**Government Business Division**
**Policies and Procedures**

| Section (Primary Department) | SUBJECT (Document Title) |
|---|---|
| Health Care Management - Case Management | Case Management - LA |

| Effective Date | Date of Last Review | Date of Last Revision | Dept. Approval Date |
|---|---|---|---|
| 01/01/2023 | | | 121/013/2022 |

Department Approval/Signature:

Policy applies to health plans operating in the following State(s). Applicable products noted below.

| Products | | | | |
|---|---|---|---|---|
| ☒ Medicaid/CHIP | ☐ Arkansas | ☐ Iowa | ☐ Nevada | ☐ Tennessee |
| ☐ Medicare/SNP | ☐ California | ☐ Kentucky | ☐ New Jersey | ☐ Texas |
| ☐ MMP/Duals | ☐ Colorado | ☒ Louisiana | ☐ New York – Empire | ☐ Virginia |
| | ☐ District of Columbia | ☐ Maryland | ☐ New York (WNY) | ☐ Washington |
| | ☐ Florida | ☐ Minnesota | ☐ North Carolina | ☐ Wisconsin |
| | ☐ Georgia | ☐ Missouri | ☐ South Carolina | ☐ West Virginia |
| | ☐ Indiana | ☐ Nebraska | | |

**POLICY:**

**Healthy Blue shall offer a comprehensive care management program to support enrollees, regardless of age, based on an individualized assessment of care needs. At a minimum, care management shall include the populations and functions described throughout this policy.**

**Special Populations:**

**The case management department in Louisiana assists members that fall into a variety of different populations. These populations have specific guidelines that must be met per LDH and have individual policies and procedures related to each. These populations include, but are not limited to:**

- **Special Healthcare Need (SHCN)**
- **Nursing home recipients that require a Pre-Admission Screening and Resident Review (PASRR)**
- **Department of Justice (DOJ) Agreement**
- **Justice Involved Members (JIM)**
- **Pregnancy Services**
- **Applied Behavioral Health Analysis (ABA)**
- **Permanent Supportive Housing (PSH)**
- **Members trying to quit smoking or have a problem gaming**
- **Eligible women, infants and children for Women, Infant and Children (WIC) Program**
- **Coordinated System of Care (CSoC)**

**All populations listed above have specific policies and procedures coordinated to their program. Please refer to those policies and procedures for specific details regarding the program.**

**Training**

**Healthy Blue shall provide initial and ongoing staff training that includes an overview of contractual, state, and federal requirements specific to individual job functions. Healthy Blue shall ensure that all staff members having contact with enrollees or providers receive initial and ongoing training on health equity and social determinants of health, beyond Culturally and Linguistically Appropriate Services (CLAS) requirements and with regard to the appropriate identification and handling of quality of care concerns.**

**Healthy Blue shall educate all staff members about its policies and procedures on advance directives.**

**Healthy Blue associates that shall be trained in the geography of Louisiana, as well as its culture and the correct pronunciation of cities, towns, and surnames. They shall have access to GPS or mapping search engines for the purpose of authorizing services in, and recommending providers and transporting enrollees to, the most geographically appropriate location.**

**Healthy Blue shall comply with cybersecurity training requirements of the contract.**

**Healthy Blue shall provide subject appropriate staff to attend and participate in meetings or events, which may be on-site, scheduled by LDH. All meetings shall be considered mandatory unless otherwise indicated.**

**For case managers and case management supervisors, additional training requirements shall include but not be limited to:**

- **Specialized behavioral health policy and procedure materials issued by LDH;**
- **Coordinate System of Care (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 behavioral health;**
- **Specialized Behavioral Health Services (SBHS) for enrollees residing in a nursing facility and/or included in the DOJ Agreement Target Population;**
- **Pre-admission screening and resident review (PASRR);**
- **Services provided by the Office for Citizens with Developmental Disabilities;**
- **Current and applicable evidence-based practices;**
- **Behavioral health services available through other funding sources, including Medicare; and**

- **Permanent Supportive Housing provided by the Office of Aging and Adult Services. case management**

**For those staff that have contact with enrollees or providers- initial and ongoing training with regard to appropriate identification and handling of quality of care concerns.**

**For staff members working directly with enrollees- Crisis intervention training.**
**For 24-hour behavioral health crisis line staff- participation in OBH-approved trainings related to the Louisiana Crisis Response System.**

