Humana Healthy Horizons™ in Louisiana

Care Management Program Description

~~2024~~2025

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Program Overview

Humana Healthy Horizons in Louisiana (Plan) offers a comprehensive Care Management (CM) Program to support members, regardless of age, based on an individualized assessment of care needs. The Plan's CM Program includes all populations and functions outlined in the ~~**Model Contract**~~ **contract with the Louisiana Department of Health (LDH).**

The Plan offers CM to all members who request CM, as well **as** identified members with SHCN, regardless of information collected through the comprehensive assessment, HNA, or risk stratification. In addition, **the Plan** offer**s CM to** all pregnant members through **the** Maternity CM Program, HumanaBeginnings™.

The Plan's CM Program is person-centric and focuses on increasing the members' health status and quality of care while improving population health outcomes and managing cost. In alignment with ~~**the Louisiana Department of Health (**~~LDH~~**) definition**~~, the Plan's CM Program will encompass a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual member's short-term, long-term, and intensive health-related needs through communication and available resources to promote quality and cost-effective outcomes.

Care Managers **(CMs)** implicitly enhance CM through the designation of a Primary ~~**Care Manager**~~**CM** whose specific responsibility is to oversee and coordinate access and care delivery targeted to high-risk members with diverse combinations of health, functional, and social needs. The CM Program is designed to collaborate with members and coordinate with providers to meet all healthcare needs of ~~**our**~~ **the** members, including Social Determinants of Health (SDOH). ~~**Our**~~ **The** CM team supports member goals and choices through a person-centered, trauma-informed, and culturally responsive approach. ~~**Our**~~ **The** fully integrated program encompasses both medical and behavioral health using an integrated comprehensive assessment to identify all needs for each member enrolled in CM and assigning a Primary ~~**Care Manager**~~**CM** based on the member need. The CM Program works in collaboration with ~~**our**~~ Utilization Management (UM) department**s**, Quality Management (QM) department and aligns with ~~**our**~~ **the Plan's** Population Health Strategic Plan ~~**and The Bold Goal**~~ to provide a comprehensive approach to improving the health status of ~~**our**~~ **the** members.

The Plan has criteria and protocols in place for determining which CM activities or programs may benefit a member. These protocols include monitoring and trending data to stratify members based on ~~**a r**~~**R**isk ~~**S**~~**s**tratification. Once the member is stratified, the member is placed into the appropriate CM Program and tier level.

The member's risk stratification and CM assignment process takes into account pertinent member demographics, medical and pharmacy claims, emergency department (ED) utilization, acute inpatient hospital admissions/readmissions and any other relevant medical history information obtained from assessments or other sources, such as the Heath Needs Assessment (HNA), or from providers or members themselves. This acuity level is then associated with a case load rating to ~~**assist**~~ **help assure** ~~**in**~~ CMs have an appropriate and manageable member load. ~~**Care Management**~~**CM** staffing ratios are a mixed caseload of 1:60 for low, medium, high, complex acuity. Pre-Release **Department of Corrections program** members will be excluded from a mixed case load and will be a 1:30 ratio.

The various components of the Program are designed to engage and empower members to navigate the healthcare delivery system.

All protocols ~~**will initially be**~~**are** submitted to LDH as part of the readiness review **at plan inception**, and ~~**on an annual basis thereafter, and**~~ prior to any subsequent revisions **thereafter**.

Purpose

~~Our~~ The Plan's purpose is consistent with the overall Humana mission and vision of becoming a world-class leader in helping people achieve life-long well-being. The purpose of the CM Program is to deliver CM services that are person-centered, collaborative, and comprehensive, supported by evidence-based care, and integrated with other health services programs to facilitate improved member outcomes, enhanced member satisfaction, and optimal resource utilization. These services are delivered in a coordinated manner that includes internal and external resources that support members.

The Plan uses a multidisciplinary approach assisting ~~our~~ members with special health care needs (SHCN) who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition(s) and who may require a broad range of primary, specialized medical, behavioral health, social and/or related services. The CM Program includes proactive, holistic, and person-centered multidisciplinary management of the member, focusing on timely and collaborative coordination of care and services.

Scope

The scope of the CM Program Description applies to all eligible Medicaid members regardless of age.

Goals

The goals of the CM Program are to provide access to quality healthcare and support to all members, based on an individualized assessment of the care needs, by addressing ~~the~~ Physical Health (PH), Behavioral Health (BH), and SDOH needs through a collaborative and coordinated approach, to provide linkage to community services and resources, to reduce inappropriate and duplicative utilization of services, and to provide ~~the~~ support and education to members that equips them with the skills to better manage and improve their health status.

~~Medical~~ Utilization Management Committee

The ~~Medical~~ **Utilization** Management Committee (**~~MMC~~UMC**) has ~~the~~ delegated authority and oversight of all CM Program activities and is chaired by the Chief Medical Officer (CMO).

The responsibilities of the ~~MMC~~ **UMC** related to the CM Program include:

- Monitoring CM referral rates;
- Monitoring CM engagement rates;
- Reviewing the effectiveness of the CM process and making changes to the process as needed;
- Monitoring the effectiveness of disease specific programs;
- Approving policies and procedures for CM that conform to industry standards, including methods, timeliness, and individuals responsible for completing each task;
- Monitor delegated (if applicable) and contractual partners adherence to the CM Program

Members of the ~~MMC~~ **UMC** include but are not limited to: Medical Directors, a Pharmacist or a delegated Pharmacy department representative, CM Health Services Director, CM Manager(s), QM leadership, Health Equity Director, BH Medical Director and additional CM and QM staff and other members of Plan leadership as appropriate. A representative of LDH shall be included as a member of the ~~MMC~~ **UMC** upon request. The ~~MMC~~ **UMC** meets at a minimum of quarterly and must have at least 50% of the MMC voting members present to establish a quorum. The Committee chair will be the determining vote in the event of a tied vote. The ~~MMC~~ **UMC** maintains a record of all ~~MMC~~ **UMC** minutes, CM statistics, and recommendations for improvement of the CM Program.

The ~~MMC~~ **UMC** will submit all minutes and reports to the Quality Assurance and Performance Improvement (QAPI) Committee and to LDH upon request.

Care Management Process

Access/Referral to Case Management

Both the Member Handbook and Humana.com provide detailed instructions on member's ability to self-refer to a CM program by calling into Member Services to request care management. The Provider Manual provides detailed instructions on the referral process for CM.

CM referrals can occur via a Care Management referral form, located on the provider website. **The form is not required but preferred.** The CM referral form includes areas for details as well as checkboxes for special needs the member may have and/or the reason for referral. Detailed instructions within the CM Referral form include the fax number and the shared email address **to use when submitting the referral.**

The Provider Manual as well as the **provider** portal ~~**and the CM referral Form**~~ include the Provider services number where CM services can be requested **via telephone** for a member.

In addition, The Plan receives referrals to CM from multiple data points (see Identification of Members section) as well as referral sources, including, but not limited to

- Member services and self-referral including member grievances
- Providers (including primary care, BH, and specialist providers)
- Medical Management Program referrals (Including but not limited to UM, Clinical Intake, Chronic Condition Management as well as other clinical programs)
- State staff, including Bureau of Health Services Financing (BHSF), Office of Behavioral Health (OBH), Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), Office of Public Health (OPH) and Department of Children and Family Services (DCFS)
- Community entities and strategic partners such as local shelters, food banks among others~~.~~

The Plan provides details on how and in what circumstances to refer members for potential CM engagement, via the Provider Manual. The details for members to self-refer to the CM Program are provided to members in the Member Handbook. The CM team ~~**considers**~~ **outreaches to** all referred members for engagement in the CM Program.

To encourage referrals from ~~**our**~~ community partners, ~~**our**~~ Community Health Workers (CHW) and Peer Support Specialists (PSS) will liaise with high-volume physician offices, hospital systems, homeless shelters, and Community Based Organizations (CBO) in their assigned areas to establish themselves as a point of contact for members with frequent ED visits or SDOH needs, and to assist in identifying hard-to-reach members. The CHWs and PSS will be accessible and have the ability to liaise as they are ~~**our**~~ "feet on the ground" representatives in the community. ~~**We**~~ **The Plan** also maintain**s** and distribute**s** a list of screening triggers, inclusive in the HNA, for Plan associates to use as a guide to identify and refer members for CM.

Referrals for CM are accepted via fax, email, or phone and ~~**our**~~ **the Plan's** documentation system allows for internal referrals from other work streams such as Member Services.

