Humana Healthy Horizons™ in Louisiana

Department:	**Policy and Procedure No: TBD**	
Policy and Procedure Title: Department of Justice (DOJ) Community Case Management Program and PASRR Level II Evaluations		
Process Cycle: Annual/Ad-hoc	**Responsible Departments: CM/UM**	
Approved By:	**Issue Date:** 1/1/2023	**Revised:**

CONTRACT REFERENCE:

2.7.6 Case Management for Individuals in DOJ Agreement Target Population (Case 3:18-cv-00608, Middle District of Louisiana)
The Contractor shall develop a specialized community Case Management program consistent with the DOJ Agreement and LDH-issued guidance for the target population transitioning or diverted from nursing facility level of care using subcontracted community case managers who meet the qualifications established by LDH. The Contractor shall make a referral to a community Case Management agency within one (1) Business Day of receipt of a referral from LDH/OBH. The Contractor shall maintain ultimate responsibility for ensuring the Case Management needs of the target population are met by community case managers and community case managers satisfactorily completing required activities.

6.1.5 The Contractor shall comply with all settlement agreements, orders, and/or judgements rendered by a court of competent jurisdiction, including, but not limited to, those that arise from A.J. v. LDH (Case 3:19-CV-00324), Chisholm v. Phillips (Case 2:97-cv-03274), and United States v. State of Louisiana (DOJ Agreement, Case-3:18-cv-00608), and subsequent implementation plans in accordance with the Contract, the **MCO Manual**, and as directed by LDH. LDH reserves the right to assess Monetary Penalties for failure to meet this requirement.

2.7.7 Independent Evaluations for PASRR Level II
2.7.7.1 The Contractor shall be responsible for conducting PASRR Level II evaluations of Enrollees, directly or through a Subcontractor, upon referral from LDH. PASRR Level II evaluations must be performed by a licensed mental health professional (LMHP). Referrals shall 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 before the Enrollee is in a nursing facility. This evaluation does not include individuals with a developmental disability (DD); there is a separate determination process outside of this Contract for DD evaluations.
2.7.7.2 In conducting the evaluation, the Contractor shall follow the criteria set forth in 42 CFR Part 483, Subpart C and shall utilize the PASRR Level II standardized evaluation form provided by LDH.
2.7.7.3 Evaluators may use relevant evaluative data, obtained prior to initiation of PASRR, if the data are considered valid and accurate and reflect the current functional

status of the individual. However, if necessary to supplement and verify the currency and accuracy of existing data, the evaluator shall gather additional information necessary to assess proper placement and treatment.
2.7.7.4 In order to comply with mandated timelines, the Contractor shall submit the completed Level II evaluation report to OBH within four (4) Calendar Days of receipt of the referral from OBH.
2.7.7.5 Level II evaluation recommendations shall focus on ensuring the least restrictive setting appropriate with the appropriate services.
2.7.7.6 When OBH determines that nursing facility services are not appropriate, the Contractor shall assist eligible Enrollees to obtain appropriate alternative behavioral health services available under this Contract.
2.7.7.7 If at any time the Contractor discovers that an Enrollee residing in a nursing home who has an SMI has not received a Level II determination, the Contractor shall notify OBH.
2.7.7.8 The Contractor shall track Enrollees in a nursing facility who have gone through the PASRR process, those identified with SMI and those receiving specialized services, as per 42 CFR §483.130.
2.7.7.9 The Contractor shall track and report quarterly to LDH the delivery of all PASRR SBHS as defined and required under 42 CFR §483.120 and the DOJ Agreement.
2.7.7.10 The Contractor shall report to LDH indicators relative to individual evaluations on a quarterly basis with information available by region, type of placements, results of recommendations, location of individuals and referral sources as outlined in the LDH-issued reporting template.

ACRONYMS & DEFINITIONS:

DOJ Agreement Target Population (Case 3:18-cv-00608, Middle District of Louisiana) –

a. 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
b. Individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement during the course of the DOJ Settlement Agreement, or have been referred within two years prior to the effective date of this Agreement, and were diverted (Diverted member) from nursing facility placement
c. Excludes those individuals with co-occurring SMI and dementia, where dementia is the primary diagnosis.
d. Members of the Target Population are considered part of the special healthcare needs population.

