Those sources include but are not limited to:

- Once an Enrollee has been stratified into a case management tier, we use predictive modeling tools to systematically monitor our Enrollees and identify Enrollees at current or future risk. LHCC's Extelligence Stratification Tool examines large data sets daily, providing a comprehensive array of targeted clinical indicators of future PH, BH, social health, and financial risk and disparities. (RFP 2.6.6.4.a) Going beyond the usual enrollee assessment and claims perspective, we create an enhanced Enrollee profile by integrating a variety of external data into our Extelligence risk stratification database. One of the 140+ data elements we utilize is a foreign-born index that identifies areas with populations born outside of the U.S., using a percentile ranking from 1 to 100, where "1" indicates no foreign-born population (most acculturated) and "100" notes geographies with the highest concentration (least acculturated) (RFP 2.6.6.3)
- Impact Pro™ – predictive modeling software that utilizes Enrollee enrollment, claims and supplemental data to stratify Enrollees at risk for health care expenditures.
- MicroStrategy- analytical and reporting platform built on top of the Enterprise Data Warehouse (EDW) that provides easily exportable data

regarding reports with Enrollee eligibility and data, provider, and affiliation data, claims and service data, authorization, and pharmacy data.

These data sources provide the following data to assist with stratifying the population: medical and behavioral claims/encounters, pharmacy claims, electronic health records, data from health plan UM and/or CM programs and advanced data sources such as all-payer claims databases or regional health information exchanges.

Care Management Enrollee Prioritization Report

To provide alignment on who is receiving case management and to streamline identification and reporting, LHCC utilizes a Care Management Enrollee Prioritization Report to assist in the identification of eligible Enrollees for screening and engagement into case management, including complex case management. Data integrated into the report includes claims/encounter data, hospital discharge data, pharmacy data, etc. The report is refreshed daily and identifies Enrollees deemed as having physical or behavioral health high needs, i.e., utilization patterns and behaviors that are impactable, based on algorithm. From here, Enrollees are triaged into health coaching, physical health case management, or behavioral health case management, which will guide the enrollee to the appropriate care team and primary care manager. The Care Management Enrollee Prioritization Report identifies Enrollees who report their health as poor on a health risk screener so is an avenue for identifying those Enrollees who trigger as being complex and potentially appropriate for enrollment into complex case management.

Additional case management and clinical program reports (e.g., state, ~~/CMS~~ enrollment process, Notification of Pregnancy forms, etc.) identifying Enrollees for case management may also be used to identify Enrollees for outreach and further appraisal for case management.

Data Sources

Enrollees are identified as potential candidates for Case Management through several data sources, including, but not limited to:

- LDH claim or enrollment data
- LHCC claim or encounter data
- Health risk assessments and/or screenings
- Specialty screening tools (i.e., PHQ2/9, CAGE AID, etc.)
- Enrollment data from another Managed Care Organization (MCO)
- Data analysis
- Predictive modeling software (Impact Pro™)
- Hospital discharge data
- Pharmacy data from LHCC, LDH or another MCO

- UM data - e.g., hospital admission data, Neonatal Intensive Care Unit (NIC)~~U~~ reports, inpatient census, precertification/prior authorization data, concurrent review data
- ED Utilization reports
- Laboratory data
- Readmission reports
- Concurrent Rounds
- Data sources to identify Enrollees who have co-occurring medical and behavioral health conditions
- Medical Director's referral
- Referrals from providers, and Louisiana Department of Health (LDH). ~~PCPs~~[CG23][PL24]
- State/Centers for Medicare and Medicaid Services (CMS) Enrollment Process and other State/CMS supplied data
- State defined groups such as Children with Special Healthcare Needs and Aged, Blind, and Disabled (ABD/SSI) Information provided by Enrollees or caregivers
- Notification of Pregnancy (NOP) indicating high risk pregnancy
- Provider requests for authorizations and referrals and notification of Enrollees
- Outreach to specialty Providers
- Information from onsite concurrent review nurses
- State Emergency Department (ED) Registry - Audacious Inquiry (AI)

Reports identifying Enrollees for Case Management are run on at least a monthly basis (although some identification reports are generated daily and/or weekly) and forwarded to the Case Management team for outreach and further appraisal for Case Management.

Referral Sources

Enrollees are also identified as potential candidates for case management through multiple referral avenues that help minimize the time between the need for and initiation of case management services. Direct referrals are considered high priority and are forwarded to the case management team as expediently as possible for further evaluation of needs.

Additionally, referrals for Case Management may come from resources such as:

- Enrollee services and self-referral (including Enrollee Grievances) (Model Contract 2.7.4.1.1)
- Health care providers – physicians, other practitioners, and ancillary providers. Providers are educated about the Care Management Program and referral process through the Provider Handbook, LHCC's website, Provider Newsletters, and by Provider Services staff. (Model Contract 2.7.4.1.2)

- Envolve People Care (EPC) Nurse Advice Line staff –the nurse advice/medical triage phone service for Louisiana Healthcare Connections Health Plan has policies and procedures in place for referring Enrollees to LHCC's Health Plan for Case Management screening. This may be accomplished via a "triage summary report" that is sent to LHCC electronically on the next business day after enrollee contact has occurred, or by direct communication with the designated contact person at LHCC.
- Health Assistance, Linkage, and Outreach (HALO) Program Referral- This program identifies Enrollees at risk for developing a substance use disorder or an enrollee with a substance use disorder diagnosis. Through a set of clinical questions, the enrollee can be identified as low or high risk. Enrollees with a high-risk score will be referred to Case Management.
- Disease Management (DM) Program staff –the DM staff works closely with the LHCC Population Health and Clinical Operations (PHCO)~~HCO~~ department and Case Management staff to refer Enrollees who could benefit from more intensive services. –Policies and procedures are in place regarding coordination of care, and regularly scheduled meetings, such as Case Management rounds, are held between the Case Management team and DM staff.
- Hospital staff, e.g., hospital discharge planning and Emergency Department staff - facility staff is notified of LHCC's Care Management Program during interactions with Utilization Management (UM) staff throughout the utilization review process. Hospital staff is encouraged to inform LHCC UM staff if they feel an enrollee may benefit from Case Management services; UM staff then facilitate the referral.
- LHCC Staff –
    - UM staff work closely with Case Management staff daily and can initiate a referral for Case Management by creating a referral within the clinical documentation system when an enrollee is identified through the UM processes, including prior authorization, concurrent review, discharge planning, and cases discussed in rounds.
    - LHCC Community Health Services Program - ~~Community Health Services Representatives (CHSRs)~~ Community Resource Coordinators (CRCs) are oriented to all staff departments within the LHCC Health Plan and have a basic understanding of all staff functions. CRCs~~HSRs~~ work closely with the Case Management team, referring Enrollees who may benefit from Case Management services.
    - LHCC Enrollee Services - Enrollee Services staff is also oriented in all departments within the LHCC and have a basic understanding of all staff functions, including the role and function of the Case Management team.
    - Other referral sources, such as:
        - Provider Specialists / Provider Consultants
        - Enrollee Services staff
        - LHCC Advocates