~~**Our**~~ Care Management Assistants (CMA) closely monitor shared mailboxes, faxes and ~~**our**~~ work queues in the clinical documentation system (CDS) throughout the day. The CMAs research if a member is already assigned to a CM, the CMA will send a notification with details, to include the priority for outreach. If a member has not been assigned to a CM, the CMA will distribute the work based on the referral received. The priority for each referral is based on the expected timeframe for response:

Critical: same day
High: 1-2 business days (e.g., LDH PSH and BH Crisis Line referrals, no later than the next business day)
Medium: 5 business days
Low: 30 business days

Identification of Members
Members may be identified as eligible for the CM Program through a variety of methods including:

- Eligibility File or Other State Files
- ~~The~~ HNA
- Medical Directors
- UM **(authorizations, facility case managers, hospital discharge planners; clinical review staff, clinical intake staff)**
- Pharmacy Benefit Manager
- Risk Stratification
- Claims and encounters to include ED visit identification
- Hospital/Facility Admission and Discharge planning
- CBO Referrals
- Provider or member/c~~C~~aregiver ~~Self~~self-~~Referrals~~referrals
- External vendors/partners (Transportation, etc.)
- Internal Partners (Quality, Grievances and Appeals, Member Services)
- Labs results

With ~~our~~ the fully integrated model, members who have been identified as having both BH and PH needs will be managed by a single ~~Care Manager~~CM to limit member abrasion ~~and~~ due to multiple outreach~~attempts~~es and to build a trusting relationship to facilitate better health education and outcomes. Those members identified as having a primary PH need will be managed by a PH ~~Care Manager~~CM, and those identified as having a primary BH need will be managed by a BH ~~Care Manager~~CM with support from the other ~~Care Managers~~CMs to effectively manage any secondary needs and provide one point of contact.

Risk Stratification and Data Analysis
The Plan will stratify members based on individualized risk to identify members who are appropriate for CM. The risk stratification model will consider physical, behavioral and SDOH needs which can be identified through claims, pharmacy, UM and supplemented by referrals and HNA results, which may lead a member to be stratified as low-risk (Tier 1), moderate-risk (Tier 2), or high risk (Tier 3).

The model uses several sources to quantify the member's risk score (including but not limited to enrollment information, demographics, utilization pattern, medical diagnosis codes, Current Procedural Terminology (CPT) codes, major clinical informs the CM team of possible change in condition and the need for CM outreach. All changes in the assigned risk level will be documented and will reflect the reason for the change in stratification. For members engaged in CM, the Care Manager makes a final risk determination based upon their assessment and discussion with the member.

Welcome Calls
~~The~~ "Welcome Calls" will be performed and utilized as another avenue of identification of members for CM and will include attempts to conduct the HNA. Welcome calls will be performed for all members entering the plan within 14 business days of the date the Plan sends the Welcome Packet and shall include a total of

three (3) attempts to contact the member. The Welcome Call includes the following:

- Completion of the initial HNA
- Review of Primary Care Provider (PCP) assignment if a PCP Automatic Assignment was made
- Assist the member in changing the PCP if requested by the member
- Explanation of the Program statement that all member Protected Health Information (PHI) shall be handled in accordance with Federal and State privacy laws;
- The availability of oral interpretation and written translation services and how to obtain them free of charge;
- The concept of the patient-centered medical home, including the importance of the member(s) making a first appointment with his or her PCP for preventive care before the member requires care due to an illness or condition and instructions about changing PCPs; and
- Inquire about any urgent health needs or previously scheduled services or advise the member how to contact the previous Managed Care Organization (MCO) to provide this information;
- Confirm receipt of Welcome Packet;
    - If member lost or never received a Welcome Packet, the Plan will resend as needed.
- Inform the member about his or her right to continue certain existing base benefits such as maternity care, psychiatric care, chronic condition management and medication, as applicable, in accordance with ~~**Section 2.8:**~~ "Continuity of Care" ~~**of this Model Contract;**~~ **requirements in the contract between the Plan and LDH.**

Health Needs Assessment Process

~~The Plan offers CM to all members who request CM, as well as, identified members with SHCN, regardless of information collected through the comprehensive assessment, HNA, or risk stratification. In addition, **we** offer all pregnant members **CM** through **our** Maternity CM Program.~~ **The HNA will be included in the Welcome Packet and available in the member portal and will aim to identify physical, behavioral and SDOH risk factors. The HNA responses will generate referrals to the CM team for outreach such as when a member is pregnant and has a chronic condition or has unstable housing.**

Based on the HNA responses, CM referrals are identified for outreach to ~~Members~~ **members** with health and functional needs, those that may require either short or long-term physical, behavioral or social needs. Should the member be a child, ~~**we will**~~ outreach to the parent/caregiver **will occur** ~~**in an effort to**~~**to** complete the HNA. Outreach to complete the HNA includes three (3) telephonic efforts to complete the HNA ~~**and**~~ **with** each attempt ~~**will be**~~ done on different days and times of the week. All attempts will be completed within 90 calendar days of member enrollment and documented in ~~**our**~~ **the Plan's** Clinical Documentation System (CDS). If a member is unreachable, ~~**we will send**~~ a letter **will be sent** on the second attempt, notifying them that ~~**our**~~ **the** Care Management team is trying to reach them, along with a contact number and hours of operation. The HNA data shall be made available to the member as well as the assigned PCP and LDH as requested.

~~The HNA will be included in the Welcome Packet and available in the member portal and will aim to identify physical, behavioral and SDOH risk factors. The HNA responses will generate referrals to the CM team for outreach (e.g. if member is pregnant and has a chronic condition or has unstable housing), a referral will generate to CM).~~

The Plan can readily identify members with new, rising, or changing risk patterns, and inform ~~**our**~~ **CMs** outreach**ing members** ~~**for CM and**~~**of** targeted needs such as chronic condition management, maternal risk and/or SDOH support.

~~**Our**~~ **The Plan's** stratification process stratifies all newly enrolled members based on individualized risk within the first 30 calendar days of enrollment and re-stratifies monthly thereafter. ~~**The risk**~~

~~**stratification model**~~

The HNA Instrument
The HNA Instrument is the approved survey developed by LDH. The following process is in place for HNA completion:

- The HNA tool will be made available via web, printable format and ~~**we will have the capacity to facilitate via telephone**~~telephonically
- Be conducted with the consent of the member
- Will be utilized to assist in identifying individuals requiring CM outreach for further in-depth assessment as part of the Plan of Care (POC)
- Screen for needs of relevant SDOH
- Include disclosures of how information will be used
- Include screening for problem gambling and tobacco usage

HNA Questions
The Plan may add additional questions with LDH approval. The basic HNA will include questions to identify the following:

- Member details (demographics, personal health history, past and present to include BH and PH)
- Perceived health status
- Cultural and linguistic needs (including hearing and/or vision impairment
- Language preference
- Health concerns and goals
- Potential gaps in care
- SDOH needs (housing, food insecurity, physical safety, transportation)

Other Avenues for Member Identification
In addition to the methods described above, the Plan will apply additional methods to ensure identification of all members who may benefit from CM. These include:

- **Enrollment files**: ~~**We review**~~ enrollment data **is reviewed** to identify members with SHCN and members who are pregnant ~~**and**~~ to generate referrals based on details obtained from the enrollment and supplemental files**.** ~~**Said**~~ **These** referrals will be distributed for outreach based on priority and risk stratification
- **Post-discharge outreach**: ~~**We will make o**~~**O**utreach post discharge **occurs** to all ~~**our**~~ members discharging from an inpatient or residential facility for transitional CM, including those not yet engaged in ~~**our**~~ **the** CM Program. Outreach will occur within seven (7) calendar days of discharge. For ~~**Members**~~ **members** who are enrolled in CM, the assigned CM will outreach ~~**member while in the facility**~~ and assist in discharge planning. For members not enrolled in CM, ~~**our**~~ Transition Coordinators will be assigned to facilitate an optimal discharge plan and follow up post discharge. Should a member require longer term CM, a referral will be made, by the Transition~~**s**~~ Coordinator, accordingly (PH CM or BH CM).
- ~~Dis-enrollments: To mitigate unintentional dis-enrollments for assigned members, because of a lapse in coverage, a member of our CM team will **receive an alert to reach out and** offer needed assistance, including support with re-enrollment, **when** an assigned member has been dis-enrolled. **Outreach will be made minimum 30 calendar days prior to renewal date as indicated in the 834 to assist members on ways to apply and/or renew.** The Plan will make (3) three attempts to contact members to assist and these may be done via telephone or mail. If unable to contact on the second attempt, a letter will be sent notifying the member that the Care Management Team is trying to~~

~~reach them. Said letter will also include details on how to contact the Care Management team.~~

- **Nurse Advice Line and BH Crisis Line notifications**: Each member who contacts the Nurse Advice Line or BH Crisis Line will receive a follow-up call on the next business day to offer assistance and evaluate the member's ongoing needs, including the potential to benefit from CM.

24-Hour Nurse Advise Line

The ~~24 hour~~24-hour Nurse Advice Line is implemented to provide ~~our Members~~ members access to ~~a twenty four (24) hours~~twenty-four (24) hours, seven (7) days a week toll-free nurse line to speak with an experienced registered nurse. This call is free for all members. The nurses can help the members with the following, but not limited to:

- Decide if they need to go to the doctor or the ED
- Find out more about prescriptions or over-the-counter medicines
- Learn about ~~a medical condition~~medical conditions or recent diagnosis
- Learn about nutrition and wellness
- Make a list of questions for doctor visits

The CM team will receive daily notifications of all member calls to the Nurse Advice Line with details of the member's call and the completed recommended follow up needs, as applicable.