**Case Management Policies and Procedures**

**Healthy Blue shall develop, implement, and maintain criteria and protocols for determining which Case Management activities may benefit an Enrollee. Healthy Blue shall submit such criteria and protocols to LDH or its designee as part of Readiness Review and prior to any substantive revisions. Where Healthy Blue delegates Case Management to a Network Provider, Healthy Blue shall have a written plan in place for monitoring and oversight of performance under any such agreements, including provisions for assessing Provider compliance and corrective actions and/or termination as appropriate.**

**All policies and procedures shall be reviewed at least annually to ensure that Healthy Blue's written policies reflect current practices. Reviewed policies shall be dated and signed by Healthy Blue's appropriate manger, coordinator, director, or CEO. Minutes reflecting the review and approval of the policies by an appropriate committee are also acceptable documentation. All medical and quality management policies shall be approved and signed by Healthy Blue's Medical Director. All behavioral health policies shall be approved and signed by Healthy Blue's Behavioral Health Medical Director. Job descriptions shall be reviewed at least annually to ensure that current duties performed by the employee reflect written requirements. Healthy Blue shall provide any policies, procedures, and evidence of reviews as directed by LDH in writing.**

**Healthy Blue shall develop, implement, and maintain procedures for providing case management. Case management procedures shall:**

- **Be subject to approval by LDH**
- **Including procedures for contacting Enrollees to complete the HNA and comprehensive assessment, including number of contact attempts and methods of contact;**
- **Include procedures for acquiring and documenting enrollees' consent (or the enrollee's family or authorized representative) to receive case management and for Healthy Blue to share information about an enrollee's care with enrollees' providers to promote coordination and integration.**

- **Include a plan describing how management of behavioral health services shall be integrated into the overall case management of the enrollee population;**
- **Include criteria and protocols for ensuring appropriate staffing ratios and caseloads for case managers and other staff involved in care management activities in line with industry practices;**
- **Include processes for Healthy Blue to measure the effectiveness and quality of Healthy Blue's case management procedures. Such processes shall include:**
    - **Tracking of Frequency and type of case management contact;**
    - **Developing and implementing inclusion criteria for different tiers of case management, including how the HNA and comprehensive assessment are utilized;**
    - **Determining expected outcomes in subgroups at different tiers of case management, including an impact analysis of Case Management on the use of the ED, inpatient admissions, and follow-up care;**
    - **Expected case management penetration and target rate of engagement;**
    - **Identification of relevant measurement processes or outcomes; and**
    - **Use of valid quantitative methods to measure outcomes against performance goals;**
- **Include protocols for providing case management activities in a variety of settings, including, but not limited to an enrollee's home, shelter, or other care setting;**
- **Include criteria and protocols regarding documentation of follow-through with identification and successful linkage to community resources;**
- **Include criteria and protocols for discharging enrollees from case management;**
- **Ensure that the case management activities each enrollee is receiving are appropriately documented;**
- **Ensure regular contacts between case management staff, the enrollee's PCP, the enrollee's primary behavioral health provider as applicable, and the enrollee; and**
- **Include a process for graduation from Tiers 2 or 3 of case management, as an enrollee's ongoing case management needs are reduced based on the enrollee's plan of care.**

**Referral to Case Management**

**Healthy Blue shall receive referrals to case management through the Health Needs Assessment (HNA), identification of individuals with Special Healthcare Needs (SHCN), as well as referral sources, including but not limited to**

- **Enrollee services and self-referral (including enrollee grievances);**
- **Providers (including primary care, behavioral health and specialist providers); and**
- **State staff, including BHSF, OBH, OAAS, OCDD, OPH, and DCFS.**

**Healthy Blue shall provide guidelines on how and in what circumstances to refer enrollees for potential engagement in case management in a manner and format that is readily accessible to providers.**

**Healthy Blue shall provide guidelines to Enrollees in the Member Handbook on how and in what circumstances Enrollees may engage in Case Management.**

**Healthy Blue shall consider all referred Enrollees for engagement in Case Management.**

**Health Needs Assessment**

**Healthy Blue shall attempt to conduct enrollee health needs assessments (HNA) as part of the enrollee welcome call to identify health and functional needs of enrollees, and to identify enrollees who require short-term care coordination or case management for medical, behavioral, or social needs. Where an enrollee is a child, the HNA shall be completed by the enrollee's parent or legal guardian.**