    - Quality Improvement (QI)I Department
    - Affiliated vendors
- Enrollees and/or their families or caregivers, including parent, foster parent, guardian, or medical consenter - Enrollees are educated about Case Management services in the Enrollee Handbook received upon enrollment and available on the LHCC's website, and through contact with Enrollee Services and/or other LHCC staff.
- Community/social service agencies – community agency staff are informed of the Care Management Program during interactions with the LHCC Case Management team while gathering information about available services, coordinating services, etc., and are encouraged to communicate potential Case Management needs to LHCC staff.
- Delegated entity staff (e.g., behavioral health, vision, dental, Durable Medical Equipment (DME)/home health, etc.) – all delegates have policies and procedures in place addressing coordination of care and referring appropriate Enrollees for Case Management. LHCC also regularly communicates with delegates through oversight meetings, Case Management rounds, coordination of care programs, etc., and makes referrals to the delegated entities as needed.
- State agency/state enrollment center including – BHSF, OBH, OAAS, OCDD, OPH, and DCFS. (Model Contract 2.7.4.1.3)

The specific means, by which an Enrollee was identified as a potential candidate for Case Management, whether a data source or other referral source as noted above, is documented in the clinical documentation system for each referral to Case Management. Multiple referral avenues help to minimize the time between need for and initiation of Case Management services. Summary results of the number of Enrollees referred by each source are analyzed on at least an annual basis, to assure referrals are being received from a variety of sources.

LHCC will offer Case Management to all Enrollees with Special Healthcare Needs (SHCN) regardless of information gathered through the comprehensive assessment or the HNA. (Model Contract 2.7.7.3) The Care Management program has mechanisms in place to identify individuals with special health care needs, including:

- Enrollees who have complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments.
- Enrollees at high risk for admission/readmission to a hospital within the next six (6) months.
- Enrollees who are at high risk of institutionalization.
- Enrollees who have been diagnosed with a Serious Emotional Disturbance, a Severe and Persistent Mental Illness, or a Substance Use Disorder, or otherwise have significant behavioral health needs, including those Enrollees presenting to the hospital or emergency department with a suicide attempt or non-fatal opioid, stimulants, and sedative/hypnotic drug overdose reason.

- Enrollees who are homeless as defined in Section 330(h)(5)(A) of the Public Health Service Act and codified by the US Department of Health and Human Services in 42 U.S.C. §254(b).
- Enrollees who are women with high-risk pregnancies (i.e., pregnancies that have one or more risk factors) or who have had an adverse pregnancy outcome during the pregnancy, including preterm birth of less than thirty-seven (37) weeks.
- Enrollees who have been recently incarcerated and are transitioning out of custody and are at high risk of inpatient admission or emergency department visits, including certain Enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting.
- Enrollees who are included in the Department of Justice (DOJ) Agreement Target Population
- Enrollees who are enrolled under the Act 421 Children's Medicaid Option or receive care from other State agency programs, including, but not limited to, programs through OJJ, DCFS, or OPH.
- Children enrolled under the Act 421 Children's Medicaid Option (CMO), effective July 1, 2021

Initial Screening and Health Needs Assessment (HNA)

Enrollee outreach is initiated telephonically at the earliest possible opportunity, but in all cases within 30 days of identification as potential candidates for Case Management. The initial tier documented in the case summary is based off of predictive model risk, Health Needs Assessment (HNA), comprehensive assessment, and supplemental tools including our SDOH mini-screening tool that captures Physical Health (PH)/ Behavioral Health (BH), and social needs as identified by the enrollee (RFP 2.6.15.1).

Once the enrollee has been successfully contacted, applicable screenings, such as Health Needs Assessment (HNA), are completed to assess the enrollee's needs. Members who are unable to be reached by days 80-90 post identification date will be closed as "unable to contact". [CG25][PL26]

The HNA is completed to help further identify clinical history, behavioral health needs, social determinants of health and/or needs that may not be available through claims data and predictive modeling. Based on the findings from the screening(s), the enrollee is warm transferred to a Care Manager, if available. If Care Manager is not available to receive the warm transfer, a task is submitted to the appropriate team queue for staff assignment. All enrollees identified for case management are offered case management services, regardless of the information gathered through the HNA or a comprehensive assessment (Model Contract 2.7.3.3).

Once the appropriate CM staff is assigned to the member, the goal is to complete the comprehensive assessment for at least 90% of the enrollees that they have been able to contact and are willing to engage within the ninety (90)

Calendar Days of being identified for case management (Model Contract 2.7.3.2).
LHCC's CM team attempts to complete a comprehensive assessment within 30 calendar days for all Enrollees identified as having SHCN and for Enrollees that may benefit from case management services (exceeding the 90-calendar day requirement). Comprehensive assessments are tailored to specific populations such as pediatric, adult, and maternal. (RFP 2.6.6.1).

Case Management staff obtain consent to complete the Case Management screening and/or initial assessment once enrollee contact is made (Model Contract 2.7.2.4.3). Case Management staff also explains the Care manager role and function and benefits of the Care Management Program to the enrollee and/or authorized representative or guardian. During this time, the Case Management staff will provide the Enrollee with information on how to contact the Care Manager to assist with coordinating services the Enrollee accesses. The Enrollee or authorized representative's consent is also obtained for LHCC to share information with the Enrollee's provider to promote coordination and integration. (Model Contract 2.7.10.3)

The Care Manager screens Enrollees 5 to under age 21 years of age for appropriate referral for Coordinated Systems of Care (CSoC) services utilizing the standardized assessment. [CG27][PL28]Enrollees who screen appropriately and, with proper consent, are referred ~~to the Statewide Management Organization (SMO).~~CSoC Contractor. [CG29][PL30]

The initial health needs assessment will identify individuals for referral to Case Managements with a more in-dept assessment to occur as part of the POC. It will screen for needs relevant to priority social determinants of health and include disclosures on how the information will be used. (Model Contract 2.7.2.4.4-2.7.2.6)

As part of the initial screenings/assessments, LHCC staff conduct a Tobacco and Gaming screening and document the results to the questions within the documentation system. Those who screen positive are encouraged to quit and offered information regarding treatment services and/or referral to care, such as the Louisiana Tobacco Quitline and/or other treatment modalities. The data is tracked and reported to LDH upon request using a designated template provided by LDH. (Model Contract 2.7.11.1-2.7.11.2)

General standardized assessments have been developed internally to address the specific issues of LHCC's unique populations. Standardized assessments allow for consistency in application of criteria and objective appraisal of appropriateness of Enrollees for Case Management. All assessments are documented in the central clinical documentation system which date/time

stamps each activity, including documentation of the staff enrollee completing the activity. All CM staff are provided training upon hire and as needed regarding CM assessments and screenings, which include identification and screening of behavioral health conditions and referral procedures.

Enrollees and/or their authorized representative or guardian are always asked if they are willing to participate in the Care Management Program and are informed, they are entitled to decline participation in or dis-enroll from Case Management at any time, if allowed per state regulations. Case Management staff explains the Care Manager role and function and benefits of the Care Management Program to the enrollee and/or their authorized representative or guardian. The enrollee/guardian is notified of the potential need for the Case Management team to contact outside sources (providers, significant others, community organizations, etc.) to gather additional information and is informed that enrollee consent is always obtained prior to any contact. Documentation of verbal enrollee consent to participate in the Care Management Program is included in the general assessment questions and/or is documented in the clinical documentation system. If an enrollee declines participation, it is also documented.

