Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management**	**SUBJECT (Document Title)** **Special Health Care Needs Population - LA**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
January 1, 2012	~~October 10, 2018~~November 13, 2019	~~March 13, 2018~~November 13, 2019	~~October 10, 2018~~November 13, 2019

Department Approval/Signature :

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

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

POLICY:

Healthy Blue arranges for the provision of health care services to members of Special Healthcare Needs (SHCN) populations. The purpose of this procedure is to describe the process whereby special needs members are identified and assessed in order to determine if a course of treatment or regular care monitoring is needed.

DEFINITIONS:

Care Coordination (CC) – Deliberate organization of patient care activities by a person or entity formally designated as primarily responsible for coordinating services furnished by providers involved in the member's care to facilitate care within the network with services provided by non-network providers to ensure appropriate delivery of health. 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 Coordination services at the health plan may include but are not limited to post–acute care stabilization, emergency room follow up as well as assisting with primary care/ specialist changes.

Care Management - Overall system of medical management encompassing Utilization Management, Referral, Case Management, Care Coordination, Continuity of Care and Transition Care, Chronic Care Management, Quality Care Management, and Independent Review.

Case Management – Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's needs through communication and available resources to promote high quality, cost-effective outcomes. Case management services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Case Management services include an individual needs assessment and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and monitoring outcomes.

Case Management Administrator/Manager – A person who oversees the case management functions and who 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 person who is either a degreed social worker, licensed registered nurse, or a person with a minimum of two years experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. Case management manager shall not provide direct care services to members enrolled with the Contractor, but shall authorize appropriate services and/or refer members to appropriate services.~~A person who is either a degreed social worker or licensed registered nurse, providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. The case manager shall not provide direct care services to members enrolled with the Contractor, but shall authorize appropriate services and/or refer members to appropriate services.~~

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Case Management Staff – at the plan will 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 case management staff necessary to assure adequate local geographic coverage for in field face to face contact with physicians and members as appropriate and may include additional out-of-state staff providing phone consultation and support.

Complex Case Management (CCM) – Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's needs through communication and available resources to promote high quality, cost-effective outcomes. Complex Case management services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Complex Case Management services at the health plan include an individual needs assessment and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and monitoring outcomes.

Medical Management Specialist and Outreach Specialist – Non-licensed staff (under the supervision of clinical staff) which provides coordination, authorization, fulfillment, monitoring and tracking of health care services as identified by case managers and care coordinators.

Special Health Care Needs (SHCN) Population – Defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized healthcare approaches, Individuals with special health care needs include:

- Individuals with co-occurring mental health and substance use disorders;
- Individuals with intravenous drug use;
- Pregnant women with substance use disorders or co-occurring disorders including but not limited to pregnant women who are using alcohol, illicit or licit drugs such as opioid and benzodiazepines or at risk of delivering an infant affected by neonatal abstinence syndrome (NAS) or fetal alcohol syndrome;
- Individuals with substance use disorders who have with dependent children;
- Children with behavioral health needs in contact with other child serving systems including OJJ, DCFS, or the judicial system, and not enrolled in CSoC;
- Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination; and
- Adults, 18 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed by the CSoC program contractor and have declined to enter or are transitioning out of the CSoC program.
- Individuals with 2 or more inpatient or 4 or more ED visits within the past 12 months;
- Individuals with co-occurring behavioral health and developmental disabilities;
- Individuals diagnosed with Autism Spectrum Disorder (ASD) or at risk of an ASD diagnosis;
- Newly diagnosed adolescents and young adults, 15-30 years of age, who experience first signs of symptom onset for serious mental illness, such as schizophrenia, bipolar disorder, and/or major depression; and
  Persons living with HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, or prevention services.

PROCEDURE:

1) Care Coordination and Complex Case Management of Special Healthcare Needs (SHCN) populations is part of a comprehensive Care Management Program that offers a continuum of services including complex case management (CCM), care coordination (CC), chronic care management (CCMP) and utilization management (UM).

2) Healthy Blue will identify members with special health care needs within ninety (90) days of receiving the member's historical claims data (if available). LDH may also identify special healthcare members and provide that information to Healthy Blue. The LMHP or the PCP can identify members as having special needs at any time the member presents with those needs. Healthy Blue must assess those members within ninety (90) days of identification, with the exception of individuals determined under PASRR Level II, who shall be evaluated within federally required timeliness within four (4) working days of receipt of the referral from OBH (Section 6.39.5.4). The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.

a) Mechanisms for identifying members with special health care needs (SHCN) that require an assessment to determine if a course of treatment or regular care monitoring is needed are as follows:
   i) Healthy Blue shall utilize Medicaid historical claims data (if available) to identify members who meet Healthy Blue, LDH approved, guidelines for SHCN criteria
   ii) Healthy Blue LMHPs and PCPs shall identify to Healthy Blue members who meet SHCN criteria.
   iii) Members may self-identify to either the Enrollment Broker or Healthy Blue that they have special health care needs. The Enrollment Broker will provide notification to Healthy Blue of members who indicate they have special health care needs.
   iv) Members may be identified by LDH, including LDH program offices, and that information shall be provided to Healthy Blue.