**Healthy Blue shall develop, implement, and maintain procedures for completing an initial HNA for each enrollee, and shall make best efforts to complete such screening within ninety (90) calendar days of the enrollee's effective date of enrollment [42 C.F.R. §438.208(b)]. If the initial HNA attempt is unsuccessful, Healthy Blue shall attempt to conduct, and document its efforts to conduct, the HNA on at least three (3) different occasions, at different times of the day and on different days of the week.**

**Healthy Blue shall provide HNA data to the enrollee's assigned PCP, and to LDH as requested.**

**The HNA shall:**

- **Utilize a common survey-based instrument, which is provided by LDH**
- **Be made available to enrollees in multiple formats including Web-based, print and telephone;**
- **Be conducted with the consent of the enrollee;**
- **Identify individuals for referral to case management, with more in-depth assessment to occur as part of the plan of care;**
- **Screen for needs relevant to priority social determinants of health; and**
- **Include disclosure of how information will be used.**

**Tiered- Case Management Based on Need**

**Healthy Blue shall implement a tiered case management program that providers for differing levels of case management based on an individual enrollee's needs. Healthy Blue shall engage enrollees, or their parent or legal guardian, as appropriate, in a level of case**

**management commensurate with their risk score as identified through predictive modeling, if applicable, combined with the care needs identified in the enrollee's plan of care (POC) and HNA. If requested by the enrollee, or the enrollee's parent or legal guardian, the frequency and/or method of engagement may be increased, reduced, or substituted or declined. Healthy Blue shall retain documentation of such requests. Where the enrollee's PCP or behavioral health provider offers Case Management, the Contractor shall support the provider as the lead case manager on the multi-disciplinary care team.**

**Tiered- case management includes:**

- **Tier 3 (High level): Those enrollee's that are the highest need and require the most focused attention to support their clinical care needs and address SDOH.**
- **Tier 2 (Medium level) : Those enrollee's that are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH.**
- **Tier 1 (Low level): Those enrollee's that are the lowest level of risk within the case management program and typically require support in care coordination and in addressing SDOH**
- **Transitional Case Management: Those enrollee's that are transitioning between institutional and community care settings, including but not limited to, transitions to/from inpatient hospitals, nursing facilities, psychiatric facilities, PRTFs, therapeutic group homes, permanent supportive housing, intermediate care facilities, residential substance use disorder settings, and transitions out of incarceration.**

**Please see Tiered CM- LA policy for more details.**

**Individual Plan of Care**
**Healthy Blue shall develop a comprehensive individualized, person-centered plan of care (POC) for all enrollees who are found eligible for case management. When an enrollee receives services from Healthy Blue, only for specialized behavioral health services (SBHS), the plan of care shall focus on coordination and integration, as appropriate. When an enrollee receives services requiring a plan of care from LDH, such as Home and Community Based Waiver services or services through OPH, Healthy Blue shall collaborate with LDH in developing the plan of care.**

**Multi-Disciplinary Care Team**

**Healthy Blue shall identify a multi-disciplinary care team to serve each enrollee based on individual need for all enrollees in case management Tiers 2 and 3 and transitional case management. Contractor shall assign lead case managers based on enrollee's priority care needs, as identified through the plan of care. Where behavioral health is an enrollee's primary health issue, the case manager shall be a behavioral health case manager. As needed, case managers with expertise in physical or behavioral health care will support lead**

**case managers where there are secondary diagnoses. If the enrollee is under the age of six (6), the lead case manager shall have expertise in early childhood mental health or access to a consultant with expertise in infant and early childhood mental health.**

**Physical and behavioral health case managers shall be co-located and based in Louisiana to allow for integration of case management for enrollees with both physical and behavioral health care needs. Healthy Blue may request exceptions to this requirement for individual case managers.**

**In addition to the case manager and the enrollee and their family or authorized representative, the care team shall include members based on an enrollee's specific care needs and goals identified in the plan of care. The team may change over time as the enrollee's care needs change. Potential team members shall include, but are not limited to:**