Enrollees unable to be contacted via telephone are mailed a letter requesting that the Enrollee call the Case Management team. ~~CHSRs~~ CRCs may also be utilized, when necessary, to assist in outreach for Enrollees who are difficult to contact. ~~CHSRs~~ CRCs go the Enrollee's physical address and attempt to initiate contact. Outreach may also be made to local community agencies and provider offices to locate an Enrollee. If a CRC~~CHSR~~ is successful in locating the Enrollee, they may perform a general screening in person, including observation of the Enrollee in their home surroundings, and identify any potential needs such as safety issues, mobility assistance, living conditions, etc.

Generally, candidates identified as stable regarding any medical condition[CG31][PL32], and with primarily psychosocial needs are assigned to Care Coordination. Enrollees with chronic or complex medical conditions or meet the criteria for Case Management or Complex Case Management based on the referral, are assigned to a Care Manager —who confirms the findings of the screening assessment and will complete a more thorough assessment with the Enrollee. If the acuity of the Enrollee cannot be determined based on the referral, a non-clinical Case Management team enrollee conducts outreach to assess the Enrollee's medical, behavioral, and social needs. Once a referral is received, a Care Manager reviews all available information, including pertinent past and present medical history gathered from the screening assessment, referral source, and/or reports. Care Managers also access pharmacy and claims data if available that provide information regarding pharmacy utilization and treatment

adherence. This review allows the Care Manager to identify specific areas of focus for the Enrollee based on their diagnosis and/or medical treatment history.

The Care Manager then attempts outreach to the Enrollee and/or authorized representative or guardian telephonically to perform an in-depth assessment to identify and prioritize the Enrollee's individual needs more closely. An additional, condition-specific assessment may also be completed, to obtain even more detailed information about an Enrollee's condition(s). These condition-specific assessments, such as Sickle Cell and Depression, are derived from evidence-based clinical guidelines. During the in-depth Case Management assessment, the Care Manager evaluates the full scope of the Enrollee's situation, including:

- The Enrollee's health status, including condition–specific issues and likely co-morbidities
- Documentation of the Enrollee's clinical history, including disease onset, key events such as acute phases and inpatient stays, treatment history, current and past medications, and compliance with current and past therapies and monitoring
- Assessment of activities and instrumental activities of daily living (ADLS) to at least six basic ADLS (–bathing, dressing, toileting, transferring, feeding and continence).
- Assessment of barriers to meeting goals, for example social barriers to treatment adherence such as transportation, childcare needs, etc.
- Assessment of behavioral health status (e.g., presence of depression and/or anxiety) and cognitive functioning
- Assessment of social determinants of health such as food, housing, safety, transportation, and other significant life stressors.
- Assessment of life planning activities such as living wills, advance directives, etc.
- Evaluation of cultural and linguistic needs, preferences, or limitations
- Evaluation of visual and hearing needs, preferences, or limitations
- Evaluation of caregiver resources and potential involvement in care plan implementation
- Assessment of personal resources and limitations
- Evaluation of available benefits, community resources and other financial resources
- Assessment of educational and vocational factors

Care Managers also frequently reach out to the referral source, the Enrollee's PCP, other providers, hospital Care Managers, and any others involved in the Enrollee's care, to gather additional information that can assist in building a complete picture of the Enrollee's abilities and needs. The role and function of the Care Manager is also explained to the Enrollee's family, providers, or other involved parties. Enrollee consent is always obtained prior to any contact with outside sources and is documented in the clinical documentation system.

The Case Management team reviews the gathered information and begins to build a Case Management plan of care. The Case Management team initiates the initial assessment within 90 days of identifying the Enrollee for case management. The Plan of Care is due within 30 days of completion of assessment for Tier 2 & Tier 3, and 90 days for Tier 1 following completion of the assessment. Case Management teams may include Care Managers, ~~Program Coordinators,~~Care Navigators, Care Management Support Coordinators, Social Workers, Behavioral Health Care Managers, and ~~CHSRs.~~CRCs. ~~—~~Each contributes different skills and functions to the management of the Enrollee's case. Other key participants in the development of the care plan may include (Model Contract 2.7.9.3-2.7.9.3.8:

- Enrollee
- Enrollee authorized representative or guardian
- PCP and specialty providers
- LHCC Medical Directors
- Pharmacists
- Home and Community Based providers and managers
- Housing Specialists if enrollee is identified as homeless
- State staff including transition coordinators
- Hospital discharge planners
- Ancillary providers (e.g., home health, physical therapy, occupational therapy)
- Behavioral health providers
- Representatives from community social service, civic, and religious based organizations (e.g., United Cerebral Palsy, food banks, WIC programs, local church groups that may provide food, transportation, companionship, etc.)
- Other non-health care entities (e.g., Meals on Wheels, home construction companies, etc.)

Multidisciplinary Teams shall meet at regular intervals as identified in the POC, based on the individual's care needs. When possible, the team shall meet in person but, when necessary, team members may participate in meetings via telephone. At a minimum, multi-disciplinary care teams shall meet monthly for Enrollees in Tier 3 Case Management and on a quarterly basis for Enrollees in Tier 2 Case Management. (Model Contract 2.7.9.4)

After completing the assessment of the Enrollee, as low (Tier 1), medium (Tier 2), or high (Tier 3) priority is determined in terms of frequency of contact and intensity of interventions, and assignment to Care Coordination, Case Management, or Complex Case Management/Intensive Case Management.

Emergency Preparedness

LHCC staff will provide hurricane preparedness and evacuation planning information to all Enrollees. Staff will also discuss the importance of completing the "Get a Game Plan" EDP (Emergency Disaster Plan). During phone interactions with Enrollees the staff will encourage Enrollees to complete an Emergency Preparedness Survey (EPS). This information will be filed in the Enrollee's records for future use.

Continuity and Coordination of Care between Medical and Behavioral Healthcare

When the Case Management staff identifies an enrollee with coexisting medical and behavioral health disorders, behavioral and physical health (or medical) Care Managers will work in collaboration to develop an integrated care plan for the enrollee. If the Enrollee's primary identified need is a behavioral health condition, the case is referred to a Behavioral Health Care Manager who serves as the case lead, working in tandem with the medical Case Management team. (Model Contract 2.7.10.4)

The lead Care Manager reviews the Enrollee's clinical information to assure the patient is receiving appropriate behavioral health care. If the patient does not appear to be receiving this care, the Care Manager:

- Contacts the medical provider to ask about a behavioral health consult
- Assists the enrollee, or coordinates with the behavioral health Care Manager, to decide for the behavioral health consult
- Follows up to make sure a behavioral health consult was conducted

When appropriate (including but not limited to when the lead Care Manager is revising the plan of care or evaluating an enrollee for discharge from Case Management), the medical and behavioral Care Managers confer with each other to ensure that the necessary expertise is available to monitor and guide Enrollees' care. The primary Care Manager is responsible for ensuring the appropriate behavioral health or physical health Case Management follow up is implemented.