Louisiana Department of Health (LDH)

Licensed Mental Health Professional (LMHP) – An individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance use disorder acting within the scope of all applicable State laws and their professional license. A LMHP includes individuals licensed to practice independently as:

- Medical Psychologists
- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Counselors (LPCs)

- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Addiction Counselors (LACs)
- Advanced Practice Registered Nurses (APRN) (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, and Family Psychiatric & Mental Health or a Certified Nurse Specialists in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice)

Office of Behavioral Health (OBH)

Pre-Admission Screening and Resident Review (PASRR) – A Federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. PASRR requires that all applicants to a Medicaid-certified nursing facility:

a. be evaluated for mental illness and/or intellectual disability; and
b. be offered the most appropriate setting for their needs (in the community, a nursing facility, or Acute Care settings); and
c. receive the services they need in those settings.

Serious Mental Illness (SMI) – Is a major mental disorder as described in 42 CFR 483 Subpart C (i)-(iii). Application of this definition should also take into consideration the current Diagnostic and Statistical Manual of Mental Disorders (DSM) definitions such as Schizophrenia Spectrum Disorders, other Psychotic Disorders, Bipolar Related Disorders, Depressive Disorders, Anxiety Disorders, Personality Disorders, Trauma Related Disorders or other major mental disorders that result in functional limitations in major life activities, including within the 6 months prior to nursing facility application, are not a primary diagnosis of dementia or co-occurring with a primary diagnosis of dementia, and are not episodic or situational.

Transition Assessment – Assessment developed by the Transition Coordinator as a precursor to the transition process. The assessment is developed in an effort to identify strengths, status, and needs for transition.

Transition Coordinator – Employed by OBH or OAAS, the Transition Coordinator will work with individuals identified as being part of the DOJ Target Population residing in nursing facilities and facilitating transition activities including conducting assessments, developing transition plans, and further providing ongoing follow up, ensuring the enrollee's needs in the community are met.

Transition Plan – Plan developed through the transition process led by the Transition Coordinator, in collaboration with the MCO and community case manager, to facilitate and operationalize items needed to ensure the enrollee's successful transition into the community.

PURPOSE:

These processes have been developed to ensure Humana Healthy Horizons in Louisiana members receive thorough and compliant PASRR Level II evaluations and, for those found to qualify for DOJ programming as part of the Target population, receive service and support in compliance with DOJ Settlement Agreement and Compliance Guide.

POLICY AND PROCEDURE:

Policy:
Humana will maintain an agreement with a PASRR Level II Evaluation Vendor (PASRR Vendor) to assist in completion of PASRR Level II evaluations and a DOJ Community Case Management (CCM) Program Vendor (CCM Vendor) to provide case management services to members of the Target population in accordance with the DOJ Agreement and Louisiana Department of Health (LDH) issued guidance for Target population transitioning or diverted from nursing facility level of care.

Procedure:

General Program Requirements:

The DOJ/PASRR Liaison in collaboration with the Behavioral Health Medical Director (psychiatrist) will serve as the main point of contact for PASRR Level II evaluations and the DOJ CCM program for LDH, OBH, the CCM Vendor, and the PASRR Vendor and will perform oversight activities to ensure compliance with the DOJ Agreement Compliance Guide.

The DOJ/PASRR Liaison will receive the following training that is also required for the Community Case Managers (CCMs):

- Overview of required case management activities, including associated timeframes, processes and procedures, and documentation requirements
- Overview of serious mental illnesses, including symptoms, signs someone is doing well/not doing well* NOTE: LMHPs are exempt from this training.
- Recognizing signs of abuse, neglect, extortion or exploitation, and critical incident reporting requirements
- Cultural competency and social determinants of health
- Principles of and approach to person-centered planning using a strength-based approach
- Motivational interviewing and successful engagement strategies
- Identifying and cultivating relationships with formal providers in the community and other community resources
- Benefits of community integration/inclusion and strategies for discussing, identifying, and assisting members to develop employment/educational goals and other community integration activities
- Strategies for identifying and addressing crisis
- Common physical health conditions impacting the SMI population, including overview of the condition, healthy ranges, modifiable risk factors, and strategies for supporting healthy behavior changes. Strategies to identify co-morbid conditions and likely medical services needed to address such conditions
- Benefits and services for adults, including home and community-based services provided the Office of Aging and Adult Services and the Office of Citizens with Developmental Disabilities and Humana covered services (including in-lieu of services and value add services). For Humana covered services, training must cover member eligibility criteria, service goals and expected outcomes
- Quality improvement expectations for target population and related reporting responsibilities