- **Primary Care provider;**
- **Behavioral health provider(s);**
- **Specialist(s);**
- **Pharmacist(s);**
- **Community Health Worker(s);**
- **Home and community based service providers and managers;**
- **Housing specialist, if the enrollee is identified as homeless; and**
- **State staff, including transition coordinators.**

**Teams shall meet at regular intervals as identified in the individual care plan, based on the individual's care needs. When possible, the team shall meet in person but when necessary, team members may participate in meetings via telephone. At a minimum, multi-disciplinary care teams shall meet on a monthly basis for enrollees in Tier 3 case management and on a quarterly basis for enrollees in Tier 2 case management.**

**Referrals for Tobacco Cessation and Problem-Gaming**

**The HNA shall screen for problem gaming and tobacco usage. The case manager shall refer Enrollees who screen positive to appropriate Network Providers offering tobacco cessation treatment and/or problem gaming treatment services, including the Louisiana Tobacco Quitline.**

**Information regarding treatment services and/or referral to care shall be entered into Healthy Blue's system for the purpose of tracking and reporting according to various demographics. Tobacco cessation and problem gaming reports shall be made available upon LDH request in a format and frequency as determined by LDH.**

**Outreach Program for Pregnancy Services**

**Healthy Blue shall develop an outreach program to encourage women to seek prenatal services during the first trimester of pregnancy. This outreach program may utilize community and religious organizations and other community groups to develop outreach programs or referral networks, as well as include issuance of brochures and/or periodic articles emphasizing the importance of such care to all Enrollees.**

**Delegated Case Management**

**Healthy Blue may develop a program to delegate Case Management services to providers, including reimbursement for services rendered. The purpose of such a program is to reimburse for Case Management services in settings where Enrollees are already accessing care and to avoid duplication with Healthy Blue Case Management services. If a program is established, it should:**

- **Include PCPs, obstetrics and gynecology providers, and behavioral health providers.**
- **Establish minimum provider qualifications for each tier of delegated case management services.**
- **Establish criteria to distinguish when an Enrollee is eligible for delegated Case Management versus Healthy Blue Case Management. Wherever appropriate, Healthy Blue should utilize delegated Case Management for eligible Enrollees.**
- **Establish monitoring and oversight procedures to ensure delegated Case Management providers are adhering to applicable Case Management requirements described in the contract.**
- **Establish a reimbursement rate for an initial assessment and POC development as well as a monthly reimbursement rate for each tier of Case Management services.**
- **Be available to Enrollees that meet criteria and providers that meet minimum qualifications.**

**DEFINITIONS:**

**Advance Directive- A written instructions, such as living will or durable power of attorney for health care, recognized under State Law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.**

**Behavioral Health Case Management Supervisor – for specialized behavioral health services shall be a Louisiana-licensed psychiatrist or a Louisiana-licensed Mental Health Practitioner (i.e., Medical Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marital and Family Therapist, Licensed Addictions Counselor, or Advanced Practice Registered Nurse, who is a nurse practitioner specialist in**

**Adult Psychiatric and Mental Health, family Psychiatric and Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health). A Case Management Supervisor for medical services is a Louisiana-licensed registered nurse. The Case Management Supervisor shall be responsible for all staff and activities related to the case management program and shall be responsible for ensuring the functioning of case management activities across the continuum of care. This position shall be located in Louisiana.**

**Care Coordination – Deliberate organization of patient care activities by a person or entity, including the Contractor that is formally designated as primarily responsible for coordinating services furnished by providers involved in the enrollee's care, to facilitate appropriate delivery of health care services. Care coordination activities may include but aren't limited to the coordination of specialty referrals, assistance with ancillary services and referrals to and coordination with community services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of member's care.**

**Care Management – Overall approach of managing enrollees' care needs and encompasses a set of activities intended to improve patient care and reduce the need for medical services by enhancing coordination of care, eliminating duplication, and helping patients and caregivers more effectively manage health conditions.**

**Care Management Staff- Assess, plan, facilitate, and advocate options and services to meet the enrollees' health needs through communication and available resources to promote quality cost-effective outcomes. Healthy Blue shall provide and maintain in Louisiana, appropriate levels of care management staff necessary to ensure adequate local geographic coverage for in-field-face-to-face contact with physicians and enrollees as appropriate and may include additional out of state staff providing phone consultation and support.**