3) All SHCN members shall be referred for, and if found eligible, offered case management, including an individualized treatment plan developed by the treating provider(s) and a person-centered plan of care (POC) developed by Healthy Blue care manager.
   a) The individualized treatment plans must be:
      i) Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to Healthy Blue no later than 30 days following the completion of the initial assessment or annual reassessment;
      ii) In compliance with applicable quality assurance and utilization management standards;
      iii) Reviewed and revised upon reassessment of functional needs, at least every 12 months, when the member's circumstances or needs change significantly, or at least the request of the member; and
      iv) A person-centered integrated plan of care developed by Healthy Blue's care manager shall be completed within thirty (30) calendar days of provider treatment plan development that includes all medically necessary services including specialized behavioral health services and primary care services identified in the member's treatment plan (individualized treatment plans are developed by the provider(s)) and meet the requirements above.
      v) Treatment Planning components, including criteria to determine: the sufficiency of assessments in the development of functional treatment recommendations; the treatment plan is individualized and appropriate for the enrollee and includes goals, Specific, Measurable, Action-Oriented, Realistic, and Time-Limited (SMART) objectives, and the appropriate service to achieve goal/objective; individualized crisis plan; members'/families' cultural preferences are assessed and included in the development of treatment plans; the treatment plan has been reviewed regularly and updated as the needs of the member changes; the treatment plan includes the

involvement of family and other support systems in establishing treatment goals/objectives; the treatment plan includes evidence of implementation as reflected in progress notes; and evidence that the member is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the member;

4) Development of an individualized comprehensive plan of care, which is based on the results of the member's individual needs assessment. The plan of care shall be developed and implements through a person-centered process in which the member has a primary role and which is based on the principles of self-determination and recover. The plan of care shall include the following elements at a minimum:
   a) Member demographics;
   b) Identification of the member's treating providers and interdisciplinary team if applicable;
   c) Member's past and present primary care and behavioral health concerns, relevant treatment history including gaps in care, significant medical history, and present health status;
   d) Member's goals;
   e) Identified strengths and needs;
   f) Identified barriers to the care plan goals;
   g) Documentation that freedom of choice of services and providers were offered to the member and/or his/her caregiver;
   h) Supports and services needed to meet the member's needs;
   i) Resources and settings of care recommended to the member's providers, including responsible party and target date for completion;
   j) Strategies to improve care coordination;
   k) Strategies to monitor referrals and follow-up for specialty care and routine health care services, including medication management. Each follow-up item includes an identified responsible party(ies); and
   l) Plan for addressing crisis to prevent unnecessary hospitalization or institutionalization for members with a behavioral heal diagnosis who may experience crisis. This crisis plan shall identify resources and contact information.

5) A framework for delivery of services, staff development, and policies and procedures for providing effective care for members with co-occurring behavioral health and developmental disabilities. If a member qualifies for services through OCDD, Healthy Blue will coordinate with OCDD, LGEs, and support coordinators concerning the care of the member. A Statement of Approval from OCDD shall not preclude services from Healthy Blue.

   Case Managers, Medical Management Specialists, and/or Outreach Specialists assist the enrollee/family with scheduling of appointments and transportation, referrals/authorizations for outpatient services when required, access to pharmacy and other ancillary services as identified by the plan of care. Member outreach via telephone or

written communication will be in accordance with federal TCPA and Non-Discrimination rules respectively.

6) In the event a Medicaid or CHIP eligible entering Healthy Blue is receiving medically necessary covered services, the day before Healthy Blue enrollment, Healthy Blue shall provide continuation/ coordination of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. Healthy Blue may require prior authorization for continuation of the services beyond thirty (30) calendar days; however Healthy Blue is prohibited from denying authorization solely on the basis that the provider is non-contract provider.

REFERENCES:

Case Management – LA
Continuity of Care – Core Process
Healthy Blue Louisiana Case Management Program Description
Louisiana Health Contract
Specialty Referrals – LA
Transfer of Cases within the Case Management Department (Internal and External of Plan)

RESPONSIBLE DEPARTMENTS:

Primary Department – Health Care Management

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
11/13/2014	• 2015 LA contract language added • Placed on generic template
09/24/2015	• Added Louisiana Bayou Health Contract Amendment 4 changes
11/03/2016	• For annual review • Definitions placed in alphabetical order • References placed in alphabetical order
10/18/2017	• For annual review • AGP references changed to Healthy Blue
03/13/2018	• Off cycle review • Amendment 11 contract language added

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10/10/2018	• For annual review • No changes
11/13/2019	• Annual Review • Edits to definition – Case Manager • Moved to updated template

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