BH Crisis Line

The Behavioral Health Crisis Line provides ~~Members~~ members with access to a twenty-four (24) hour~~s~~, seven (7) days a week toll-free crisis line. The Crisis Line specializes in BH needs, crisis stabilization and ~~Member~~ member support. Additional services provided during a crisis call, once the crisis is stabilized, will include:

- Coordinating with community resources to expand the crisis response.
- Warm transfers to mobile crisis teams, collaboration with law enforcement, crisis stabilization in alternative settings, and crisis stabilization/crisis receiving centers for adults and others to expand the crisis response.

The CM team will receive a daily file with details of the BH Crisis Line calls from the previous 24 hours. The assigned CM will outreach as a critical priority the following business day. The CM will maintain an active role in managing the process to ensure resolution of BH crisis in the community and referral to and assistance with placement in BH services required by the individual in need.

A member of the CM team will educate members, verbally or in writing, on the availability of crisis services, the statewide phone number for accessing the services, and the ~~24 Hour Nurse~~24-Hour Nurse Advice Line.

Upon identification for CM, the Plan will make outreach using two (2) mechanisms of communication, a minimum of three (3) telephonic outreach attempts~~,~~ within a two (2) week period and a mailed letter within the first thirty (30) days, to contact the member for completion of an assessment~~. The CM~~ Outreach will be prioritized ~~outreach~~ based on the member's level of risk. Contacts are made on different days and different times of the day. If the second telephonic attempt is not successful, a mailing is sent to the member requesting a call back. Research for alternate contact details will be completed when unable to

reach members, such as outreaching to PCP, pharmacy, specialists, or community entities the member may engage with. However, ~~our~~ engagement efforts extend far beyond telephone calls and mailings~~, as we recognize that these efforts do not work for all segments of our member population. Our engagement methods~~ and also include:

- In-person outreach from Plan CHWs~~.~~: ~~Our~~ CHWs will conduct research and in-person outreach to locate high-risk members identified for CM who~~m we~~ have been unable to contact after ~~three (3)~~ telephonic attempts~~ and one mailing~~. When possible, ~~we will pair in-person~~ HNA completion attempts, as described above, will be paired with CM education and engagement for identified members. If the CHW engages ~~w/~~with the member, the CHW will call the assigned CM to facilitate an introduction of the member to the CM and schedule a time for the comprehensive assessment.
- Community engagement events: A member of the ~~Plan~~ CM team will regularly attend events hosted by the Plan's ~~Louisiana Medicaid~~ Community Engagement team, such as community baby showers for expectant mothers, to educate and engage members eligible for the Maternity CM Program.
- Inpatient and ~~P~~post-discharge outreach: ~~Our t~~Transitional CM and discharge planning processes include identification and engagement of members eligible for CM who have been difficult to reach or who have previously declined CM.

- Engagement following inbound calls to the Nurse Advice Line and/or BH Crisis Line: During contact following a call to the Nurse Advice Line or BH Crisis Line (as described above), ~~our associates~~CM team members will educate and engage eligible members in CM.

Initial Assessment

Upon successful contact with a member, the Primary ~~Care Manager~~CM will inform the member of their eligibility to participate in CM, discuss the CM Program and the benefits of participation in CM with the member, and inform the member that participation in CM is not mandatory and is based on their participation preferences, the program is an "opt-in" program. ~~how to opt out of the Program.~~ Once the Primary ~~Care Manager~~CM has fully explained the Program purpose, benefits, and that enrolling in the CM Program includes sharing information about their care with their providers, the Primary ~~Care Manager~~CM will offer the member the option of enrolling in the CM Program upon assessment, regardless of assessment outcomes**.** The member's consent or declination will be documented in the CDS. Upon member consent to enroll in the CM Program, members are assessed using the Plan's Comprehensive Assessment to evaluate physical, behavioral, and psychosocial factors, including SDOH and environmental identifiers that may contribute to chronic diseases such as asthma. The Primary ~~Care Manager~~CM will coordinate with the member and their support system to identify a date and time to complete the assessment and create the member's Plan of Care (POC), as needed. Based on the assessment,~~ the member is~~members are stratified to the appropriate tier level ~~and level~~ of CM. The Plan will utilize the appropriate assessment tools and Health Care Professionals to assess a member for PH and BH care needs. The ~~Care Managers~~CMs document a summary of the assessment data to develop a personalized and effective CM POC. ~~Our~~ The Plan's CDS identifies opportunities, goals and interventions for a POC based on certain assessment responses. The clinicians can modify the POC to reflect the member~~'s~~ specific needs and do not have to utilize the identified opportunities. These activities can be provided in a variety of settings including the member's home or shelter, provider's office, or other care setting based on the member's choice or need.

The Comprehensive Assessment includes the following topics:

- Residential status
- Member's health status, including self-reported health status, condition-specific issues relating to the event or diagnosis that led to identification for CM, and SHCN

- Assessment of health risks, chronic conditions, comorbidities, and current symptoms
- ~~**Social/cultural history, including an**~~ **Initial** assessment of at least the six **(6)** basic activities of daily activities (Bathing, Dressing, Toileting, Transferring, Feeding and Continence), and functional status
- **Social history including household and familial experience and support**
- **Cultural history including race, ethnicity, cultural preferences that may impact interactions with members of the health care team/system**
- Evaluation of caregiver resources including adequacy, involvement and level of decision-making and support systems
- **Evaluation of cultural and ~~Cultural/~~**linguistic needs, preferences or limitations **to include cultural health beliefs and practices and preferred language**
- Life planning activities such as wills, living wills, Advance Directives and Power of Attorneys
- BH status, including psychosocial and cognitive functioning (member ability to communicate and understand instructions and process information about an illness), mental health conditions, and substance use disorders
- SDOH assessment including, at a minimum, housing, safety, employment, food insecurity, and transportation
- Clinical history, including dates related to past medical history such as significant illness**es**, hospitalizations, or major procedures
- Medication assessment including current medications (schedules and dosages), medication needs, and relevant past medications
- Evaluation of available benefits within the Plan and a determination of whether the benefits alone are adequate to fulfill the treatment plan
- Evaluation of community resources available that may supplement the Plan benefits, such as community mental health, transportation, wellness programs, palliative care programs and nutritional support
- Evaluation for hearing and visual preferences or limitations to identify potential barriers to effective communication or care
- Assessment of over- or under-utilization of services and benefits

For members referred for CM and identified in Tier 2 (Moderate) or Tier 3 (High or Complex), ~~T~~the assessment **must be completed within 30 calendar days of being identified for CM. The ~~and~~** POC **for these members** must be completed within 30 **calendar** days **of the completion date of the assessment. F~~f~~**or members **referred for ~~identified to Tier 2 and Tier 3 (High and Complex). For members in~~** Tier 1 **(Low)**, ~~POC and **Assessments**~~ **assessments** must be completed within 90 **calendar days of being identified for CM. The POC for Tier 1 CM members must be completed within that same 90 calendar day ~~.~~timeframe**.

Members with a Demographic Change

The CM will inquire about and validate demographic changes upon initial and ongoing contact and document changes in the CDS including, but not limited to changes in:

- Living arrangements for families or individual members
- Mailing address
- Residential address
- E-mail address, and
- Telephone number

The CDS coordinates with enrollment file feeds to report demographic changes to LDH, in the manner and format determined by LDH. Any changes in demographic information or living arrangements for families or individual members within five (5) business days of discovery, including changes in mailing address,

residential address, e-mail address, and telephone number will be communicated to LDH.

Authorized Representatives

The CM has the ability to document, validate accurate and current information granting authority to Authorized Representatives to make health care decisions on a member's behalf, per contractual, federal and state regulations. ~~Our~~ **The Plan's** CDS includes an area to obtain release of information (ROI) for Providers and/or external CM to view care coordination documentation **as appropriate.**

Stratification Process

Tiers 1, 2, 3, Chronic Condition Management and Transitional Care Management

The Plan has a three (3) tiered CM Program that provides for differing levels of CM based on an individual member's needs. The Plan engages members, or their parent or Authorized Representative, as appropriate, in a level of CM commensurate with their risk score as identified through Risk Stratification and the HNA, as described below**, as well as member need**. Where the member's PCP or BH provider offers CM, the Plan shall support the provider as the lead ~~Care Manager~~**CM** on the Multi-Disciplinary Care Team (MDT).

The Plan will use assessment results, in conjunction with the ~~Care Manager~~**CM**'s clinical judgment, to refine the member's stratification level in accordance with the objective measures and criteria.

Intensive Care Management for High/Complex Risk Members ~~(High)~~ (Tier 3)

Members engaged in Intensive CM are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH.