- **An adequate number of care management staff necessary to support enrollees in need of specialized behavioral health services shall be certified in treatment planning through the completion of specialized training in the Treatment Planning Philosophy.**
- **For the population receiving specialized behavioral health services, Healthy Blue shall have integrated care management centers/ care management staff that physically co-located with the care management staff. Healthy Blue shall employ case managers to coordinate follow-up to specialty behavioral health providers and follow-up enrollees to improve overall health care.**
- **Healthy Blue shall have an adequate number of care management staff necessary to support enrollees who meet target population criteria for the DOJ agreement. This care management staff for the DOJ Agreement Target Population shall include coverage for in field face-to-face contact with physicians/ providers, enrollees, family members, LDH Transition Coordinators, and other community resources/ supports as appropriate.**

**Case Management – Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual enrollee's health-related needs through communication and available resources to promote quality and cost-effective outcomes. Case management implicitly enhances care coordination through the designation of a case manager who's specific responsibility is to oversee and coordinate access and care delivery targeted to high-risk patients with diverse combinations of health, functional, and social needs.**

**Case Management Administrator/Manager – A person who oversees the case management functions and shall have the qualifications of a case manager and a minimum of five (5) years of management/supervisory experience in the health care field.**

**Case Manager – A licensed register nurse, licensed mental health practitioner, or other trained individual who is employed or contracted by Healthy Blue or an enrollee's PCP. The case manager is accountable for providing intensive monitoring, follow-up referral, clinical management of high risk enrollees, and care coordination activities, which include development of Healthy Blue's plan of care, ensuring appropriate referrals and timely two-way transmission of useful enrollee information; obtaining reliable and timely information about services other than those provided by the PCP; supporting the enrollee in addressing social determinants of health; and supporting safe transitions in care for enrollees moving between institutional and community care settings. The case manger may serve on one or more multi-disciplinary care teams and is responsible for coordination and facilitating meetings and other activities of those care teams.**

**Coordinated System of Care (CSoC) – A component of the system of care for youth who have significant behavioral health challenges and who are in or at imminent risk of out-of-home placement, and their families, which is a collaborative effort among families, youth, the Department of Children and Family Services, the Department of Education, the Department of Health and Hospitals, and the Office of Juvenile Justice.**

**DOJ Agreement Target Population (Case 3:18-cv-00608, Middle District of Louisiana) – (a) Medicaid eligible individuals over age eighteen (18) with serious mental illness (SMI) currently residing in nursing facilities; (b) individuals over age eighteen (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 this Agreement, or have been referred within two years prior to the effective date of this Agreement; and (c) excludes those individuals with co-occurring SMI and dementia, where dementia is the primary diagnosis.**

**Health Needs Assessment - A person-centered assessment of an enrollee's care needs, functional needs, accessibility needs, goals, and other characteristics.**

**Interdisciplinary or Multidisciplinary Care Team - a group that reviews information, data, and input from a person to make recommendations relevant to the needs of the person. The team consists of the person, high legal Representative if applicable, professionals of varied disciplines who have knowledge relevant to the other person's needs, and may include his family enrollees along with others the person has designated.**

**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:**

- **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 (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)**

**Medical Management Coordinator – A person who is a Louisiana-licensed registered nurse, advanced practice registered nurse, physician or physician's assistant if required to make medical necessity determinations; or have a Master's degree in health services, health care administration, or business administration if not**
**required to make medical necessity determinations, to manage all required Medicaid management requirements under LDH policies, rules and the contract. This position shall be located in Louisiana. The primary functions of the Medical Management Coordinator include:**

- **Ensuring adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria;**
- **Ensuring that appropriate concurrent review and discharge planning of inpatient stays is conducted;**
- **Developing, implementing and monitoring the provision of care coordination, disease management and case management functions;**
- **Monitoring, analyzing and implementing appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services; and**
- **Monitoring prior authorization functions and assuring that decisions are made in a consistent manner based on clinical criteria and meet timeliness**

**standards.**

**MCO Plan of Care - The plan developed by Healthy Blue in conjunction with the enrollee and other individuals involved in the enrollee's case management to support the coordination of an enrollee's care and provide support to the enrollee in achieving care goals.**

**Peer Specialist - A paraprofessional with specialized training who has a personal experience in social health care needs and chronic or complex illness and who engaged with enrollees, providing person-centered, culturally sensitive support building on the values, strengths and preferences of the enrollee.**