Program Management:

The DOJ/PASRR Liaison will:

1. Refer members with SMI, who are found to be residing in a nursing home and have not received a PASRR Level II evaluation, to OBH.

2. Refer member to the PASRR Vendor for PASRR Level II evaluation within one (1) calendar day of referral from LDH/OBH.
   a. Request for evaluation is sent via encrypted email to: MerakeyPASRR@merakey.org; brittney.leeper@merakey.org; kathryn.nutt@merakey.org; Lauren.Durocher@merakey.org
   b. Template for PASRR requests:
      - Please evaluate:
      - Individual Name:
      - DOB and SSN:
      - Type of Request:
      - Referral Contact:
      - Referral Phone:
      - Referral Email:
   c. Include/attach Behavioral Health claims (when and where) inpatient or outpatient

3. Ensure that PASRR Vendor completes the PASRR Level II evaluation and returns the evaluation to Humana within 2 (two) calendar days of referral date from Humana.
   a. In the event that the PASRR Vendor is unable to engage the member using the provided demographic information, the DOJ/PASRR Liaison will notify OBH in writing to OBH.PASRR@la.gov.

4. Review all PASRR Level II evaluations submitted by the PASRR Vendor prior to submission to OBH ensuring that evaluation:
   a. was performed by a Licensed Mental Health Professional, face to face, with the member and through interviews with staff and family members when available. Exception to the face-to-face requirement can only be made by OBH and must be in writing.
   b. occurred using the PASRR Level II standardized evaluation form provided by LDH
   c. recommendations focus on ensuring the least restrictive setting appropriate with the appropriate services.

5. Submit the PASRR Level II evaluation and supporting documentation to LDH/OBH within four (4) calendar days of the receipt of the referral from OBH.
   a. Submissions are uploaded to the FTP site located at: https://mvaftp.dhh.la.gov/?Command=Login or if site is non-functional, can be emailed to: OBH.PASRR@la.gov (cc'ing Jacqueline.Whitmore@la.gov and Ann.Darling@la.gov)

Commented [MR1]: Do we need to document that it must be conducted face to face through interviews with the individual, staff and their family whenever available? Exception to the face to face requirement can only be made by OBH.

Commented [NT2R1]:

Commented [MR3]: If need to include how/where to upload, I have the FTP site https://mvaftp.dhh.la.gov/?Command=login if that site is not functioning, email to OBH.PASRR@la.gov (cc'ing Jacqueline.Whitmore@la.gov and Ann.Darling@la.gov) Also, do we need to add that the PASRR submission should include supporting documentation?

6. Actively link the member, through the PASRR Level II evaluation process, to alternate services individualized to their needs and necessary to maintain them in the community including:
    a. those services needed to address the member's physical and behavioral healthcare needs; and
    b. community resources necessary to ensure their social needs are met; and
    c. referrals to home and community-based supports intended to assist the member with their activities for daily living (ADL) and instrumental activities for daily living (IADL) needs.

7. Receive referrals for members who meet the criteria and are considered Target population members directly from LDH/OBH Transition Coordinators.

8. Make a referral to the CCM Vendor within one (1) business day following the request from the LDH/OBH Transition Coordinator or the PASRR Level II decision date for those members diverted from nursing facility placement.

9. Ensure Target population members identified by LDH/OBH Transition Coordinators are assigned and have access, through the CCM Vendor, to a qualified CCM in their region of residence that will help divert them from the nursing facility (Diverted member) or facilitate the transition from nursing facility to the community, as well as provide ongoing case management for at least one (1) full year (365 days) after successful transition or diversion.

10. Monitor to ensure CCM services and processes are individualized and person-centered, reflecting the member's unique strengths, needs, preferences, experiences, and cultural background.