Outreach may also occur to treating providers and individual practitioners when appropriate. The Care Manager assures proper enrollee consent, specific to information pertaining to behavioral health treatment, is obtained prior to any communication regarding the enrollee.

Ongoing Management

Care Plan Development

The initial assessment serves as the foundation for the Enrollee's Case Management care plan. The care management team collaborates with Enrollees, caregivers, treating providers, etc. to initiate a person-centered integrated plan

of care that address Enrollees' specific needs, preferences, and goals. The POC shall be based on the principles of self-determination and recovery and shall include all medically necessary services identified by the Enrollee's providers as well as the care coordination and other supports to be provided by LHCC. (Model Contract 2.7.8.3) Behavioral Healthcare coordination is incorporated in the care plan as needed. Prioritized goals are established and barriers to meeting short- and long-term goals or complying with the plan of care are identified, as well as possible solutions to the barriers. The proposed care plan is based on medical necessity, appropriateness of the discharge plan for seamless transition as applicable, support systems to assist the patient in the home setting, community resources/services availability, and the potential for Enrollee adherence to the prescribed care plan.

In addition to the person-centered integrated plan of care, an individual treatment plan is developed by the Enrollee's primary care provider and/ or other lead provider as appropriate, with enrollee participation, and in consultation with any specialists caring for the enrollee. For SHCN Enrollee's, the treatment plan shall be submitted to the Enrollee's MCO no later than 30 days following the completion of the initial assessment or annual reassessment. The treatment plan must also follow applicable quality assurance and utilization management standards. The person-centered integrated plan of care, developed by the Care Manager, will be completed within (30) calendar days of the provider treatment plan development that includes all medically necessary services including specialized behavioral health services and primary care services identified in the Enrollee's treatment plans.

Development of the care plan is person-centered led by the Care Manager with significant input from the member as well as another multi-disciplinary team. For members with physical and behavioral needs, a Physical Health Care Manager and Behavioral Care Manager will collaborate regarding the plan of care and the Care Manager's actions. Assignment of Primary Care Manager is based on the member's primary needs. Additional multi-disciplinary care team members are included in the plan of care based on the Enrollee's specific care needs.

LHCC will develop a comprehensive individualized, person-centered POC for all Enrollees who are found eligible for Case Management according to the following:

- When an Enrollee receives services requiring a POC from LDH, such as Home and Community Based Waiver services or services through OPH, LHCC will collaborate with LDH or its designee in developing the POC. (Model Contract 2.7.8.1)
- ~~When an Enrollee receives services from the LHCC only for SBHS, the POC shall focus on coordination and integration, as appropriate~~[CG33][PL34]~~.~~

- -When an Enrollee receives services requiring a POC from LDH, such as Home and Community Based Waiver services or services through OPH, LHCC will collaborate with LDH or its designee in developing the POC. (Model Contract 2.7.8.1)
- When an Enrollee receives services only for Specialized Behavioral Health Services, the POC will focus on coordination and integration, as appropriate. When the Enrollee receives Specialized Behavioral Health Services and has treatment plans developed through their behavioral health providers, LHCC shall work with the Enrollee's behavioral health providers to incorporate the treatment plans into the Enrollee's overall plan of care and to support the enrollee and the provider in their efforts to implement the treatment plan. (Model Contract 2.7.8.2)
- For Enrollees with special healthcare needs, LHCC's Care Management Teams will meet with the Enrollee, and/or their chosen support (as requested), to discuss and revise the Plan of Care, addressing any changes in services or providers (RFP 2.6.8.2.8)

The proposed plan of care is discussed with the Enrollee and/or Enrollee authorized representative or guardian, the PCP, and the health care team. The Enrollee's role is discussed and enrollee/caretaker and provider input is obtained and used to modify the goals according to Enrollee's/Enrollee's caregiver's ability and willingness to participate. The Care Manager assures all parties agree with the care plan to ensure successful implementation.

Enrollees assigned to Care Coordination, or Enrollees identified as moderate/medium priority assigned to Case Management have an abbreviated care plan. The care plan for Enrollees in complex Case Management includes, at a minimum:

- Prioritized goals – goals are specific, realistic, and measurable. Goals are designed to be achievable and to help the Enrollee make changes towards the most optimal recovery possible based on their strengths and weaknesses
- Reflect cultural, language, and disability considerations of enrollee
- Identification of barriers to meeting the goals and recommended solutions for each barrier
- Facilitation of Enrollee referrals to resources and follow-up process to determine whether Enrollees act on referrals to community resources (Model Contract 2.7.10.8)
- Offering Enrollee freedom of choice in finding new providers and/or obtaining services
- Interventions to reach those goals, including development of Enrollee self-management plans. The Care Manager assures the enrollee has a full understanding of their responsibilities per the self-management plan.
- Planning for continuity of care
- Collaboration with and involvement of family and significant others, health care providers, interdisciplinary team, etc.

- The schedule for on-going communication with the Enrollee and other involved parties, based on individual needs and Enrollee preference
- Time limits – providing points in time for which successful outcomes can be determined, and agreement with the Enrollee/guardian on how progress will be demonstrated
- For Enrollees with behavioral health related disorders and may experience crisis, a plan for addressing crisis, including resources and contact information, to prevent unnecessary hospitalizations or institutionalization

The care plan, which includes condition-specific goals and interventions, is derived from evidence-based goals and interventions outlined in condition-specific clinical guidelines such as for diabetes, Sickle Cell Management, or ADHD, and nursing-based guidelines for issues such as skin integrity, mobility, safety, etc.

Monitoring and Evaluation

Once the Enrollee's plan of care is agreed upon, the agreement is documented in the clinical documentation system and timelines are put into place to evaluate and monitor the effectiveness of LHCC. Revisions to the care plan are made, when necessary, e.g., when the Enrollee's condition progresses or regresses, when goals are reached, etc. Significant revisions to the plan of care are also shared with the PCP. A schedule for follow up and monitoring of the Enrollee's progress is developed, using as a minimum the intervals defined according to acuity level and current needs. Case Management will provide activities in a variety of settings, including, but not limited to an Enrollee's home, shelter, or other care setting. (Model Contract 2.7.10.7) The Care Manager may consult with other members of the Integrated Care team, such as a ~~Program Specialist~~Care Navigator ~~or Care Coordinator~~ to manage or assist with psychosocial issues or a ~~Program Coordinator~~Care Management Support Coordinator to assist with coordination of non-clinical functions such as verifying appointments, obtaining lab results, etc.

The clinical documentation system allows for automatic reminders/tasks to be created for each case, alerting the Case Management team when follow-up contacts are needed. Follow-up reminders can be set for daily, weekly, monthly, etc. contacts. Intervals for follow-up are based on the goals and timelines in the Case Management care plan.