~~1. Tier~~ ~~2. Minimum Contact~~ ~~3. Assessment~~ ~~4. POC~~Activities	Risk/Acuity	Co-Horts, Factors and Co-morbidities*	Utilization (ED/IP)*
~~1.~~ **Tier 3 (High)** 1. Weekly outreach ~~and~~ 2. Monthly ~~Face to Face~~face-to-face 3. Comprehensive, ~~Assessment,~~ Environmental, **HNA,** and SDOH **assessments as applicable** 4. POC completed within 30 days 5. **Monthly MDTs** 6. **Monthly POC updates** 7. **Quarterly reassessments**	**Risk Stratification Score:** 700-1000 High Acuity	• High risk maternity (Low Birth Weight and Preterm Labor) • Multiple uncontrolled/ noncompliant Chronic Conditions >2 • Severe and Persistent Mental Illness (SPMI) • Formerly Incarcerated (up to 1 year) • Chronic Homelessness • Active Substance Use Disorder /Opioid Use Disorder • I/DD with services • Foster and Adoption Assistance Children in Early Steps • Department of Justice/Pre-Release • Clinical Judgment	• 2 or more ED visits/60 Days for acute exacerbation of chronic or new diagnosed condition; OR • 2 or more Inpatient unplanned stays/60 days

~~1.~~ **Tier 3 (Complex)** 1. Minimum ~~**Bi-**~~weekly outreach ~~**with a-**~~ 2. ~~**m**~~Monthly ~~**Face to-Face**~~face-to-face visit 3. **Comprehensive, Environmental, HNA, and SDOH assessments as applicable** ~~3. **HNA and Comprehensive Assessment, Environmental**~~ 4. POC **completed** within 30 days 5. **Monthly MDTs** 6. **Monthly POC updates** ~~4.~~7. **Quarterly reassessments**	**Risk Stratification Score:** 700-1000 Complex Acuity	• NICU/Congenital Abnormalities • High Cost/High Utilizers (e.g. Systemic Lupus Erythematosus (SLE), Sickle Cell Disease (SCD), End State Renal Disease (ESRD), Congestive Heart Failure (CHF) Transplant) • Serious and Persistent Mental Illness with exacerbation • Clinical Judgment	• 2 ED visits/30 Days for acute exacerbation of chronic or new diagnosed condition • 2 unplanned stays/30 days

***Can include, but not limited to**

A POC must be completed in person**, if the member agrees to an in person visit,** within thirty (30) calendar days of identification and will include assessment of the home environment and priority SDOH. CM meetings will occur at least monthly, in person, in the member's preferred setting, or more as required within the member's POC, with monthly updates to the POC**, monthly MDTs,** and formal in person re-assessment quarterly**, if the member agrees to an in person visit**. CM may integrate CHW support. **POC updates will occur through communications with the member, guardian, caregiver and/or providers (with member consent) involved in the member's care.**
Attestations of monthly updates to the POC and communication of POC to the member and the member's PCP will be completed. ~~**Care Managers**~~**CMs** serving Tier 3 members will focus on implementation of the member's POC, preventing institutionalization and other adverse outcomes, and supporting the member in meeting his or her care goals, including self-management. BH ~~**Care Managers**~~**CMs** shall be the lead whenever there is a member with primarily BH needs. MDT meetings, further described, will be scheduled minimum monthly.

Care Management **for Moderate Risk Members** ~~**(Medium)**~~ (Tier 2)
Members engaged in the ~~**medium-**~~**moderate** level of CM are ~~**typically of**~~**typically** rising risk and need focused attention to support their clinical care needs and to address SDOH.

~~1. Tier~~ ~~2. Minimum Contact~~ ~~3. Assessment~~ ~~4. POC~~Activities	Risk/Acuity	Co-Horts, Factors and Co-morbidities*	Utilization (ED/IP)*
~~1.~~ **Tier 2** 1. ~~Monthly outreach~~Monthly outreach ~~with a~~ 2. ~~q~~Quarterly ~~Face to Face~~face-to-face 3. Comprehensive ~~,~~ Environmental, HNA, and SDOH assessments as appicable ~~3. HNA and Comprehensive Assessment, Environmental~~ 4. POC completed within 30 days 5. Quarterly MDTs 6. Quarterly POC updates 7. Quarterly reassessments	**Risk Stratification Score:** 500-699.9 Moderate Acuity	• Pregnant Women • Atypically abled Under 65 • High Persistent unmet social needs • Moderate BH Condition support (non-Serious and Persistent Mental Illness (SPMI)) • Pre-Diabetic (A1C 5.7-6.4) • Toxic Environment (i.e. lead)	• 2 or more ED visits/90 Days for acute exacerbation of chronic or new diagnosed condition; OR • 2 or more unplanned Inpatient stays/90 days

***Can include, but not limited to**

A POC must be completed in person**, if the member agrees to in person,** within thirty (30) calendar days of identification and include assessment of the home environment and priority SDOH. CM meetings will occur at least monthly, with quarterly updates to the POC**, quarterly MDTs,** and formal in-person**, if member agrees to in person,** re-assessment quarterly. **POC updates will occur through communications with the member, guardian, caregiver and/or providers (with member consent) involved in the member's care. Attestations of quarterly updates to the POC and communication of POC to the member and the member's PCP will be completed.** CM may integrate CHW's and support specialists (Peer and Housing). ~~Members~~

When members ~~who~~ are identified as homeless ~~at the time of care transition~~, the CM team will include a housing ~~specialist,~~**specialist** on the MDT. Housing specialists will also be used to ensure members transitioning from facility to community are connected to appropriate housing resources, including, but not limited to, referral of Potential members to Contractor's PSH liaison for application to the Louisiana PSH Program. ~~Attestations of quarterly updates to the POC and communication of POC to the member and the member's PCP will be completed.~~

A member of the CM team serving Tier 2 members will focus on implementation of the member's POC, preventing institutionalization and other adverse outcomes, and supporting the member in meeting his or her care goals, including self-management. A member of the BH CM team will be the lead whenever there is a member with primarily BH needs. ~~**MDT meetings, further described, will be scheduled minimum quarterly.**~~

Care Management **for Low-Risk Members** ~~(Low)~~ (Tier 1)
Members engaged in this level of CM are of the lowest level of risk within the CM Program and typically require support in CM and in addressing SDOH.

Members are assigned an acuity level of low when they do not meet the requirement for any other level of CM and meet any of the following criteria:

~~1. Tier~~ ~~2. Minimum Contact~~ ~~3. Assessment~~ ~~4. POC (POC)~~Activities	Risk/Acuity	Co-Horts, Factors and Co-morbidities*	Utilization (ED/IP)*
~~1.~~ **Tier 1** 1. Quarterly outreach~~,~~ 2. ~~a~~Annual ~~Face to Face~~face-to-face 3. HNA, ~~Environmental~~Environmental, and SDOH ~~if applicable~~assessments as applicable 4. POC ~~:~~completed within 90 days 5. **Annual POC updates** ~~4.~~6. **Annual reassessment**	**Risk Stratification Score:** 1-499.9 Low Acuity	• Healthy Children • Healthy Expansion Adults Mild/Well Controlled BH • Well Controlled Chronic Conditions <2 • Members who use Tobacco/Vape • Members who are Overweight/Obese • All Others	Not Applicable

***Can include, but not limited to**

A POC will be completed in person**, if member agrees to in person,** within ninety (90) calendar days of identification and include assessment of the home environment and priority SDOH. CM meetings will occur at least quarterly, or more as required within the member's POC, with annual updates to the POC and formal in-person**, if member agrees to in person,** re-assessment annually. **POC updates will occur through communications with the member, guardian, caregiver, and/or providers (with member consent) involved in the member's care.** Attestations of annual updates to the POC and communication of POC to the member and the member's PCP will be completed.

Chronic Condition Management
The Chronic Care Management (CCM) efforts, previously referred to as Disease Management, are interventions that apply a member-centric model focused on behavioral change and condition self-management. The Plan is able to differentiate between those members who will benefit from ~~our~~ CM

interventions and those members who require specific assistance to manage a chronic condition. The Plan has taken into consideration LDH's selected population health priorities, disease prevalence among the Louisiana Medicaid population, and feedback from ~~our~~ CBOs on the conditions that they find to have the largest impact on the populations they serve.

Interventions for focused CCM include:

- Disease specific evidenced-based guideline education to help ~~our~~ members and caregivers understand and manage chronic and infectious diseases
- Clinical interventions to manage chronic disease and reduce associated risks
- Counseling to support healthy living and compliance with POCs
- Education, promotion and support of telehealth
- Outreach aligned with the member's risk stratification and/or member request

Transitional Care Management

The Plan will coordinate the services that it furnishes to the member between settings of care regardless of the member's diagnosis (BH or PH), 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). Transition planning is a core CM activity that supports the ~~Member~~ member between institutional and community care settings, including but not limited to, transitions to/from inpatient hospitals, nursing facilities, psychiatric facilities, Psychiatric Residential Treatment Facilities (PRTF), therapeutic group homes, permanent supportive housing (PSH), intermediate care facilities, residential substance use disorder settings, and transitions out of incarceration.