11. Monitor to ensure CCM services are comprehensive, culturally competent and of sufficient intensity to ensure community case managers are able to identify and coordinate services and supports to assist members with obtaining good health outcomes, achieve the greatest possible degree of self-management of disability and life challenges, prevent institutionalization or hospitalization, and connect members with resources that are based on their desires and hopes that build stability and enable them to recover and thrive.

12. Collaborate with the CCM to ensure services include access to all medically necessary services covered under the State's Medicaid program and address social determinants of health which serve as barriers to good health outcomes, including but not limited to behavioral and physical health services, specialty services, and referrals to community resources.

13. Support the LDH Transition Coordinator as they lead the development of the transition assessment and transition plan, with support from the CCM, for the purpose of securing providers, resources, and supports in the community that will begin immediately upon the member's transition to the community.

14. Monitor CCM services to ensure each transitioning member has all services, including prescription medication and durable medical equipment, in place necessary to transition the member at the appropriate time, with necessary services authorized at the point of transition to the community.

15. Assist in linking members with services and/or evaluations necessary to support the determination of SMI and/or an appropriate diagnosis related to an Alzheimer's or dementia related disorder.

16. Collaborate with Utilization Management team members to ensure service authorizations, consistent with the plan of care, are reviewed for medical necessity and issued to appropriate providers and authorization information is shared with the assigned CCM.

17. Collaborate with CCM to secure services and linkages to other necessary community and social supports as necessary including but not limited to transportation scheduling.

18. Inform CCM of member health status and other factors that contribute to successful community living that is evident or contained within Humana data such as pharmacy data, hospitalizations, etc.

19. Provide monthly claims monitoring data to CCM on a monthly basis to help identify and address care gaps, missed linkages, uncoordinated services.

20. Review and approve initial and ongoing assessments and plan of care for adherence to program requirements.

21. Conduct Weekly Rounds to provide oversight for CCM Vendor, review Target population member status, identify and address member needs, coordinate care.

22. Monitor program quality through routine monthly chart audits, at a minimum, to ensure that CCM services are provided in compliance with the DOJ Settlement Agreement and Compliance Guide. Audit results are to be shared with the CCM and PASRR Vendor(s) in quarterly review meetings and as needed to ensure and improve compliance as required.

23. Complete the report 317-PASRR Report as scheduled and required by LDH.

24. Monitor completion of the 361-Community Case Management Report by the CCM Vendor as scheduled and required by LDH.

If the PASRR Vendor is unable to perform PASRR evaluations, regardless of reason, case management staff (LMHP or equivalent licensure) from the Humana Healthy Horizons health plan will perform PASRR evaluations per the requirements outlined in the Contract with LDH, DOJ Compliance Guide, and this policy.

Commented [NK4]: Added additional verbiage to ensure we identify only our appropriate licensed CM staff will complete the PASSR

If the CCM Vendor is unable to provide/perform CCM programming case management staff from the Humana Healthy Horizons health plan, with the approval from LDH, will perform CCM per the requirements outlined in the Contract with LDH, DOJ Compliance Guide, and this policy.

CCM Vendor Quality Monitoring

The DOJ/PASRR Liaison and/or designee will be responsible for managing and completing the 317-PASRR Report as scheduled by LDH.

The DOJ/PASRR Liaison will collaborate with the CCM Vendor to ensure completion of the 361-Community Case Management Report as scheduled by LDH.

The DOJ/PASRR Liaison will perform routine monitoring of the CCM Vendor activities through documentation reviews (weekly and monthly) to ensure compliance and that the needs of the Target population members are met by the CCM program and CCMs satisfactorily complete required activities as follows:

Members residing in nursing facility:

- Review case files for documentation showing compliance with the below required activities:

  Pre-Transition Phase
  - CCM program activities began at least 60 days prior to the member's discharge from the nursing facility, earlier engagement more than 60 days prior to discharge can occur if recommended by the LDH/OBH Transition Coordinator
    - CCM attendance at transition planning meetings with the LDH/OBH Transition Coordinator and member.
    - At least four (4) CCM face-to-face contacts in the 60-day period prior to the member's transition from the nursing facility.
      - At least two (2) of these face-to-face contacts occurring in the last 30 days prior to the member's transition from the nursing facility.
    - Comprehensive Transition Plan