The Care Manager is responsible for oversight to ensure all information is documented by the appropriate team member and is updated after each contact with the enrollee, providers', or other involved parties. The information documented in the clinical documentation system includes, but is not limited to:

- Enrollee or caretaker agreement to participate in Case Management (agreement may be oral or written; if oral, the Care Manager documents the discussion with the enrollee/caretaker)

- Notes, including a summary of team conferences and all communications with the enrollee/family, Healthcare providers and any other parties pertaining to the Enrollee's case
- Provider treatment plan developed by the PCP in collaboration with the enrollee/caretaker outlining the course of treatment and/or regular care monitoring, if available
- The Case Management care plan, including:
    - Prioritized goals (both long term and short-term treatment objectives), barriers to meeting the goals and/or adhering to the care plan and interventions for meeting the Enrollee's goals and overcoming barriers
    - Schedule for follow-up and communication with the enrollee, Enrollee's family, providers, etc.
    - LHCC to follow-up with the enrollee/caretaker to determine whether Enrollee has acted on referrals made by the care team
    - The Enrollee's self-management plan
    - Progress toward meeting the goals outlined in the care plan, changes to the care plan, goals attained, etc. as described below

The Care Manager regularly evaluates the Enrollee's progress considering the following factors:

- Change in the Enrollee's medical status or behavioral health status
- Change in the Enrollee's social stability
- Change in the Enrollee's physical or behavioral functional capability and mobility
- Progress made in reaching the defined goals
- The Enrollee's adherence to the established Case Management care plan, including adherence to the self-management plan such as monitoring of weight, activity level, glucose levels follow up behavioral health appointments etc.
- Changes in the Enrollee or family's satisfaction with Case Management services and other services addressed in the care plan
- The Enrollee's quality of life
- Benefit limits and financial liability

The individualized treatment plan is reviewed and revised upon reassessment of functional need. The POC revisions will occur at least at the frequency required in the Tiered Case Management requirements or when the Enrollee's circumstances or needs change significantly (new problem, goal, barrier, or acuity change), or at the request of the enrollee, parent or legal guardian, or a member of the multi-disciplinary team. (Model Contract 2.7.8.4) LHCC's plan of care is also updated at these times and shared with the PCP, as applicable.

The Care Manager implements necessary changes to the Case Management care plan and modifies the goals based on the findings of on-going evaluation. The Care Manager contacts the PCP, appropriate specialists, or other Enrollees of the healthcare team, as needed to discuss modifications, and obtain an updated

medical or behavioral treatment plan. (Model Contract 2.7.10.11) The Care Manager shall also provide the Health Needs Assessment data to the Enrollees PCP, or LDH as requested. (Model Contract 2.7.2.3) The Case Management team also maintains the care plan along with necessary referral services when the Enrollee changes PCP/behavioral health provider. The Case Management team considers alternatives in healthcare delivery settings and available funding options during the process and communicates the alternatives to the providers and the enrollee/family. Any changes in status, goals, or outcomes are documented in the clinical documentation system. As with the initial development of the care plan, the Care Manager assures all involved agree with changes the care plan to ensure ongoing success. The Case Management team also monitors the case on an ongoing basis for quality indicators and, if present, makes the appropriate referral to the Quality Improvement department.

Discharge from Case Management

The Care Manager may receive input from the PCP, enrollee/family/guardian/caretaker, and other health care providers involved in the Enrollee's plan of care to determine the appropriateness for closing the case. The following criteria are used on an ongoing basis to determine when discharge from Case Management should occur (Model Contract 2.7.10.9):

- Enrollee terminates with LHCC
- 60 days of unsuccessful outreach[CG35][PL36]
- Enrollee/family requests to dis-enroll from Case Management
- The Enrollee/family refuses to participate in Case Management despite efforts to explain how it can benefit the Enrollee
- LHCC is unable to reach Enrollee despite at least three (3) different types of attempts (phone attempts at different times during day, visit to home, letter submission with address correction request, and/or contacting PCP/WIC/Specialists/Programs) to locate and engage the Enrollee [CG37][PL38]
- The Enrollee reaches maximum medical or behavioral improvement once their established goals are completed. ~~[CG39]~~[PL40]~~or reaches established goals regarding improvement or medical/behavioral stability (which may include preventing further decline in condition when improvement is not medically possible) and is directed to community resources~~
- Insurance benefits are exhausted and community resources are in place[CG41][PL42]
- Enrollee expires

If the above criteria indicate a case should be closed, the Care Manager, as appropriate:

- Coordinates care with the new medical or behavioral entity and community resources as required, allowing for a smooth transition for the Enrollee
- If Case Management has been refused by the Enrollee/family, the Care Manager provides the enrollee with contact information for future reference and documents the refusal in the clinical documentation system
- Contacts the PCP and other providers, when appropriate, regarding impending discharge from Case Management

- Discusses the impending discharge from Case Management with the Enrollee/family
- Presents community resources and assists in deciding with those relevant at the time of discharge

A letter noting the Enrollee has discharged from Case Management is generated and sent to the PCP and the Enrollee. The letter documents the reason for discharge and includes, if the Enrollee has not terminated with LHCC, a reminder to contact the care team in the future should medical or behavioral concerns arise. The case is closed in the clinical documentation system and the circumstances and discharge activities are thoroughly documented.

Exhaustion of Benefits:

LHCC assists enrollees with accessing alternatives for continuing care if an enrollee's covered benefits are exhausted or the enrollee has met a benefit limitation and care is still needed.

1. The enrollee's provider makes a request to LHCC for continued services, and it is identified that the benefit coverage has ended, and the enrollee is still in need of the medically necessary care. Examples may include:
2. If enrollee is not in Care Management, the enrollee is referred for outreach and assessment of transition needs.
3. Alternative resources are discussed with the enrollee or enrollee's authorized representative if needed.
4. At least three telephonic outreach attempts are made to contact the enrollee. If the enrollee cannot be reached, an unable to reach letter is sent including a contact number to reach Care Management Department.
5. All attempts and discussions are documented in the enrollee's clinical documentation system record.

Program Assessment and Impact Measurement

Population Assessment

At least annually, LHCC will assess the entire Enrollee population and any relevant subpopulations (e.g., Foster Care, Chisholm, Home Community Based Services (HCBS), etc.) to determine if the Care Management Program meets the needs of all Enrollees eligible for Case Management. Data utilized for assessment of the entire Enrollee population includes information provided by CMS and/or the state agency and includes information such as age (especially children/adolescents and elderly), gender, ethnicity, race, and/or primary language, and benefit category. Other data used includes diagnostic and utilization data (e.g., overall claims received, inpatient admissions and ER visits, and pharmacy data). The population assessment will specifically address the needs of children and adolescents, individuals with disabilities, and Enrollees with serious and persistent mental illness (SPMI).

Results of the population assessment are analyzed, and subsequent enhancements made to the Care Management Program if opportunities for improvement or gaps in Case Management services are identified. Potential revisions to the Care Management Program may include:

- Changes related to number of staff or staffing ratios, reduction in caseloads, etc.
- Revisions to types of Case Management activities assigned to specific Enrollees of the Case Management team (e.g., clinical versus non-clinical staff responsibilities)
- Implementation of targeted training, (e.g., related to cultural competency, specific medical or behavioral health conditions, cross-training for medical and behavioral health staff)
- Improvement in identification of appropriate community resources provided to Enrollees and process for assisting Enrollees in accessing resources
- Identifying regionalized geographic trends to target specific Care Management programs

The annual population assessment may be a separate document or included as part of an annual Case Management and/or Quality Improvement program evaluation and will be presented to appropriate committees, such as the Quality Assessment and Performance Improvement Committee (QAPIC), for review and feedback.