When a member is admitted to a facility the CDS captures the detail based on the authorization and alerts the assigned CM or the Transitional Coordinator's as applicable. Transitional CM activities will include:

- Development of a transition POC in coordination with the care setting, the member and other key members of a member's MDT prior to the transition, which is available in writing and in the member portal, to the member upon discharge and includes post discharge care appointments and linkages as appropriate, medication reconciliation, patient education and self-management strategies; addresses prior authorization needs; and a CM contact person and phone number for the member.
- For members preparing for discharge from a PRTF, Therapeutic Group Home (TGH), or Immediate Care Facility (ICF), aftercare services will be in place thirty (30) calendar days prior to discharge.
- Ensuring that the setting from which the member is transitioning is sharing information with the member's PCP and BH providers regarding the treatment received and contact information.
- Follow up with members within seventy-two (72) hours following discharge/transition to ensure that services are being provided as detailed within the member's transition POC. The POC shall identify circumstances in which the follow-up includes a face-to-face visit.
- Additional follow-up as detailed in the ~~Discharge Plan~~Discharge Plan**.**
- Coordination across the MDT involved in transitional CM for members.
- For members identified as homeless at the time of care transition, the CM team shall include a Housing Specialist, on the MDT. Housing Specialists will also be used to ensure members transitioning from facility to community are connected to appropriate housing resources, including, but not limited to, referral of potential members to the Plan's PSH Liaison for application to the Louisiana PSH Program.

With ~~our~~ the fully Integrated Model, members who have PH and BH needs will be managed by a PH ~~Care Manager~~ CM or BH ~~Care Manager~~CM with support from the other CM (depending on which condition is of highest need/priority) to effectively manage the member and provide one point of contact.

When members are identified from the initial assessment as having a primary behavioral health and/or

substance use need, a BH CM will be assigned to the member. Regardless of the member's diagnosis (PH or BH), ~~our~~ transition CM activities and processes are consistent but modifiable and can be individualized to meet the member's needs, taking into consideration required timeframes for the activities.

Special Populations

Members with Special Health Care Needs
The CM will comprehensively assess each member identified as having SHCN, to identify any ongoing special conditions of the member that requires a course of treatment or regular care monitoring. An assessment shall be conducted, with all willing members, by the appropriate healthcare professional, within 30 calendar days of being identified as SHCN. Identification of these members can include all those described in the *Identification of Members* section and referrals to CM will occur.

LDH defines members with SHCN as any member who:

- has complex needs such as multiple chronic conditions, co-morbidities, and co-existing functional impairments;
- are at high risk for admission/readmission to a hospital within the next six (6) months;
- are at high risk of institutionalization;
- 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;
- are homeless as defined in Section 330(h)(5)(A) of the Public Health Services Act and codified by the US Department of Health and Human Services in 42 U.S.C. 254(b);
- 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 37 weeks;
- have been recently incarcerated and are transitioning out of custody;
- are at high risk of inpatient admission or ED visits, including certain members transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting;
- are members of the Department of Justice (DOJ) Agreement Target Population;
- 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.

The Plan will offer CM to all members with SHCN regardless of information gathered through the comprehensive assessment and the HNA. The SHCN population will have specific procedures in place for the following:

Continuity of Care
Where a new or existing member is identified as SHCN and is actively receiving medically necessary covered services at the time of Plan enrollment, the Plan will provide continuation of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The CM assigned will collaborate with the UM team via MDT or ad hoc meetings, to ensure any gaps in care are quickly addressed. Furthermore, when a member's coverage of service ends and the member still requires medically necessary services a member of the CM team will research and offer education on alternatives for continuing care and assist the member in obtaining them.

Outreach/Unable to Contact Process for Members with Special Health Care Needs
Members with SHCN will also receive outreach attempts as follows: A member of the CM team will make three (3) call attempts and a mail out the "Unable To Contact" letter between call 2 and 3 to reach SHCN

members within 30 days of identification.

- If attempts are unsuccessful, the CM team will engage ancillary staff to conduct research and in-person outreach to locate the member and complete the HNA, if not completed, in order to achieve completing a comprehensive assessment on 90% of those SHCN members willing to engage.

Coordinated System of Care Management (CSoC)

The CSoC program is a key component of the system of care for youth who have significant BH challenges or may be at imminent risk for ~~out of home~~out-of-home placement. The program focuses on coordinating with the youth, the family, the Department of Children and Family, the Department of Education, the Department of Health and the Office of Juvenile, among others. ~~The CM program will accept enrollment of children who are functionally eligible and participate in the Coordinated System of Care (CSoC) Program for all services specified in the *Services* section, except Specialized BH Services and CSoC services. For this population, PRTF, TGH, and Substance Use Disorder Residential services (ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7) remain the responsibility of the Plan. The CM will coordinate services with CSoC contractor on a weekly basis including sharing the results of any identification and assessment of that member's needs to prevent duplication of those activities as required by 42 C.F.R. §438.208(b)(4).~~

The Plan will apply initial risk screen for CSoC eligibility. These screenings will be performed for members 5-20 years of age and the outcome and next steps will be documented in CDS. When a member is screened by the CM or Member Services, all positive answers will require a referral to CM. If all responses are negative, but judgement indicates additional needs, a referral to CM, along with the details will be sent via the CDS.

Regardless of who initiates the screening, the Plan will refer calls, via warm transfer, to the contracted administrator of the CSoC Program, who will apply Brief CANS assessment tool to access for CSoC presumptive eligibility and the Plan will document in the child's health record whether or not (according to CSoC contracted administrator) the child met criteria for CSoC presumed eligibility, when the child was referred to the WAA, and the date on which the Freedom of Choice (FOC) was signed. Additional documentation will include outcome of warm transfer and details of the interaction.

The Plan will also document in the child's health record if the child does not become enrolled in CSoC, for the reasons of 1) the youth and family refused CSoC services, or 2) the youth does not meet clinical eligibility based on the comprehensive Child and Adolescent Needs and Strengths (CANS) Assessment, or 3) for any other reason.

For youth who screened positively on the initial risk screen, but who do not complete enrollment in CSoC, the Plan will offer voluntary participation in the CM Program, and/or other BH services to meet the child and family's presenting needs.

If members are admitted to a Psychiatric Residential Treatment Facility (PRTF) and/or Therapeutic Group Home (TGH), the transition will include a referral to the CSoC contractor 30-90 days prior to discharge.

The CM will coordinate services with CSoC contractor on a weekly basis including sharing the results of any identification and assessment of that member's needs to prevent duplication of those activities as required by 42 C.F.R. §438.208(b)(4). The Plan will participate in weekly calls with the CSoC contractor to discuss new referrals, referral status, review of discharges and review of high complexity members. The Plan will monitor those members that may be aging out to ensure continuity of care applies.

Community Care Management (CCM) for Members in Department of Justice (DOJ) Agreement Target Population

In accordance with CM for Individuals in DOJ Agreement Target Population (Care3:18-cv-00608, Middle

District of Louisiana), a specialized ~~community~~ CCM Program consistent with the DOJ Agreement has been developed. The Program will refer the targeted population to ~~said~~ the ~~Community~~ CCM agency within one (1) business day of receipt of a referral from LDH. Members that are identified for transition from a nursing facility to the community as part of the DOJ Agreement Target Population shall begin to receive ~~Transitional~~ CCM services prior to release from the nursing facility as part of their discharge planning process. The Plan will support the State Transition team in the development of the transition plan required as part of the DOJ Agreement.

The Plan will maintain ultimate responsibility for ensuring the CM needs of the target population are met by Community ~~Care Managers~~CMs and Community ~~Care Managers~~CMs satisfactorily ~~completing~~ complete required activities. The Plan will have clear lines of communication with the contracted ~~Community Case Management (~~CCM~~)~~ agency ~~program~~ to ensure the requirements are met timely and based on the member's needs. The process to refer will include specific details for the CCM agency to identify when a referral is made and the urgency of the referral. Weekly meetings between the Plan and the CCM agency will enhance communication and allow for quick identification of opportunities for improvement. Further detail is provided in the **CM role and process tool documents for CM.** ~~Department of Justice (DOJ) Community Case Management Program and PASRR Level II Evaluations policy.~~

Independent Evaluations for Pre-Admission Screening and Resident Review Level II

The Plan will conduct Pre-Admission Screening and Resident Review (PASRR) Level II evaluations of ~~Members~~members**,** upon referral from LDH, and such evaluations shall be performed by a licensed mental health professional (LMHP). Referrals will be based upon the need for an independent evaluation to determine the need for nursing facility services and/or the need for specialized services to address mental health issues

while the member is in a nursing facility. This evaluation does not include individuals with an OCDD Statement of Approval; there is a separate determination process outside of this Plan for these evaluations.

In conducting the interview, the Plan will follow the criteria set forth in 42 C.F.R. Part 483, Subpart C and will utilize the PASRR Level II standardized evaluation form provided by LDH. Evaluators will use relevant evaluative data, obtained prior to initiation of the PASRR, if the data is considered valid, accurate and reflect the current functional status of the member. However, if it is necessary to supplement and verify that the existing data is accurate and current, the evaluator will gather additional information necessary to assess proper placement, treatment and will ensure the evaluation ~~are~~ is submitted within the required ~~timeframe (~~4 calendar day~~s)~~ timeframe ~~of~~ from receipt from OBH. The Plan will comply with the ~~United States~~ DOJ **Settlement** Agreement to reduce reliance on nursing facility-based care for individuals with **severe mental illness (**SMI**)**. Level II evaluation recommendations will ensure the least restrictive setting appropriate with the appropriate services.