  Post Transition Phase – Assessments/Plan of Care (POC)
  - CCM performed an initial comprehensive CCM assessment, using the agreed upon assessment tool for the DOJ CCM program, within 14 days of transition date.
    - For members not connected to CCM prior to transition, CCM performed an initial CCM assessment, using the agreed upon assessment tool for the DOJ CCM program, within 14 days of referral date.
    - Team based assessment approach with member, natural supports, providers, peers, and other important to member.
  - CCM reassessed member at least monthly and/or with significant change in member status with updates to the POC as appropriate.
  - CCM assessments and reassessments focus on member's needs to include medical, behavioral health, social/recreational, educational/vocational, and other services and supports to meet the daily needs and preferences of members. These other services and supports include but are not limited to housing and housing supports, employment, health/wellness, safety, transportation, health

Commented [MR5]: I would think these members are Complex. Will the CCM use our Comprehensive Assessment as it is NCQA inclusive? Merakey is not and will not be getting NCQA certification.

Commented [NT6R5]: No, we have to use the CCM assessment that all the other MCOs are using. This population will be exempt from NCQA from what I understand.

Commented [NK7R5]: If theyre excluded we cannot identify these members as complex. We should not have them in the complex acuity w/in the CM PD

care services and adaptive equipment, nutrition, and dental services. Assessments should include:

- Functional status: The degree to which a person can fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care.
- Co-morbidities: Identifies potential complications in the course of illness due to level of acuity or disability related to co-occurring medical illness, substance use disorder and/or intellectual/developmental disability. This includes an assessment for information and education needed for management of these co-morbidities.
- Physical health needs.
- Recovery environment: This dimension considers factors in the environment, the social and interpersonal determinants of health and wellbeing that may support efforts to achieve or maintain mental health and/or abstinence.
- Family and/or natural support system.
- Purpose and productivity: Include queries about the person's interests, concerns, perceived barriers and preferences about work and education.
- Housing preferences: Identification of feelings, choices and supports needed for people to be successful in living independently. This can include choice of living arrangement, neighborhood and other aspects that are important to the person for their housing environment.
- Community inclusion and engagement: Identifies the opportunities for low demand social engagement, such as settings the public at large uses (i.e., libraries, senior centers, recreation centers, park programs etc.) as desired by the member.
- Risk of harm: This dimension of the assessment considers a person's potential to cause significant harm to self or others.
- Treatment and recovery history: Past experience may be one predictor of future engagement and response to treatment and supports and shall be taken into account in determining service needs and related person-centered plan of care.
- Crisis and relapse triggers: Some situations or behaviors, called triggers, can lead to a relapse. Identifying triggers through the assessment process will allow the development of strategies to deal with them and reduce the risk of crisis or relapse.

- CCM developed/updated POC, within 14 days of assessment date, in collaboration with the member, natural supports, and care team, using the agreed upon POC tool for the DOJ CCM program, to reflect assessment results and changes in member needs. The POC must:
  - Be person-centered
  - Be based on principles of self-determination, and recovery
  - Contain interventions/strategies stemming from a strengths-based approach
  - Be reflective of member choices, preferences, strengths, needs, goals – in member's own words
  - Include comprehensive, integrated formal and informal services and supports

- Type, amount, duration, and frequency of services, including service providers.
- Include strategies to address barriers
- Include crisis planning, including potential causes and strategies for recognizing and addressing crisis
- Include emergency preparedness plans, including back up plan
- Show member participation and that member was offered freedom of choice in services and providers.
- Documentation must show evidence that notice of care planning meeting was provided to members of the care team and anyone member identified at least seven (7) day prior to meeting date/time.