Enrollee Experience with Case Management

Enrollee satisfaction with Case Management is assessed no less than annually. Enrollee satisfaction surveys, specific to Case Management services, are completed at least annually for Enrollees enrolled in Case Management. On a monthly basis, Enrollees who had been enrolled in Case Management for ≥ 45 days and successfully completed the Care Management Program in the prior month, as well as a random sample of Enrollees who are currently enrolled for ≥ 45 days, are outreached telephonically to survey their assessment of the program. The results of the surveys are aggregated and evaluated and are included in the overall evaluation of the Care Management Program, which may be part of the annual Quality Improvement and/or Care Management program evaluation as described below.

Enrollee complaints and grievances regarding the Care Management Program are also monitored no less than quarterly. Results of the analysis of enrollee satisfaction surveys and the monitoring of complaints/grievances are used to identify opportunities for improvement, set priorities and determine which opportunities to pursue regarding changes to the Care Management Program, as needed.

Outcomes

Louisiana Healthcare Connections measures effectiveness of Case Management no less than annually using at least three measures that assess the process or

outcomes of care for Enrollees in Case Management. Additional details regarding these measures are identified in the QI work plan. Measures of effectiveness may include indicators such as:

- Repeat ED visits for Enrollees in Case Management
- Rate of Enrollees at risk of pre-term birth receiving 17-P
- Incidence of Neonatal abstinence syndrome (NAS) ~~NAS~~ diagnosis for newborns of mothers enrolled in Perinatal Substance Use Disorder Program
- Post Discharge Outreach to prevent readmissions

Measurement and analysis of the Care Management Program is documented as part of the annual Quality Improvement and/or Care Management Program Evaluation. Valid quantitative methods are used to measure outcomes against performance goals. (Model Contract 2.7.10.6.6) The Care Management Program is evaluated at least annually and modifications to the program are made as necessary. LHCC evaluates the impact of the Care Management Program by using:

- Results of the population assessment.
- Expected outcomes in subgroups.
- The results of enrollee satisfaction surveys (i.e., Enrollees in Case Management.
- Enrollee complaint, grievance, and inquiry data regarding the Care Management Program.
- Practitioner complaints and practitioner satisfaction surveys regarding the Care Management Program.
- Other relevant data as described above.

The evaluation covers all aspects of the Care Management Program. Problems and/or concerns are identified, recommendations for removing barriers to improvement are provided, and opportunities to improve satisfaction are identified. Based on the results of the measurement and analysis of the Care Management program effectiveness and satisfaction, at least one intervention will be implemented to improve clinical performance and one intervention to improve enrollee satisfaction after the first annual evaluation. The evaluation and recommendations are submitted to the PHCO Committee for review, action, and follow-up. The final document is then submitted to the Board of Directors/governing body through the Quality Improvement Committee for approval.

Population Management

LHCC's Care Management Programs focused on specific enrollee populations may include, but are not limited to:

- **Adolescence to Adulthood, "a to A" Program**
  This program is designed to help Foster Care Enrollees acquire skills to self-manage their healthcare and transition to independent living. Case

Management staff assist youth to take ownership of their health through education and coaching in collaboration with DCFS staff. (RFP 2.6.6.3)

- **Crisis Program**
  Louisiana Healthcare Connections Behavioral Crisis Program aims to intervene, support, and resolve the crisis experienced by Enrollees and to connect Enrollees to post-crisis care. Louisiana Healthcare Connections will also be responsible for facilitating or participating in state/local crisis system of care collaboratives/workgroups with a focus on care coordination, review of performance data, assessment and remediation of gaps and needs, and other crisis system improvement strategies. The program will collaborate and use innovative ways to communicate with partner systems including healthcare systems, judicial systems, law enforcement, child protective services, educational systems, homeless coalitions, as well as any other system that touches individuals who may experience a behavioral health crisis.
- **Transition of Care Program (TOC)**
  LHCC's TOC program will coordinate care for Enrollees moving from one care setting to another while ensuring continued quality of care, reducing any potential risk to enrollee safety, and facilitating a controlled plan so that the enrollee receives care in the least restrictive care setting. Transitions from one care setting to another involve both planned and unplanned transitions. Our team-based transitions program emphasizes prevention, continuity of care, coordination, and integration of PH and BH, incorporating the Coleman principles that have been shown to reduce avoidable readmissions. Some of the core focuses of this program are:
  - Educating the Enrollee on medication self-management,
  - Establishing a Primary Care Provider and Specialist follow-ups as needed.
  - Educating the Enrollee of "red flag" indicators of worsening condition and appropriate next steps when applicable.
- **Perinatal/NICU Management Program**
  LHCC's Start Smart for Baby® pregnancy management program emphasizes early identification and stratification of pregnant Enrollees, and education and Case Management interventions to improve birth outcomes for all pregnant Enrollees. The program includes:
  - Early identification of pregnancy
  - Risk screening and stratification to determine appropriate interventions
  - Enrollee outreach and education
  - Enrollee incentives for accessing prenatal and post-partum care
  - A Progesterone injection program that may include home visits
  - Specialized management of pregnant Enrollees with depression or substance use disorder
  - NICU management and follow up
  - Provider education and incentives for improving birth outcomes and access to appropriate prenatal and post-partum care

It also includes high risk OB management for reproductive age women with a history of poor birth outcomes and those with high-risk pregnancies. Start Smart staff assist Enrollees, in person, when necessary, to gain access to prenatal care, provide education on healthcare needs, assist with social needs and concerns, and coordinate referrals to appropriate specialists and non-covered services, such as specialty BH services and dental services, and community resources. The program extends through the postpartum period to improve maternal outcomes and prevent risk in subsequent pregnancies and extends through the first year of life for LHCC-enrolled babies.

- **Emergency Department (ED) Diversion Program**
  The goal of our ED Diversion Program is to decrease inappropriate ED utilization through the redirection of Enrollees to appropriate levels of care, including referral to community behavioral health specialists for behavioral health emergencies. A specialized Integrated Care Team, consisting of experienced Care Managers, Social Workers, and Behavioral Health Care Managers, focuses on access to care issues and resource education. Interventions include linking the enrollee to a PCP, educating them about and helping them to access transportation, and providing education on the importance of getting the right care, at the right time, in the right setting. CRCs~~CHSRs~~ provide in-person visits and education for Enrollees who need intensive assistance. We also provide education and incentives to providers, such as incentives for serving as a Patient Centered Medical Home.
- ~~**REDI TEAM**~~
  ~~In addition to our ED Diversion efforts, starting in 2022, our regionally based Rapid ED Intervention Team (REDI), comprised of CHWs and clinicians, can be deployed to the hospital to meet with Enrollees to help them follow up with post-ED instruction, connect them to primary care resources, address SDOH gaps, and offer ED alternatives in their area. (RFP 2.6.4.2) Transplant Management~~
  ~~Designated Case Management staff coordinates care and assist with access to transplant centers of excellence for Enrollees who need transplants through LHCC's specialized Transplant Program. Program staff work closely with appropriate providers to obtain necessary clinical information and required lab work to facilitate timely evaluation of transplant candidates, assist in processing prior authorization (PA) requests for transplant services, assist Enrollees in coordinating needed care and transportation and lodging for out-of-town evaluations or procedures, and follow Enrollees for up to 12 months post transplant.~~
- **Palliative Care Program**
  This program serves Enrollees with cancer and other advanced chronic and debilitating illnesses with indicators of persistent challenges with pain and symptom management, as identified by such factors as pharmacy and ED use. Care Managers will make referrals for and incorporate hospice services into the care plan, as indicated.
- **Pharmacy Lock-In Program**
  LHCC's Pharmacy Lock-In Program uses LDH approved policies and procedures to ensure appropriate use of Medicaid benefits and serve as an

educational and monitoring parameter. Pharmacy staff will monitor claims data to identify signs of a consistent pattern of misuse or overuse.