When OBH determines that nursing facility services are not appropriate, the Plan will assist eligible members in obtaining available, appropriate, alternative behavioral health services. If at any time the Plan discovers that a~~n~~ ~~Enrollee~~ member residing in a nursing home who has a~~n~~ SMI has not received a Level II determination, the Plan will notify OBH as defined by OBH.

Documentation of Resident Review will include identification if the member was determined to have a ~~Serious Mental Illness (~~SMI~~)~~ and/or Intellectual Disability (ID) prior to admission to the ~~Nursing~~ nursing facility.

For the ~~diversion~~ Diverted population, the Plan will ensure those at risk of nursing facility placement are provided adequate services while in the community in an effort to ensure their needs are met and the need for a higher level of care is mitigated whenever possible. Upon **diversion or** transition[NT1][LM2], members will receive face-to-face CM services on a monthly basis for a ~~minimal~~ minimum of twelve (12) months post

diversion/transition as identified in their individual POC to include type of placement, results and recommendations and referral sources. The POC will incorporate recommendations of ~~**LDH**~~ **OBH** staff and Transition Coordinators.

Should the Plan engage with a contracted agency to perform the PASRR Level II evaluations, all requirements will be audited, and a contingency plan will be in place for any issue that may arise to ensure evaluations are done timely and by the appropriate licensed mental health professionals (LMHP). ~~**Further detail is provided in the Department of Justice (DOJ) Community Case Management Program and PASRR Level II Evaluations policy.**~~

Chisholm

The Plan will adhere to the requirements described in the Chisholm Compliance Guide to include specialized staffing requirements; Prior Authorization Liaison. Said staff will provide all necessary coordination by assisting in locating providers, ensuring Prior Authorization Liaison (PAL) requests are submitted in a timely fashion and that services have started in the designated times. The PAL will also facilitate timely authorization decisions and verify decisions are made based on medical necessity. Additional tasks will include:

- Coordination with LDH assigned PAL to resolve issues
- Works with the member's Support Coordinator
- Locate willing service providers and arrange for needed services within 10 working days
- Communicate details of said service providers to members/caregivers
- Monitor PA requests and communicate with member/caregiver until services are delivered
- Document all attempts to locate willing and able providers that can provide member with medically necessary services
- Communicate with EPSDT caser managers, providers and members on the PA request
- Request medical records necessary for determinations
- Prior Authorization Requirements

The Plan will issue written letters for approvals, partial approvals and partial denials as stipulated in the Chisholm Compliance Guide; within 10 calendar days of the member's request except when there is insufficient information to issue a decision. If written request has not been met, further telephonic outreach to the EPSDT coordinator will be made to explain missing documentation.

For additional authorization process details, please refer to MCD-LA-CLI-006 Timeliness of UM Determinations and Notifications, Louisiana Utilization Management Program Description

AJ v. LDH

Class members in AJ v. LDH, as defined by LDH, will be considered as Special Healthcare Needs and will be outreached for engagement in Case Management. The Plan's focus will be to provide continued Extended Home Health (EHH) Services as well as Intermittent Nursing (IN) based on the member's needs understanding these members are medically fragile children.

~~**Our c**~~C~~**s**~~r~~**r**~~e managers will promptly refer members to the Crisis Response Team (CRT) for ~~**Extended Home Health (**~~EHH~~**)**~~ or ~~**Intermittent Nursing Services (**~~IN~~**)**~~ as defined by LDH, when any of the following occurs:

- Receive less than 90% of the prior authorized EHH or medically necessary IN services for at least two consecutive weeks
- Has been unable to locate a home health provider or has been denied enrollment by home health providers

- Otherwise facing a serious risk of institutionalization due to lack of EHH or IN services
- When a need for IN has been identified and class member is terminated from existing EHH services where region does not have a provider for IN services on the date that the notice of denials has been sent
- Access to care issues such as termination of existing EHH services

Additional considerations for this population include detailed documentation when referring to the CRT as follows:

- For denied EHH services, include identified needs for IN services with duration of nursing services requested
- Include documentation that reflects detailed member current and historical needs, detailed received services and member and/or caregiver refusal for any service
- Access to care issues such as inability of a provider for IN services

Reporting to LDH shall include actions taken and detailed hours and service provision for class members.

JUSTICE-INVOLVED PRE-RELEASE ENROLLMENT PROGRAM

The Plan will collaborate with LDH and the Louisiana Department of Public Safety & Corrections (DOC) on a pre-release enrollment program for the justice-involved population in both DOC Prisons and DOC Regional Re-entry centers. The plan will further expand services to local jail facilities based on LDH guidance.

The Plan will collaborate to provide details specific to Value Added Benefits (VAB) necessary for pre-release educational packets.

The assigned CM will identify the appropriate eligibility and assignment and will continuously monitor for release dates. ~~**We will identify those m**~~Members with high needs **will be identified** based on the pre-determined Levels of Care documented in the DOC MCO Program Manual ~~**V5**~~. ~~For Serious Mental Illness (SMI) members assigned Level of care 1, 2 and 3, a single **Case** Manager will be assigned.~~ The Plan will manage co-occurring conditions, such as pregnancy, HIV, disability and ~~**with**~~ multiple medical issues. Management will be based on priority needs to ensure coordination of care is individualized and comprehensive.

All attempts to initiate contact with the facility will be made based on the timelines defined; approximately sixty (60) to seventy-five (75) days prior to the member's earliest known release date, in an effort to obtain the Medical Record Transfer Summary and schedule the first case management appointment. All appointments with the member will be coordinated based on the recommended timeline and frequency and in collaboration with the DOC facility. Reminders and scheduled meetings will be included in ~~**our**~~ **the Plan's** CDS and meeting invites will be sent by the Plan as required by the DOC where member is incarcerated. The content of each Case Management visit will occur based on the guidance noted in the DOC MCO Program Manual ~~**V5**~~ and the outcomes of every interaction will be documented in the CDS. Prior to the second case management session, and at least 24 hours in advance, we will complete and submit the pre-determined Healthy Louisiana Case Management Transition of Care Plan Form ~~**(Appendix N).**~~ If member is identified as requiring intensive case management, a multi-disciplinary care conference will be scheduled prior to the scheduled release, when possible.

Upon release from ~~**prison**~~**incarceration**, the ~~**Case Manager**~~**CM** will make efforts to continue member engagement until health conditions are stable, and members ~~**can self**~~ **can** ~~**manage,**~~**manage** by linking each individual to the appropriate services such as primary care and/or behavioral care, medications and gaps in SDOH within 30 days of release. Any discrepancy in member demographics, to include address and phone number, the Plan will notify the Medicaid Project Manager as assigned. When members cannot be reached after utilizing all internal and external resources such as the Probation, Parole district or the Medicaid

Project Manager, the Plan will close the case. ~~**Should the member request and sign an Opt Out form at any time during the program, the Plan will close the case as appropriate however, case management may be offered post- release to all Level of Care 1, 2 and 3.**~~

~~**Case**~~ CMs~~**Managers**~~ will limit caseloads to a maximum of 30 members at any given time and will strive to maintain high-needs members engaged in the case management process for a minimum of 120 calendar days post-release. Should the member require long term CM, the member will be transitioned to a CM based on the member's specific needs (PH, BH and/or SDOH).

Maternity Care Management Program

All pregnant members will be eligible to ~~**join our**~~**participate in the** Maternity CM Program. Through ~~**our**~~ **the** Maternity CM Program, ~~**our**~~ members will receive CM services that are tailored to their acuity level. The Maternity CM Program will assist members with support for the development and adherence of treatment plans for high- risk members, resources and support for substance abuse or mental health concerns and referrals
to community-based programs and resources. Furthermore, ~~**we**~~ **CMs** will coordinate referrals to community resources and programs such as Women, Infant, and Children (WIC) Program Referral (WIC).

Outreach attempts will be made to include a letter if unable to contact. A pre-natal Obstetric (OB) Assessment is completed, which includes a series of pregnancy related questions of the enrolled participant. The assessment includes screening questions specific to pregnancy but also includes screening for smoking, gambling, safety, depression, SDOH, medical history and more. The Primary ~~**Care Manager**~~**CM** will
provide resources for nutritional counseling and/or nutritional education, breast-feeding promotion, and family planning during the course of the assessment or thereafter. Once the member has been fully assessed, a POC will be created to focus on priority needs and member preference. Additional assessment opportunities include a detailed assessment that identifies post-partum needs and another assessment within 6 weeks post-partum to ensure member has followed up with the specialist and has all the necessary tools and resources to maintain the best health for baby and mom.

~~**We**~~ **Our CMs** will employ engagement techniques tailored to ~~**our**~~ pregnant members, to include coordination with OB/GYNs to successfully engage members with high-risk pregnancies, including those related to substance use disorder.

The Maternity CM Program will assist all pregnant members enrolled in the Program in choosing a pediatrician or other appropriate PCP, for the care of their newborn baby at least 60 calendar days prior to the expected date of delivery. The CM will educate the Member on the timeframe required (14 days) to choose a Pediatrician or other appropriate PCP for the newborn, before assigning one.