- Monthly POC reviews with member and/or caregiver, at a minimum, or as needed and following a significant change to address unmet or changing needs. Documentation must show evidence that notice of care planning meeting was provided to members of the care team and anyone member identified at least seven (7) day prior to meeting date/time.
- CCM provided a copy of the care plan to the member and/or caregiver and providers as necessary and with appropriate consent.
- CCM linked member to services and support identified in POC.
- CCM monitored and followed up on services and supports through both member and provider contacts to ensure:
  - Member received services and supports per POC, remediating as necessary
  - Progress towards POC goals
  - Member satisfaction with services and supports
  - Member continued access to services
  - Member does not feel isolated
  - Living situation is safe, stable, and healthy including member satisfaction
- CCM maintained ongoing contact with member as follows:
  - First 60 days:
    - Four contacts per week with the member, with two contacts being face to face with the member.
    - One contact with each service/support provider within the first two weeks.
  - 61 – 180 days:
    - Two contacts per week with the member, one of those contacts being face to face with the member.
    - One contact with each service/support provider each 60 days.
  - 181 – 365 days:
    - Two contacts per month with the member, with one of those contacts being face to face with the member.
    - One contact with each service/support provider each 60 days.
  - 365+ days:
    - Based on assessment to determine ongoing need and desire for case management.
    - A minimum of two contacts per month with the member, with one face-to-face contact with the member.
    - One contact with each service/support provider each quarter.

- CCM reported critical incidents to appropriate agencies and provided follow-up activities to prevent further incident.
- CCM reported deaths as applicable to the single point of contact: Brooks.Malbrough@LA.GOV within one (1) business day of discovery

Discharge Phase

- CCM performed formal reassessment, using the agreed upon assessment tool for the DOJ CCM program, at least 60 days prior to discharge date from CCM program.
- Member experienced continued enrollment/engagement in CCM program for at least 365 days.
- CCM and member made determination of whether continuation of CCM program services is necessary.
- CCM developed a discharge plan at least 30 days prior to discharge date to include all services and supports that will remain in place past the discontinuation of CCM services. The plan includes contact information for Humana and all service providers.

Members who are admitted or readmitted to nursing facilities:

- Review case files for documentation showing compliance with the below required activities:
  - CCM meeting within 14 days following the member's admission/readmission to the nursing facility.
    - Meeting attendees to include transitioned and diverted members, the member's TC if available, and others the member wishes to include in the meeting.
  - CCM post meeting consultation with DOJ/PASRR Liaison and LDH/OBH Transition Coordinator, if applicable, to determine if CCM program shall continue given the length of time the member is expected to reside in the nursing facility and member preferences.
    - If the stay is short-term (approximately 30 days or less), documentation that CCM services continued unless the member declined. Member declination must be documented.
    - If CCM services will be discontinued, documentation that the CCM met with the member to develop the discharge plan prior to the member's discharge from CCM services.

Diverted Members:

- Review case files for documentation showing compliance with the below required activities:
  - CCM connected member with service providers to address urgent needs within seven (7) days following the referral.
  - CCM performed an initial CCM assessment, using the agreed upon assessment tool for the DOJ CCM program, within 14 days of referral date.
    - Team based assessment approach with member, natural supports, providers, peers, and other important to member.
  - CCM reassessed member at least monthly and/or with significant change in member status with updates to the POC as appropriate.

- CCM assessments and reassessments focus on member's needs to include medical, behavioral health, social/recreational, educational/vocational, and other services and supports to meet the daily needs and preferences of members. These other services and supports include but are not limited to housing and housing supports, employment, health/wellness, safety, transportation, health care services and adaptive equipment, nutrition, and dental services. Assessments should include:
  - Functional status: The degree to which a person can fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care.
  - Co-morbidities: Identifies potential complications in the course of illness due to level of acuity or disability related to co-occurring medical illness, substance use disorder and/or intellectual/developmental disability. This includes an assessment for information and education needed for management of these co-morbidities.
  - Physical health needs.
  - Recovery environment: This dimension considers factors in the environment, the social and interpersonal determinants of health and wellbeing that may support efforts to achieve or maintain mental health and/or abstinence.
  - Family and/or natural support system.
  - Purpose and productivity: Include queries about the person's interests, concerns, perceived barriers and preferences about work and education.
  - Housing preferences: Identification of feelings, choices and supports needed for people to be successful in living independently. This can include choice of living arrangement, neighborhood and other aspects that are important to the person for their housing environment.
  - Community inclusion and engagement: Identifies the opportunities for low demand social engagement, such as settings the public at large uses (i.e., libraries, senior centers, recreation centers, park programs etc.) as desired by the member.
  - Risk of harm: This dimension of the assessment considers a person's potential to cause significant harm to self or others.
  - Treatment and recovery history: Past experience may be one predictor of future engagement and response to treatment and supports and shall be taken into account in determining service needs and related person-centered plan of care.
  - Crisis and relapse triggers: Some situations or behaviors, called triggers, can lead to a relapse. Identifying triggers through the assessment process will allow the development of strategies to deal with them and reduce the risk of crisis or relapse.
- CCM developed/updated POC, within 14 days of assessment date, in collaboration with the member, natural supports, and care team, using the agreed upon POC tool for the DOJ CCM program, to reflect assessment results and changes in member needs. The POC must:
  - Be person-centered
  - Be based on principles of self-determination, and recovery