- **HCBS Waiver Opt-In**
  The Home and Community Based Services (HCBS) Waiver Program identifies all Enrollees receiving HCBS services monthly to perform outreach and aid all HCBS Enrollees to understand new benefits provided by Healthy Louisiana within 90 days of identification. The LHCC Case Management department will work collaboratively with the Enrollee, family, and waiver service providers to ensure continuity of care.
- **Chisholm**
  The Chisholm population is a result of a class action lawsuit filed by the Advocacy Center in 1997 to make the Louisiana Department of Health (LDH) live up to its obligation to arrange for necessary services under regular Medicaid to children on the "New Opportunities Waiver" waiting list. In April 2015, Louisiana Managed Care Organizations (MCO) were designated by State authorities to ensure that Enrollees who fall in the Chisholm population receive appropriate services to accommodate their most fragile Enrollees with chronic conditions. All Chisholm class Enrollees are under the age of 21. Identification and outreach are completed to assist enrollee with Medicaid services to which they are entitled. The program staff also collaborates with the Enrollee's Support Coordinator, Care Manager (BH) or provider of services on the plan of care for the enrollee. This includes, but not limited to, providing education regarding healthcare benefits, and assisting to ensure the health and safety of the enrollee.
- **Early and Periodic Screening Diagnosis and Treatment (EPSDT) Extended Home Health (EHH) and IN Waiver Enrollees**
  The Early and Periodic Screening Diagnosis and Treatment (EPSDT) Waiver Enrollees receiving Extended Home Health (EHH) and Intermittent Nursing (IN) must be monitored to ensure they are receiving all hours of authorized services whenever possible. This is a result of a class action lawsuit and corresponding settlement agreement approved by the court on March 31, 2020. The Class Enrollees in AJ v. LDH are defined as follows: All current and future Medicaid recipients under the age of twenty-one (21) in Louisiana who are certified in the Children's Choice Waiver, the New Opportunities Waiver, the Supports Waiver, or the Residential Options Waiver who are also prior authorized to receive EHH or IN services. In coordination with Louisiana Medicaid's Crisis Response Team (CRT), LHCC's Transition of Care team will initiate notification for any class Enrollee who has received less than 90% of his or her prior approved EHH or IN services for at least two (2) consecutive weeks and will work to ensure services are in place at the existing or alternate level of care to ensure the Enrollee is not at serious risk of institutionalization due to lack of EHH or IN services.
- **Act 421 Children's Medicaid Option (CMO)**
  Enrollees who qualify for the Act 421 Children's Medicaid Option are those individuals who are 18 years or younger with a disability 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, even if their parents earn too much to qualify for Medicaid. Effective July 1, 2021, this population will be treated as a Special Health Care Needs population and will be offered Case Management services outlined in this policy to assist with their physical, behavioral, or psychosocial needs.

- **Preadmission Screening and Resident Review (PASRR) and PASRR Transition**
  The PASRR program uses Licensed Clinicians to provide education, assessments, and linkage to resources to LHCC Enrollees applying for nursing home placement. LHCC Enrollees who have applied for admission to a nursing facility (NF) must be "screened" for evidence of serious mental illness (MI) and/or intellectual disabilities (ID), developmental disabilities (DD), or related conditions. The purpose of PASRR is to ensure that all NF applicants are thoroughly evaluated, that they are placed in nursing facilities *only* when appropriate. The PASRR process consists of the Level I Am screening, Level II MI Evaluation, and Determination. The goal is to provide support and resources for Enrollees who are going into a nursing home and to ensure successful transition from nursing home into the community with social supports.
- **Department of Justice (DOJ) Population**
  The DOJ target population includes:
  - Medicaid-eligible individuals over 18 with SMI currently residing in a nursing facility and those individuals who have transitioned from a nursing facility and are referred for case management by a My Choice Louisiana Transition coordinator.
  - Individuals over age 18 with Serious Mental Illness (SMI) who are referred for Pre-Admission Screening and Resident Review (PASRR) Level ii evaluation of nursing facility placement during the course of this Agreement or have been referred within two years prior to the effective date of this Agreement and were diverted from nursing facility placement.
  - Excludes those individuals with co-occurring SMI and dementia where dementia is the primary diagnosis. See LA.CM.32 policy for more information regarding the DOJ Target Population and the Community Case Management Program.
  - Enrollees within the DOJ program are also identified as "DOJ At Risk Population (DOJ AR), which consists of Enrollees meeting the following criteria: Members shall be considered at-risk when the following criteria is met:
    • Member has full benefits with the MCO (P-linkage) and is not residing in a nursing facility; and
    - Member is 18 – 79 years of age; and
    - Member has a qualifying primary mental health condition including F20-24, F25.0, F25.1, F25.8,
    F25.9, F28-33, F41-42, F43.1, F43.10, F43.11, F43.12, F60); and
    • Member has at least two (2) chronic conditions based on the CMS Chronic Condition Warehouse (CCW) Algorithm within a one year look-

back period to include Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease and Bronchiectasis, Diabetes and Heart Disease or Stroke (note: Heart Disease or Stroke is defined as any of the 5 CCW conditions – acute myocardial infarction, atrial fibrillation, heart failure, ischemic heart disease, and/or stroke/transient ischemic attack).
• Member has 6 or more all-cause emergency department and/or inpatient hospitalizations within a 1 year look-back period (an ED visit which results in an inpatient hospitalization should be considered 1 visit as opposed to 2 visits).

Once enrollee is identified as DOJ AR, the Care Management team attempts to engage with the enrollee in case management for at least 80 days using an approved assertive engagement strategy. Each month, LHCC reviews claims and predictive modeling to identify members for the at-risk population. The Care Management team offers assistance with coordinating services and connecting the enrollee to community resources to help manage their healthcare needs and remain in the community. Case management services are provided to the enrollee for a minimum of 6months or longer based on the Enrollee's needs unless the enrollee declines or has loss of engagement from case management for 60 days or more; the enrollee may change tiers of case management if requested by the enrollee.