**Peer Support Specialist Staff - focus on peer to peer activities providing advocacy and the creation of a system which will enable an individual's resiliency and recovery.**

**Person-centered - A care planning process driven by the enrollee that identifies supports and services that are necessary to meet the enrollee's needs in the most integrated setting. The enrollee directs the process to the maximum extent possible and is provided sufficient information and support to make informed choices and decisions. The process is timely and occurs at times and locations convenient to the enrollee, reflects the cultural and linguistic considerations of the enrollee, providers information in plain language and in a manner that is accessible to enrollees, and includes strategies for resolving conflict or disagreement that arises in the planning process.**

**Targeted Case Management - Case management for a targeted population of persons with special needs described in the Louisiana Medicaid State Plan.**

**Transitional Case Management- the evaluation of an enrollee's medical care needs and coordination of any other support services in order to arrange for safe and appropriate care after discharge from one level of care to another level of care, including referral to appropriate services.**

**WIC - Federal program administered by the Office of Public Health that provides nutritional counseling; nutritional education; breast-feeding promotion; and nutritious foods to pregnant, postpartum and breast-feeding women and infants and children up to the age of five (5) who are determined to be at nutritional risk and who have a low to moderate income. An individual who is eligible for Medicaid is automatically income eligible for WIC benefits.**

**PROCEDURE:**

1) **Healthy Blue conducts a yearly training to incorporate all aspects of the contract. This training is provided on PowerPoint either in person or via teams. Attendance is**

monitored for this training. The PowerPoint is then emailed to the entire team following the training for those who were not in attendance. Attestation is then required that they read through the training material. The PowerPoint is provided to all new hires to read through and attest to.

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2) Determining Members for Case Management – Based on the CI3 Model:
   a) Members in need of case management services are identified through a variety of sources, which may include, but are not limited to the following in which all referrals are to be considered for engagement in Case Management:
      i. UM associates
      ii. Disease Management referrals
      iii. Customer Service associates
      iv. Appeals/grievances associates
      v. 24-hour nurse advice line
      vi. Health Information line
      vii. Physicians, vendors and other health care providers, including electronic referrals
      viii. Members or their families/caregivers
      ix. Hospital staff, including discharge planners and social workers
      x. Community social service organizations/ agencies/ vendors
      xi. Data mining (high utilization, frequent Emergency Room Visits, medical and pharmacy claims, High Length of Stay reports), as appropriate.
      xii. Data collected through UM management process
      xiii. Health Risk Assessment (HRAs)/ Screeners processed electronically or on an individual basis
      xiv. Interactive Voice response (IVR) Outreach Surveys
      xv. Member advocate referrals
      xvi. Self-reported data (such as form a health risk appraisal, delivered directly from a member, caregiver or provided by a client) and provider referrals of identified members from co-managing organizations (such as patient centered medical homes) may also be available via a data feed to the health plan.
      xvii. State-Regulatory Agency representative

   b) The following types of cases may initiate a case management review by Disease Management and/or at the LA Plan Level:

i) Using a prospective systematic approach, members with a risk of poor health outcomes are identified and targeted for CM services. This Continuous Case Finding (CCF) predictive modeling system evaluates members of a given population based on disease factors and claims history with the goal of improving quality of life through proper utilization of necessary services and a reduction in the use of unnecessary services.

ii) CM member candidate lists are updated monthly and prioritized to identify members with the highest expected needs for service. CM resources are focused on meeting listed members' needs by using a mix of standardized and individualized approaches.

iii) The CCF identification process results in members being assigned to risk groups as follows:

| Clinical criteria and CI3 Score | Stratification into Risk Groups |
|---|---|
| At least one clinically manageable condition and LIPA score ≥8.0 | Group 3 (High Risk) |
| At least one clinically manageable condition and LIPA score >0 and <8.0 | Group 2 (Moderate Risk) |
| At least one clinically manageable condition and no LIPA score | Group 1 (Low Risk) |
| No clinically manageable conditions | Group 0 |

Background: Healthy Blue's Case Management Program is a member-centric, integrated continuum of care model that strives to address the totality of each member's physical, behavioral, cognitive, functional, and social needs. The team ensures integration by having open communication between the BH and PH team members to collaborate on a member's care. The team has regular rounds in which a member can be discussed and receive input from both teams. These rounds include a BH and PH medical director as well. Social Determinants of Health are also addressed by all team members during interactions with members.