Commented [MR8]: Our NCQA inclusive Comprehensive Assessment per our CM PD includes: The Comprehensive Assessment includes, at a minimum, 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 assessment of at least the six basic activities of daily activities (Bathing, Dressing, Toileting, Transferring, Feeding and Continence), and functional status
- Evaluation of caregiver resources including adequacy, involvement and level of decision-making and support systems
- Cultural/linguistic needs, preferences or limitations
- 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, 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

        - Contain interventions/strategies stemming from a strengths-based approach
        - Be reflective of member choices, preferences, strengths, needs, goals – in member's own words
        - Include comprehensive, integrated formal and informal services and supports
        - Type, amount, duration, and frequency of services, including service providers.
        - Include strategies to address barriers
        - Include crisis planning, including potential causes and strategies for recognizing and addressing crisis
        - Include emergency preparedness plans, including back up plan
        - Show member participation and that member was offered freedom of choice in services and providers.
        - Documentation must show evidence that notice of care planning meeting was provided to members of the care team and anyone member identified at least seven (7) day prior to meeting date/time.
    - Monthly POC reviews with member and/or caregiver, at a minimum, or as needed and following a significant change to address unmet or changing needs. Documentation must show evidence that notice of care planning meeting was provided to members of the care team and anyone member identified at least seven (7) day prior to meeting date/time.
    - CCM provided a copy of the care plan to the member and/or caregiver and providers as necessary and with appropriate consent.
    - CCM linked member to services and support identified in POC.
    - CCM monitored and followed up on services and supports through both member and provider contacts to ensure:
        - Member received services and supports per POC, remediating as necessary
        - Progress towards POC goals
        - Member satisfaction with services and supports
        - Member continued access to services
        - Member does not feel isolated
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    - CCM maintained ongoing contact with member as follows:
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            - One contact with each service/support provider each 60 days.
        - 365+ days:

- Based on assessment to determine ongoing need and desire for case management.
- A minimum of two contacts per month with the member, with one face-to-face contact with the member.
- One contact with each service/support provider each quarter.

- CCM reported critical incidents to appropriate agencies and provided follow-up activities to prevent further incident.
- CCM reported deaths as applicable to the single point of contact: Brooks.Malbrough@LA.GOV within one (1) business day of discovery

Discharge Phase

- CCM performed formal reassessment, using the agreed upon assessment tool for the DOJ CCM program, at least 60 days prior to discharge date from CCM program.
- Member experienced continued enrollment/engagement in CCM program for at least 365 days.
- CCM and member made determination of whether continuation of CCM program services is necessary.
- CCM developed a discharge plan at least 30 days prior to discharge date to include all services and supports that will remain in place past the discontinuation of CCM services. The plan includes contact information for Humana and all service providers.

ADDITIONAL RESOURCES:

Department of Justice Agreement Compliance Guide
LOUISIANA MEDICAID MANAGED CARE ORGANIZATION Contract

VERSION CONTROL:

Version.Review.Approval History				
Department:	**Purpose of Review**	**Reviewed and Approved By:**	**Date:**	**Additional Comments:**

DISCLAIMER:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by an issue, to allow for consistency, Humana will follow the most stringent requirement.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/procedure) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/procedure) supersedes all other policies, requirements, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained by CMU to ensure no modifications have been made.

NON-COMPLIANCE:

Failing to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to non-compliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Associate Support Center via Humana's secure intranet of Hi! (Workday & Apps/Associate Support Center).