Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management**	**SUBJECT (Document Title)** **Tiered Case Management – LA**

Effective Date 11/02/2022	Date of Last Review	Date of Last Revision	Dept. Approval Date 11/02/2022
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		

PURPOSE:

Healthy Blue shall implemenet a tiered case management program that provides for differing levels of case management based on an individual enrollee's needs.

POLICY:

Healthy
~~Healthy~~ Blue shall engage enrollees, or their parent or legal guardian, as appropriate in a level of case ~~managmenet~~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 and HNA, as described below. 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. ~~. If requested by the enrollee, or the enrollee's parent or legal guardian, the frequency and/or method of engagement may be reduced or substituted (i.e. the hierarchy for method of engagement is face-to-face, simultaneous audio/visual, telephonic). Healthy Blut must obtain a signed waiver from the enrollee approving the change. The waiver form shall be developed by Healthy Blue and include an option for the enrolle to decline case management altogether.~~ Where the enrollee's PCP or behavioral health provider offers case management, Healthy Blue shall support the provider as the lead case manager on a multi-disciplinary care team.

Healthy Blue shall have three (3) levels of case management and transitional case ~~managmenet~~management for individuals as they move between care settings.

Intensive Case Management for High Risk Enrollees (High) (Tier 3)

Enrollees engaged in intensive case management are of the highest need and require the most focused attention to ~~suppor~~support their clinical care needs and to address

SDOH. A plan of care shall ~~–~~be completed in person within thirty (30) calendar days of identification and shall i~~t~~nclude assessment of the home environment and priority SDOH. Case management meetings shall occur at least monthly, in person, in the ~~nerollee's~~enrollee's preferred ~~seting~~setting, or more as required within the enrollee's plan of care, with monthly updates to the plan of care and formal in person re-assessment quarterly. Case management may integrate community health worker support. Attestations of monthly updates to the plan of care and communication of plan of care to the enrollee and the ~~enorllee's~~enrollee's primary care provider shall be completed. Case managers serving Tier 3 enrollees shall focus on implementation of the enrollee's plan of care, preventing institutionalization and other adverse outcomes, and supporting the enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an enrollee with primarily behavioral health needs.

Case Management (Medium) (Tier 2)

Enrollees engaged in the medium level of case management are typically of rising risk and need focused attention to support their clinical care needs and to address SDOH. A plan of care shall be completed in person within thirty (30) calendar days of identification and include assessment of the home environment and priority SDOH. ~~(see *Population Health and Social Determinants of Health* section).~~ Case management meetings shall occur at least monthly, with quarterly updates to the plan of care and formal in-person re-assessment quarterly. Case management may integrate community health worker support. Attestations of quarterly updates to the plan of care and communication of plan of care to the enrollee and the enrollee's primary care provider shall be completed. Case managers serving Tier 2 enrollees shall focus on implementation of the enrollee's plan of care, preventing institutionalization and other adverse outcomes, and supporting the enrollee in meeting his or her care goals, including self-management. Behavioral health case managers shall be the lead whenever there is an enrollee with primarily behavioral health needs.

Case Management (Low) (Tier 1)

Enrollees engaged in this level of case management are of the lowest level of risk within the case management program and typically require support in care coordination and in addressing SDOH. A plan of care shall be completed in person within ninety (90) calendar days of identification and include assessment of the home environment and priority ~~SDOH (see *Population Health and Social Determinants of Health* section).~~SDOH. Case management meetings shall occur at least quarterly, or more as required within the enrollee's plan of care, with annual updates to the plan of care and formal in-person re-assessment annually. Attestations of annual updates to the plan of care and

communication of plan of care to the enrollee and the enrollee's primary care provider shall be completed.

Transitional Case Management

Healthy Blue shall implement procedures to coordinate the services that it furnishes to the enrollee between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 C.F.R. §438.208(b)(2)(i). Healthy Blue shall provide transitional case management for enrollees to support transitions between institutional and community care settings, including, but not limited to, transitions to/from inpatient hospitals, nursing facilities (not including members of the DOJ Agreement Target Population), psychiatric residential –facilities (PRTFs)~~, PRTFs~~, therapeutic group homes (TGHs), ICF/IIDs, residential substance use disorder treatment setting, and incarceration and transitions to permanent supportive housing. ~~permanent supportive housing, intermediate care facilities, residential substance use disorder settings, and transitions out of incarceration.~~

Transitional case management shall include:

- Development of transition plan of care in coordination with the care setting, the enrollee and other key members of an enrollee's multi-disciplinary team prior to the transition which is provided in writing to the enrollee upon ~~discharge and includes~~discharge, includes post discharge care appointments and linkages as ~~approrpraite~~appropriate, medication reconciliation, patient education and self-~~managemenet~~management strategies; ~~addresses prior authorization needs; and a contact person and phone number for the enrollee.~~and addresses Prior Authorization needs. The Enrollee shall be provided the case manager's name and contact information prior to discharge.
- For enrollees preparing for discharge from a PRTF, TGH, or ICF, aftercare services shall be in place thirty (30) calendar days prior to discharge.
- Ensuring that the setting from which the enrollee is transitioning is sharing information with the enrollee's PCP and behavioral health providers regarding the treatment received and contact information.
- Follow up with enrollees within ~~seventy two (72) hours~~seven (7) Calendar Days following discharge/ transition to ensure that services are being provided as detailed within the enrollee's transition plan of care. The plan of care shall identify circumstances in which the follow-up includes a face-to-face visit.
- Additional follow-up as detailed in the discharge plan.
- Coordination across the ~~mtuli~~multi-disciplinary team involved in transitional case management for enrollees.

- For enrollees identified a homeless at the time of care transition, the care management team shall include a housing specialist, on the multi-disciplinary care team. Housing specialists shall ~~aslo~~also be used to ensure ~~enorllees~~enrollees transitioning from ~~faicliyt~~facility to community are connected to ~~approrpaite~~appropriate housing resources, including, but not limited to, referral of potential enrollees to ~~Healhty~~Healthy Blue's Permanent Supportive Housing liaison for application to the Louisiana Permanent Supportive Housing Program.

Special Healthcare Needs (SHCN)

Members identified as Special Healthcare Needs (SHCN) must have the following as well:

Healthy Blue shall implement mechanisms to provide each Enrollee identified as having SHCN with a comprehensive assessment conducted by a qualified healthcare professional to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring.

Healthy Blue shall complete this comprehensive assessment for at least ninety percent (90%) of those Enrollees ~~that the Contractor~~that Healthy Blue is able to contact and are willing to engage within ninety (90) Calendar Days of being identified as having SHCN.

Healthy Blue shall offer Case Management to all Enrollees with SHCN regardless of information gathered through this comprehensive assessment or the HNA.

Individual Plan of Care (POC)

Healthy Blue shall develop a comprehensive individualized, ~~personcentered~~person centered POC for all Enrollees who are found eligible for Case Management. When an Enrollee receives services from Healthy Blue only for SBHS, the POC shall focus on coordination and integration, as appropriate. When an Enrollee receives services requiring a POC from LDH, such as Home and Community Based Waiver services or services through OPH, Healthy Blue shall collaborate with LDH or its designee in developing the POC.

Development of the POC shall be a person-centered process led by the Enrollee and their case manager with significant input from members of the Enrollee's interdisciplinary care team. When an Enrollee receives SBHS and has treatment plans developed through their behavioral health providers, Healthy Blue shall work with the Enrollee's behavioral health providers in order to incorporate the treatment plans into the Enrollee's overall POC and to support the Enrollee and the provider in their efforts to implement the treatment plan.

The POC shall be based on the principles of self-determination and recovery, and shall include all medically necessary services identified by the Enrollee's providers as well as the care coordination and other supports to be provided by Healthy Blue.

The POC shall be reviewed and revised upon reassessment of functional need. The POC revisions shall occur at least at the frequency required in the Tiered Case Management Based on Need section, or when the Enrollee's circumstances or needs change significantly, or at the request of the Enrollee, their parent or legal guardian, or a member of the multi-disciplinary care team.

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. Healthy Blue shall assign lead case managers based on an Enrollee's priority care needs, as identified through the POC. 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 in writing 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 POC. 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 providers;
- Specialists;
- Pharmacists;
- Community health workers;
- Home and community based service providers and managers;
- Housing specialists, if the Enrollee is identified as homeless; and
- State staff, including transition coordinators.

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

DEFINITIONS:

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

Care Coordination – Deliberate organization of patient care activities by a person or entity, including Healthy Blue that is formally designated as primarily responsible for coordinating services furnished by providers involved in the enrollee's care, to facilitate the 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 the enrollee's care.

Care Management- An overall approach to ~~managining~~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.