3) Case Management supports the integrated provider relationship and plan of care and emphasizes prevention of exacerbations using relevant evidence based practice guidelines

4) The Case Management program includes but is not limited to:
   a) Identification and screening of members who have or may have special needs within ninety (90) days of identification.
   b) Initial and ongoing assessment of member risk factors
   c) Problem based care planning, including measurable goals and interventions tailored to the complexity level of the member and in accordance to applicable NCQA standards.

i. Members are identified and prioritized based on expected CM needs. Those predicted to have CM needs are assigned to one of three groups.
ii. Based on their predicted CM need and complexity, members are contacted via phone or in person via community outreach and assessed to identify service needs and gaps.
iii. Based on this "gap analysis" a comprehensive individualized treatment care plan is developed in collaboration with the member (or family/caregiver/ guardian), and, where possible, input from the member's PCP and other active service providers is sought. If a change of PCP is identified, the health plan Case Manager will coordinate sending the new PCP the care plan and coordinate care for any referrals.
iv. Interventions are prioritized in terms of those that are expected to have the most immediate impact on reducing the risk of poor health outcomes (e.g. an intervention focused on admission or readmission to inpatient care).
v. The Case Managers then work with the member using motivational interviewing and other engagement techniques to develop an individual, member agreed-upon treatment care plan. The treatment care plan will incorporate the member's strengths; meet the members medical, functional, social and behavioral health needs as well as take into consideration the member's specific cultural and linguistic needs. Member care plans are constantly monitored, evaluated and updated based on real outcomes and ongoing cooperation and agreement with the member.
vi. Once the Case Manager and member have maximized progress toward achieving the goals of the individualized treatment care plan, then the member may be stepped down to a less intensive level of CM services or the case may be closed, according to established transfer or case closure requirements.

d) Continuity & coordination of care with primary or specialty providers, residential, social, community or other support services when needed.
e) Referrals and assistance to ensure timely access to providers including supporting the member when selecting or changing Primary Care / Specialist physicians.
f) Member education regarding and referral to a patient centered medical home when appropriate.
g) Effective member and provider communication, follow up and documentation within one business day.
h) Program monitoring and evaluation using quantitative and qualitative analysis of data.
Conduction of a member satisfaction survey with the case management program. As well as monthly monitoring of our case management program through internal and external reports to ensure contract requirements are abided by including monitoring of target rate of engagement. Monthly rounds are held to examine high utilizers of emergency room, repeat inpatients admission and lack

of follow-up care in which members identified are referred to case management. These reports are done with the assistance of our health analytics and quality teams, as well as reports to help monitor effectiveness of Case Management. Healthy Blue also completes yearly reports and analyses to determine the effectiveness of case management and to adjust the case management program as needed based on these results, which includes monitoring of goals. Healthy Blue also completes yearly reports and analyses to determine the effectiveness of case management and to adjust the case management program as needed based on these results, which includes monitoring of goals.

~~h)~~i)

~~i) Conduction of a member satisfaction survey with the case management program. As well as monthly monitoring of our case management program through internal and external reports to ensure contract requirements are abided by including monitoring of target rate of engagement. Monthly rounds are held to examine high utilizers of emergency room, repeat inpatients admission and lack of follow-up care in which members identified are referred to case management. These reports are done with the assistance of our health analytics and quality teams, as well as reports to help monitor effectiveness of Case Management. Healthy Blue also completes yearly reports and analyses to determine the effectiveness of case management and to adjust the case management program as needed based on these results, which includes monitoring of goals. .~~

5) Upon receiving a new referral, the Case Manager will verify current eligibility and review Member Privacy Information. If a member is not eligible, refuses or has other primary health insurance, the case is closed. If there is privacy information restricting contact, the Case Manager will make contact with the personal representative as indicated.

6) The Case Manager will make contact with the member/guardian/family member within one business day for cases considered urgent. The Case Manager will contact a member within five (5) business days for all other referrals.