- **Justice-Involved Pre-Release Program**
  The Justice-Involved Pre-Release Program is a collaborative effort among the Department of Corrections (DOC), Louisiana Department of Health, and Managed Care Organizations to identify high need incarcerated Enrollees prior to release to engage in Care Management. The program involves face-to-face care management via videoconferencing with the enrollee prior to release to improve continuation of healthcare after incarceration. These Enrollees are provided CM services like all other Enrollees, but additional requirements and procedures for this population are provided within the Justice-Involved Pre-Release Enrollment Program Manual.

Condition Specific CM and DM Programs

Enrollees in condition specific care/disease management programs are identified, screened, and managed as documented in the individual programs' policies and procedures. The Case Management policies provide the instructions for identification, referrals, screening and assessment, enrollment, care plan development, implementation, monitoring and evaluation, coordination with behavioral health, and discharge from Case Management when not specifically addressed in the program.

LHCC has developed several focused Chronic Care Management Programs (CCMPs) as per state contract requirements which are designed to manage Enrollees in areas of high utilization and/or who are in greater need for healthcare support and coordination of services. All CCMPs align with the 2020 Care Management Program Description relating to Case Management activities

and initiatives unless otherwise specified within the below noted program summaries.

- **Hemophilia**
  The Hemophilia Program provides Case Management services, either in partnership with our specialty pharmacy affiliate, or by using in-house Case Management and Pharmacy staff. Case Management staff assist Enrollees in navigating the complexities of treatment plans, including condition specific education, assistance with reimbursement issues, home care needs and care coordination.
- **Sickle Cell**
  The program uses Care Managers to provide sickle cell disease education related to inheritance patterns, disease complications, symptoms and treatment, comorbid conditions, and special issues that arise with children and adolescents. Care Managers also promote use of hydroxyurea.
- **Chronic Pain Management**
  LHCC's Pain Management Program addresses multiple types of chronic pain, including but not limited to Enrollees with sickle cell disease and those with four or more ED visits in a 12-month period for a chief complaint of pain. In addition to Exercise Physiologists that currently focus on low back pain, the expanded Pain Management Program will use Health Coaches as well as Care Managers to work with the Enrollee, PCP, treating providers, and, as applicable, ED staff, to develop, implement, and monitor a pain management plan.
- **Children with Type 1 Diabetes Mellitus**
  We engage children with type 1 diabetes mellitus who can benefit from case management services through a multi-faceted approach that includes outreach and education to families; referrals from schools and providers that are interacting with the enrollee and using data and analytics to identify children with care gaps and medication non-adherence. We also refer the child/family to our Diabetes Disease Management Program, which includes health coaching and interventions for Enrollees and families, such as self-management tools, education, behavior change coaching, and remote telemonitoring services through our partnership with Ochsner Health System (Ochsner) and our OnDemand Diabetes Program. (RFP 2.6.6.3)
- **Substance Use Disorder**
  The HALO program is focused on identifying Enrollees at risk for developing a substance use disorder or with a substance use disorder diagnosis. The enrollee is screened using the Screening, Brief, Intervention, and Referral to Treatment (SBIRT) technique. If the enrollee is deemed high risk, a case management referral will be appropriate.
- **HIV/AIDS**
  Collaboration with the enrollee, providers, caregivers/family, and community services if applicable, to address all co-morbid conditions; provide specialized medication therapy monitoring, assist with anti-retroviral drug adherence and other co-morbid condition medication regimens; while supporting

independence, self-sufficiency, effective family functioning, caregiver assistance, and use of appropriate health services

- **Hepatitis C**
  Outreach, engagement, education, assessment, support, and referrals as needed to help increase Enrollee's understanding of risk factors; promoting medication compliance and nutrition; managing fatigue and nausea; and avoiding infection risks and spread of disease.
- **Attention Deficit Hyperactive Disorder (ADHD)**
  ADHD disease management is available to Enrollees at any age with a diagnosis of ADHD, and their families. Utilizing integrated treatment planning, the goals are to increase enrollee/families understanding of the disease, its effects, and possible treatment options; to achieve appropriate enrollee self-management and appropriate use of medications to treat ADHD.
- **Anxiety**
  The program is available to Enrollees aged 12 and above and is based on clinical practice guidelines and includes research evidence-based practices. The program goals are to increase Enrollee/family's understanding of the disease (including possible treatment options), increase appropriate self-management, improve appropriate use of medications to treat anxiety, and increase integrated treatment planning.
- **Depression**
  The goal of depression disease management is to help Enrollees achieve the highest possible levels of wellness, functioning, and quality of life. This is accomplished through increased enrollee/families understanding of the disease, its effects, and possible treatment options; increased appropriate enrollee self-management; appropriate use of medications to treat depression; and integrated treatment planning. The program is available to Enrollees aged 12 and above.
- **Perinatal Depression**
  The goal of depression disease management is to help pregnant Enrollees, at risk or with a history of postpartum depression, achieve the highest possible levels of wellness, functioning, and quality of life. This is accomplished through increased enrollee/families understanding of the disease, its effects, and possible treatment options; increased appropriate enrollee self-management; appropriate use of medications to treat depression; and integrated treatment planning.
- **Perinatal Substance Use Disorder (PSUD)**
  The Perinatal SUD program aims to provide education, resource linkage, and connect pregnant Enrollees to appropriate providers when utilizing substances which may negatively affect birth outcomes. The goal is to engage pregnant Enrollees by providing support, resources, education and ultimately increase positive outcomes for newborns, as well as allowing the mother an opportunity to achieve and maintain the best possible quality of life.

  The Perinatal SUD Team utilizes medical and behavioral health care managers and/or disease managers to provide person centered care to the

Enrollees. The Perinatal SUD Program goal is to provide an integrated treatment approach within the enrollee and their identified treatment team to increase positive outcomes for newborns. The staff has specialized training in addiction and utilizes evidence-based techniques to engage the enrollee in treatment and facilitate change. The multi-disciplinary team is comprised of staff with the following expertise: Start Smart for your Baby Care Manager, Behavioral Health CM and/or Behavioral Health Disease Manager, Medical Director, and Clinical/PHCO Leadership.

Disease Management Program Delegation

LHCC may develop a program to delegate Case Management services to providers. The purpose of such a program is to reimburse for Case Management services in settings where Enrollees are already accessing care and to avoid duplication with MCO Case Management Services. Any case management programs LHCC delegates to another provider, including reimbursement for services rendered will have the following requirements (Model Contract 2.7.15.-2.7.15.6):

- Purpose of the program
- PCP, Obstetrics, Gynecologists, and Behavioral Health Providers.
- Establish minimum provider qualifications for each tier of delegated case management.
- Establish monitoring and oversight procedures to ensure delegated Case Management providers are adhering to applicable Case Management requirements described in Model Contract.
- Establish criteria to distinguish when an Enrollee is eligible for delegated Case Management versus MCO Case Management. Wherever appropriate, the Contractor should utilize delegated Case Management for eligible Enrollees
- Establish a reimbursement rate for an initial assessment and POC development as well as a monthly reimbursement rate for each tier of Case Management services.
- Be available to Enrollees that meet criteria and providers that meet minimum qualifications.

More Information regarding disease management can be found in LA.DM.257:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure Diabetes
- Heart Disease
- Hypertension
- Hyperlipidemia
- Obesity
- Pain Management-Low Back Pain

Program descriptions for each program can be found in the attachments section of this policy.