Case Management – 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 whose 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 Manager – A licensed registered nurse, licensed mental health practitioner, or other trained individual who is employed or contracted by the Contractor or an enrollee's PCP. The case manager is accountable for providing intensive monitoring, follow-up, clinical management of high risk enrollees, and care coordination activities, which include development of the MCO 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 manager may serve on one or more multi-disciplinary care teams and is responsible for coordinating and facilitating meetings and other activities of those care teams.

Community Health Worker (CHW) – As defined by the American Public Health Association, frontline staff who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery for enrollees.

Enrollees with Special Health Care Needs (SHCN)- Enrollees with Special Health Care Needs (SHCN) – Individuals of any age with a behavioral health disability, physical disability, developmental disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized care approaches. Enrollees with Special Health Care Needs shall include any Enrollees who:

- have 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, including those Enrollees presenting to the hospital or emergency department with a suicide attempt or non-fatal opioid, stimulants, and sedative/hypnotic drug overdose reason;
- 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 emergency department visits, including certain Enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting;
- are members of the 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.

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

Homeless – As defined in 42 U.S.C. §254b, means, an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing. A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or any other unstable or non-permanent situation. A person may be considered to be homeless if that person is "doubled up," a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness (HRSA/Bureau of Primary Health Care, Program Assistance Letter 99-12).

Interdisciplinary or Multidisciplinary Care Team – A group that reviews information, data, and input from the Enrollee to make recommendations relevant to the needs of the Enrollee. The team consists of the Enrollee, his legal representative, if applicable, professionals of varied disciplines who have knowledge relevant to the Enrollee's needs, and may include the Enrollee's family along with others the Enrollee has designated.

MCO Plan of Care – The plan developed by the MCO 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.

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, provides 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.

Plan of Care (POC) – The plan developed by the Contractor 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.

Social Determinants of Health (SDOH) – The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

Specialized Behavioral Health Services (SBHS) – Mental health services and substance use services that are provided outside of primary care, unless furnished in an integrated care setting, and include, but are not limited to, services provided by a psychiatrist, LMHP, and/or mental health rehabilitation provider.

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.

PROCEDURE:

1) 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:
        i. UM associates
        ii. ~~Disease Management~~ Condition Care 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/ ~~agencie~~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 ~~cenetered~~centered medical homes) may also be available via a data feed to the health plan.
xvii. State-Regulatory Agency representatives

b) The following types of cases may initiate a case management review by ~~Disease~~ Condition Care 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 ~~43~~ (High Risk)- Tier 3
At least one clinically manageable condition and LIPA score >0 and <8.0	Group ~~32~~ (Moderate Risk)- Tier 2

At least one clinically manageable condition and no LIPA score	Group 2 ~~1~~ (Low Risk)- Tier 1
No clinically manageable conditions	Groups 1 & ~~-~~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.

Once member is identified a case is built into our documentation system. The case is assigned to a ~~primary case manager and if needed a secondary case manager~~case management staff member. Primary and/or secondary assignment will be based off the members claims and/or needs. A member is assigned a stratification based off of the tier that the member falls into. Tiering is based off of the program or the group that the member is assigned. ~~to.~~

2)

3) Member is outreached by the case manage~~r~~ment staff within 5 days of assignment. Upon member connection (member answering the telephone), the HNA information is verified or obtained, a face-to-face is scheduled and MDT team identified.
4) The face-to-face occurs based on the members tier level and will encompass the member's care team. At the face-to-face ~~an in depth~~a comprehensive assessment will occur as well as a plan of care being built. The plan of care will be sent to the members PCP, ~~and other providers~~additional providers and the member.
5) Any barriers identified through the face-to-face/ MDT meeting will be ~~resolved~~addressed with the work of the case manager, member and providers. All progress towards goals will be documented in the care plan. Any new barriers that are identified will also be documented in the care plan.
6) The case manager will schedule telephonic, in-person or video-conference MDT meetings at the requirements of the members tier level.
7) The member will decrease or increase in tier levels based off of their group identification. This will be assessed on at least a monthly basis. Once a member reaches a Group 1, the member will have graduated from the case management program as long as no additional needs are identified at time of discharge.

REFERENCES:

- Louisiana RFP Contract

RESPONSIBLE DEPARTMENTS:

Primary Department: Health Care Management

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
~~10/23~~11/02/2022	• New Policy and Procedure created for LA 2023 Contract