7) The Case Manager makes three (3) attempts within 10 (ten) business days to contact the member/guardian/family member. If the individual can't be reached, the Case Manager sends a letter to the individual offering the Case Manager's telephone contact and hours of operation. For all members who receive telephonic outreach, member mailing includes information regarding Healthy Blue On Call/24-Hour Nurse Helpline and the importance of establishing a relationship with Primary Care Provider. If a number is disconnected or incorrect, the Case Manager will attempt to retrieve updated demographic information from the primary, specialty provider or pharmacy provider, recorded member contact information, if he or she called in to the health plan, or phone directories.

8) **Once a member/guardian/family member is contacted, the Case Manager must verify the member's demographic information before continuing. The Case Manager will verify the following: member name, date of birth and/or address. The Case Manager will communicate the name and title of the Case Manager and organization name, reason for the case management activity, Case Manager availability, how the member will be notified of actions on their behalf and the right to refuse assistance or "opt out" of case management services.**

9) **After verification and member consent for active participation in the program, a case management assessment will be completed. The Case Manager will utilize designated assessments within the case management system for completion.**
   **The Case Manager makes an overall assessment of the complexity and severity of illness, the presence of high-risk conditions and/or diagnosis, the member's readiness to change health risk behaviors and the intensity of case management intervention. The Case Manager is responsible for assigning complexity levels based upon the completed assessment (see complexity level grid in the Case Management Program Description). Upon completion of assessment, the Case Manager documents the member's relative information within the case management system. The Case Manager will document: attempted contacts, assessments and care plans, location of where the case management s all there services were provided, progress of member, evaluation, outcomes, and disposition.**

10) **The Case Manager will develop in collaboration with the member/ guardian/ family /provider an individualized problem based treatment care plan that includes identification of problems for each diagnosis and interventions specific to assisting the member to reach short and long term goals for that problem.**
   **a) Based on a collaborative evaluation with case management staff, the medical director as necessary, the involved physician and/or the member/guardian/ family, case management needs will be determined and initiated, where applicable. This may include outreach intervention either telephonically, field based or a combination of both from a variety of sources, depending on the member's needs, severity or complexity of the case and/or specific types of interventions requested or indicated. Interventions include but are not limited to: health education, referral for tobacco cessation program, referral for gambling addiction services, discharge planning assistance, community resource referrals, post-discharge service authorizations (DME), service coordination, self-care management, field based services (home care), interpretation of benefits and/or SSI eligibility.**
   **b) A copy of the member's individualized care plan will be faxed or mailed to the Primary and/or Specialty provider. Under HIPAA regulations, member**

**authorization is not required for such communication as this is considered "coordination of care."**

c) **The Case Manager will monitor the member's progress to meet the goals of the care plan. Care plans are updated to meet the member's current needs. The Case Manager will maintain communication with the member/guardian/family and provider on the progress of meeting set goals.**

11) **Clinical rounds highlighting care planning for CI3 members are held no less than monthly with the health plan Medical Director. The purpose of the rounds is to assess and evaluate individual care plans by gathering multidisciplinary input from physician, nurse and social work expertise. Criteria for selection and presentation of cases include cases with diverse and complex needs that require interdisciplinary collaboration when other interventions have been exhausted. Case Management rounds are documented and filed as appropriate.**

12) **The Case Manager shall review at least monthly, the progress for each member and/or changes in health status. The Case Manager will determine if transfer for chronic care management to the Disease Management team and / or discharge from case management is indicated utilizing set criteria. (See Transfer and Discharge Criteria, Case Closure Criteria and The Case Management Flow Chart which are included in the Case Management Program Description.)**

13) **Case Management meetings are held on a minimum bi-weekly basis to update Case Managers on health plan initiatives, and/or discussion of topics related to Case Management programs.**

14) **Member outreach via telephone or written communication will be in accordance with federal TCPA and Non-Discrimination rules respectively.**

**REFERENCES:**

- **Louisiana Contract**

**RESPONSIBLE DEPARTMENTS:**

**Primary Department: Health Care Management- Case Management**

**Secondary Department: Disease Management**

**EXCEPTIONS:**

**None**

| **Section (Primary Department)** | **SUBJECT (Document Title)** |
|---|---|
| **Health Care Management - Case Management** | **Case Management - LA** |

**REVISION HISTORY:**

| Review Date | Changes |
|---|---|
| 121/013/2022 | • New policy for 2023 LA contract |