A quarterly report is generated to reflect the number and percentage of newborns for which a PCP has been selected prior to birth.

The Plan will provide direct access to a health specialist(s) in-network for Plan covered services necessary to provide women's routine and preventive health care services. This access will be in addition to the member's PCP if that provider is not a women's health specialist.

The Plan shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or

authorization. Family planning services will be available to help prevent unintended or unplanned pregnancies and include examinations, assessments, and traditional contraceptive devices. Family planning services also include preconception and inter-conception care services to optimize the member's health entering pregnancy. All family planning services are available to members as specified in the Model Contract.

Confidentiality of family planning information and records for each individual member including those of minor patients will be maintained.

Outreach Program for Pregnancy Services

The Maternity CMs will outreach to encourage women to seek prenatal services during the first trimester of pregnancy. This outreach may utilize community and religious organizations and other community groups to develop outreach initiatives or referral networks, as well as include issuance of brochures and/or periodic articles emphasizing the importance of such care to all members.

Pregnant members with 1 or more risk factors that are classified as members with SHCN, will receive services that follow all CM requirements. In addition to the engagement mechanisms described above, ~~we~~ **CMs** will employ engagement techniques tailored to ~~our~~ pregnant members, including the following:

- Coordination with Obstetrics and Gynecologists and the Community Partners-
    - To successfully engage members with high-risk pregnancies, including those related to ~~Substance Use Disorder~~**substance use disorder**, we will establish relationships with community partners and ~~our~~ network OB/GYNs' offices to encourage CM referrals for members with high-risk pregnancies and enable in-person interventions by CM associates. In addition, ~~we~~ **the Plan** will offer ~~our~~ participating providers a monetary incentive for each completed Notification of Pregnancy (NOP) form submitted for a Plan member. Formal provider communication

      through the NOP form will enable us to more quickly identify and engage pregnant members in ~~our~~ **the** Maternity CM Program. The NOP will be accessible to providers via the unsecure provider portal and includes details on how and where to send the form.

Permanent Supportive Housing

For the Louisiana PSH Program, the Plan will provide a comprehensive Program to support members in gaining permanent housing. The Plan's PSH liaison will be a resource for all CM to address housing needs and facilitate information and resources. ~~Said~~ **The** PSH Liaison will attend MDT meetings, participate in discharge planning as needed and be an active participant in creating the POC for those members that require supportive housing. More information and details on ~~our~~ **the** PSH Program is located in ~~policy and procedure titled "~~**the** Permanent Supportive Housing (PSH) Services~~",~~ **" Policy document.**

Core Care Management Supports

The Plan offers core supports for all members, regardless of their stratification and takes into account essential elements of CM-related activities proposed and adopted by the Centers for Medicare and Medicaid (CMS) for members of all ages who have functional limitations and/or chronic illnesses. The Plan supports a no wrong door entry for members seeking CM support, health and wellness information, and/or benefit education or guidance.

Member's core supports for all risk stratifications include but is not limited to:

- Identification and mitigation of physical, mental, environmental and SDOH risks by completing comprehensive assessments and/or supplemental assessments which are targeting specific member needs (e.g. Environmental Assessment, specific chronic condition screening, disaster planning assessment and more),

- Identification of barriers such as language, visual, financial, motivation, etc. and identification of resources to overcome
- Comprehensive evaluations, as applicable, to determine needs
- Incorporation of wellness promotion and illness prevention activities
- Provide adequate POC and transition strategies for a comprehensive person-centered Program
- CM support for episodic issues
- Assistance in navigating the health care system
- Education on available benefits, including Value Added Benefits (VAB), the BH Crisis Line, ~~Member~~ member ~~Portal~~ portal and details within
- Disease-specific education and self-management support, including linkage with educational materials and referrals to classes conducted by local resources
- Education on access to care (e.g. ED diversion, Nurse Advice Line, BH Crisis Line)
- Referrals to resources to address SDOH with ~~our~~ the Plan's closed loop SDOH Platform or VABs
- Resource Directory for locating providers
- Resource Directory for locating community resources for PH and BH needs
- Consultation with an internal Peer Support Specialist

Documentation of Care Management Activities

~~Our~~ The Plan's CDS supports the efficient delivery and coordination of covered services. The CDS functionality enables direct management of BH, social, and PH services, ~~enhancing our~~and enhances ~~ability~~the ability to document gaps in care, develop POCs, monitor Plan compliance, proactively address co-occurring needs and changes in condition, and to document/review information pertinent to effective and timely management of the member's needs.

All CM activities are fully and appropriately documented within the CDS including barrier analysis, referrals to community resources, internal referrals and appropriate follow up to ensure successful linkage to those resources. All documentation in the CDS automatically records the associate identification and the date and time of documentation while allowing the CM team to document the actual date of the interaction in the event that it is different from the time it was documented.

The CDS allows automated notifications to be triggered to ensure timely follow up with the member in a variety of situations including, but not limited to scheduled follow up, POC follow up, assessment follow up, inpatient admissions, readmissions, and ER visits. ~~The CDS allows for automated tasks to be triggered to ensure timely follow-up with the member in a variety of situations including, but not limited to, scheduled follow-up, particular milestone dates in the POC, inpatient admissions, and inpatient discharges.~~

The CDS provides the necessary tools and information to help ~~our~~ the CM team perform their jobs effectively including ~~our~~ a comprehensive assessment and access to evidenced based clinical guidelines, a database of member educational materials that can be provided to a member and are based on specific member conditions.

Plan of Care Development

All ~~Members~~ members who are found eligible for CM will have a comprehensive and individualized POC. The POC is person-centered and member-driven, collaboratively developed, with the support of the member's Authorized Representative and other members of their chosen support system. Additionally, ~~we will incorporate~~ treatment plans developed through BH providers will be incorporated into ~~our~~ the POC for those members receiving services for Specialized BH Services. For ~~our~~ members receiving Specialized BH Services only, the POC will focus on coordinating and integrating services as appropriate. When a member

receives services requiring a POC from LDH, such as Home and Community Based Waiver services or services through OPH, the Plan will coordinate with LDH or designee to develop the POC. Using the assessment as its base, the POC focuses on those services and supports that can help the member achieve their prioritization goals, strengthen self-determination, and move the member along the path to improved health and recovery. The POC is fully comprehensive, including the member's PH, BH, and SDOH services and needs. ~~Our Care Managers~~CMs complete the POC in real time, in conjunction with the member and their support system. Upon completion, the member and their Authorized Representative can access the POC via the ~~Member~~ member ~~Portal~~portal, with a printed copy provided upon request, while the member's providers (including their PCP and BH provider) can access the member's POC, with appropriate member consent, via ~~our~~ the Plan's Provider Portal.

~~We will complete a~~Attestations of monthly, quarterly, or annual updates to the POC (as dictated by the member's CM tier) and communication of the POC to the member and the member's PCP will be completed. During subsequent CM meetings, ~~we will discuss~~ the member's progress toward goals will be discussed, identifying any needed services and/or barriers to care to meet the treatment goals. ~~We will update t~~The POC goals and interventions will be updated to reflect changes identified in the CM meetings as needed and in compliance with the schedule outlined by LDH, including when the member's circumstances or needs change significantly; upon request of the member, their parent, or legal guardian; or upon request of a member of the MDT. As the member makes progress towards goals, the Primary ~~Care Manager~~CM and the member together, evaluates the member's acuity level and transitions the member through the tiers as appropriate and document this movement on the POC .

As members make progress towards their goals, the ~~Care Manager~~CM and the member together with the Care team reevaluate the member's risk level, transition them through the levels as appropriate, and document this in the POC. The POC will include, at a minimum, the elements listed below:

- Measurable goals, interventions, barriers and outcomes agreed upon by the member.
- Prioritization of goals based on member/Authorized Representative/caregiver needs and preferences, as well as feedback from providers, in an effort to support provider-member and/or Authorized Representative relationship.
- Validation services are received or not received, with the appropriate actions necessary to close gaps in care.
- Retention of the person-centered POC and sharing with the MDT as appropriate.
- When appropriate or necessary development of a schedule for follow-up (scheduled time or timeframe) will be documented and contact method of communication with member will be defined. The schedule for follow-up includes, but is not limited to counseling, member education and determining when follow-up is appropriate
- Development and communication of member self-management plan when appropriate or necessary
- Planning for continuity of care, including transition of care and transfers between settings.

Additional detailed documentation may include:

- Diagnosis, including both BH and PH
- BH Crisis Line contacts
- Facilitation of referrals to resources and the need for timely follow up to assess member actions as appropriate with referrals, member education, counseling and self-management.
- Determination of timely and appropriate follow-up as needed
- Member risk factors and interventions to minimize them
- Confirmation services were received or actions necessary to be taken to mitigate gaps
- **T**he POC will be culturally and linguistically appropriate and address any age, medical or BH

disability, gender, race, sexual orientation and gender

- Reflect the individual's strengths and preferences.
- Emergency preparedness plan
- Barrier analysis, including lack of [barriers]. Barriers may include:
    - Language or literacy level
    - Transportation needs
    - Health condition specific education
    - Motivation
    - Financial and/or insurance issues
    - Cultural and/or spiritual beliefs
    - Hearing or visual impairment
    - Psychological impairment
    - Past traumatic events

The POC will be revised at least once every twelve (12) months, when member circumstances or needs change significantly, or at the request of the member and is accessible through the Member and Provider Portals. The POC will be provided to any individual requested by the member.

Multi-Disciplinary Care Team Engagement

The lead CM will lead the Multi-Disciplinary Care Team (MDT) calls and will identify the required resources to participate in the MDT for all Tier 2 and 3 as well as the Transitional CM. Participants include the member's lead ~~Care Manager~~CM (who may be their Plan ~~Care Manager~~CM or a ~~Care Manager~~CM from their PCP or BH provider's office) with the objective of gathering feedback on the member's POC from their support
system, providers, ~~Care Managers~~CMs from State agencies and other plans, and other individuals identified by the member. This feedback is incorporated into the member's POC, along with their treatment plan for Specialized BH Services (with ~~Member~~ member consent). Lead ~~Care Managers~~CMs will be assigned based on member's priority care needs as identified in the POC and the appropriate ~~Care Manager~~CM skill level and expertise will influence the assignment.

The MDT will meet at regular intervals, based on individual needs as identified in the POC, either in person or telephonically. For members in Tier 3, monthly MDTs shall be scheduled. For members in Tier 2, the MDT shall meet minimum quarterly. Invitations for participation will be sent to the participating parties with sufficient notice via ~~the CDS~~email, telephonic outreach, etc. Outcomes of the MDT are documented and accessible to the parties and POC is updated to reflect recommendations received during the MDT

Participants may include:

- Lead ~~Care Manager~~CM
- Member, Authorized Representative and/or family
- PCP;
- BH providers;
- Specialists;
- Pharmacists;
- CHWs and/or PSS;
- Home and community-based service providers and managers;
- Housing Specialists, if the member is identified as homeless or at risk for homelessness and
- LDH staff, including Transition Coordinators

Should a member have PH, BH and/or SUD needs the MDT will include key participants such as a BH CM, PH CM, PSS. For members under 6 years of age, the assigned lead CM will include experience in early

childhood mental health or shall have access to a consultant with experience in infant and early childhood mental health.

Coordinating Care Management with External Partners
The Plan will work with each provider or agency providing CM to ~~our~~ members to develop a process for identification of members receiving services, referral to the agency when a member is in need of services, and a process for communicating updates in member condition. ~~Our~~ external partners and State agencies will have access to the CM team, via phone, fax, as well as a shared e-mail inbox to transmit information and send queries. A member of the CM team will respond to all messages received within one (1) business day.

The Plan will continue to evolve its process for coordination with provider-led CM, including supporting providers to offer more CM services. This works hand in hand with ~~our~~ **the Plan's** value-based purchasing approach, which aims to move providers into full value arrangements over the life of the Contract.

Benefit Program Closure
Prior to benefit program closure, the member is informed that they should contact the CM team if they identify any needs in the future for which they require or request management assistance. Benefit programs are closed when the:

- Member's needs are self-managed by the member/Authorized Representative, and it is mutually agreed that goals of the POC are met
- Member becomes unreachable after 3 attempts completed and an Unable to Contact (UTC) letter is mailed to member
- Member requests to discontinue participation
- Member expires
- Member is no longer enrolled in the Plan
- Member chooses to no longer engage in continued CM

The CM team will receive notifications for changes in disposition, such as admission or ED visits, which will prompt the CM team to resume outreach. Prior to case closure, members are advised on how to reach the CM program, how to contact the ~~24 Hour Nurse~~**24-Hour Nurse** Line and the BH Crisis Line.

Fraud, Waste, and Abuse and Quality of Care
The CM team, in collaboration with the Special Investigation's Unit (SIU) and Quality **of Care Investigations team**~~Operations Compliance and Accreditation (QOCA)~~, will report all questionable occurrences of Fraud, Waste and Abuse and Quality of Care (QOC) concerns. Fraud committed by providers, pharmacies or members will be addressed by the CM staff through timely reporting and monitoring and investigation by the SIU. The Plan will report all tips, confirmed and suspected fraud, waste and abuse to LDH and the appropriate agencies, including LDH Program Integrity and Medicaid Fraud Control Unit (MFCU). Reports made to the SIU can be made using one of three ways: calling, mailing a letter or visiting the Plan's website and completing the appropriate form. Detailed annual training includes how to identify Fraud, Waste and Abuse and most important, how to report as appropriate.

CM staff will monitor and take action to report both confidentially and in a timely manner to QOCA in accordance with appropriate timeframes as outlined in their protocols.

Training
Care management has a six (6) week training program. Through courses such as Motivational Interviewing, Mental Health First Aid, Trauma Informed Care, Suicide Prevention, Crisis management, person centered care planning, and multiple practice sessions with use case scenarios; we are able to ensure ~~our care~~

~~managers~~CMs are thoroughly trained on how to assess members, identify gaps to improve member's health.
The comprehensive training enhances member engagement, Member retention in the CM program and provides the tools and resources necessary for ~~our care managers~~CMs to succeed and support ~~our~~ members.

In addition to the above noted courses, training for ~~Care Managers~~CMs and ~~Care Manager~~CM Supervisors include the following:

- Specialized BH policy and procedure manuals issued by LDH;
- CSoC system of care values, the wraparound process, and processes and protocols for screening and referral;
- OJJ system, population, and processes;
- DCFS system, population, and processes;
- Contract requirements
- Approved Waivers and State Plan amendments (SPAs) for Specialized BH;
- Specialized BH Services for members residing in a nursing facility and/or included in the DOJ Agreement Target Population;
- PASRR;
- Services provided by the Office for Citizens with Development Disabilities;
- Current and applicable evidence-based practices;
- BH services available through other funding sources, including Medicare; and
- PSH provided by the Office of Aging and Adult Services.

Initial and ongoing training has been developed for associates having contact with members or providers with regard to the appropriate identification and handling of quality of care concerns. Crisis intervention training is also included for those associates working directly with members.

Care Management Policies and Procedures
All staff members will be educated on policies, changes and updates prior to implementation with a combination of Computer Based Trainings (CBT), in person training and/or self-paced modules. The CM Leadership team has developed protocols for determining which CM activities may be beneficial to a member and the most efficient way to deliver CM services based on the individual member's needs. Procedures developed include a multitude of topics to include the following:

- CM activities in a variety of settings, including, but not limited to a member's home, shelter, or other care setting;
- Specific to documentation of follow-through with identification and successful linkage to community resources;
- Discharging members from CM;
- Appropriate CM documentation reflecting activities
- Timely and regular contacts between CM staff, the member's PCP, the member's primary BH provider, as applicable and the ~~Member~~member; and
- Include a process for graduation from Tiers 2 or 3 of CM to a lower tier, as a member's ongoing CM needs are reduced based on the member's POC .
- Appropriateness and timely referrals to VABs and other programs such as Tobacco Cessation, Problem Gambling, Woman, Infants, and Children (WIC) , Outreach Program for Pregnancy Services, PSH and others.
- Advanced Directives

All policies and procedures will be accessible to ~~our associates~~case management team members via the pre-

determined distribution channels and changes will be highlighted for ease of reference.

Annual Evaluation
The Plan evaluates the CM Program and all policies annually to determine if it remains current and appropriate and to determine if modifications to the program are needed. Policies will be dated and signed by the appropriate manager, coordinator, director, Chief Executive Officer (CEO), or Medical Director. The Plan will review staffing, job descriptions, and evaluate to confirm current duties performed reflect ~~our~~ written policies and procedures established. The evaluation will include:

- Frequency and type of CM contact
- Inclusion criteria for different tiers of CM
- Expected outcomes in subgroups at different tiers of CM, impact of use of the ED, inpatient admissions and follow-up care
- Expected penetration and target rate of engagement
- Identification of relevant measurement processes or outcomes
- Use of valid quantitative methods to measure outcomes against performance goals
- Applicable results of the Member Satisfaction Survey reviewed to identify quality improvement within CM practices.
- Any other relevant CM data

There is consideration of members' and providers' experience data when evaluating the CM Program. The Plan updates the CM Program based on this assessment. The evaluation is presented to the Plan QAPI Committee for approval. Based on the annual evaluation, the Director(s) of CM review and revise the CM Program as necessary.

Program Approval
The Plan's CM Program Description, as with any policy and procedure created and updated, will be approved initially by LDH and annually by both LDH, the ~~**Medical**~~ **Utilization** Management Committee and QAPI Committee.

Version Control History		
Date	**Changes**	**Associate Submitting Change**
1/16/2024	**Annual Review~~.~~. No changes approved by LDH.**	**Nicole Thibodeaux, HSD**
5/1/2025	Annual Review – grammar corrections, clarifications on Tier requirements.	Nicole Thibodeaux, HSD, Cher Allen, LaShelle Mitchell-Johnson