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| **UnitedHealthcare Community Plan of Louisiana, Inc.** | DEPARTMENT:<br>**Clinical Operations – Behavioral Health** |
| | LINE OF BUSINESS:<br>**UHC C&S Louisiana** |
| POLICY TITLE:<br>**Coordination, Continuity and Transition of Behavioral Health Care Addendum** | POLICY NUMBER: |
| EFFECTIVE DATE: | PAGE:<br>**Page 1 of 18** |
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## I SCOPE:

This addendum to the Optum Behavioral Health (BH) Solutions National Medicaid policy *Transition and Coordination of Care Addendum* and to the Optum BH All Lines of Business National Policies, *Transition of Care for Members Receiving Behavioral Health Services, Transition of Members – Pediatric to Adult Treatment or to another MBHO, and the Coordination of Behavioral Healthcare* applies to members whose benefit coverage is provided through the Louisiana Medicaid plan and whose behavioral/mental health benefits are managed by UnitedHealthcare Community Plan of Louisiana and its behavioral health affiliate, Optum Behavioral Health Solutions (United Behavioral Health), hereinafter referred to as UHCCP LA.

## II PURPOSE:

National requirements as found in the Code of Federal Regulations (CFR), other applicable Federal regulations such as the Mental Health Parity and Addiction Equity Act (MHPAEA), as well as the National Committee for Quality Assurance (NCQA) and URAC are reflected in the Government National Policies.

This addendum reflects the requirements governing the coordination, continuity and transition of behavioral health care as described in the Medicaid Managed Care Organization Contract between the State of Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF~~LDH~~) and UnitedHealthcare Community Plan of Louisiana (hereinafter referred to as the Contract), regulatory requirements of the State of Louisiana, the Medicaid State Plan and waivers, and the court-ordered requirements, including but not limited to, United States v. State of Louisiana (Department of Justice (DOJ) Agreement- Case 3:18-cv-00608) of Chisholm v. Gee (Case 2:97-cv-03274).

UHCCP LA recognizes that that mental illness and addiction are health care issues and integrate this care into a comprehensive physical and behavioral health care system that includes primary care settings. Many people suffer from both mental illness and addiction. As care is provided, both illnesses are understood, identified, and treated as primary conditions. UHCCP LA's system of care is accessible and comprehensive and fully integrates an array of prevention and treatment services for all age groups. It is designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement. Relevant clinical information is accessible to both the primary care and behavioral health providers consistent with Federal and State laws, regulations, rules, policies and other applicable standards of medical record confidentiality and the protection of patient privacy.

Please refer to separate procedural type documentation to review details regarding processes in how the requirements outlined within this policy are met as well as for monitoring reports, analysis documentation, actions taken to demonstrate compliance, etc.

**III DEFINITION~~(S)~~:**

- **Care Coordination –** Deliberate organization of patient care activities by a person r 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 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 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. [KF1][OJA2]
- **Case Management –** An overall approach to 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. ~~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.~~[KF3][OJA4]
- **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 Service 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 thirty-seven (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 the Office of Juvenile Justice (OJJ), the Department of Children and Family Services (DCFS), or Office of Public Health (OPH).

- **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)[KF5][OJA6].

~~**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.~~

- **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 UHC 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.
- **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.
- **Treatment Planning -** An administrative treatment planning activity provided under Medicaid requirements at 42 CFR §438.208(c) for developing and facilitating implementation of POCs for Enrollees with SHCN and other Enrollees as required under applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, Waivers, and this Contract. Treatment Planning is provided to address the unique needs of clients living in the community and does not duplicate any other Medicaid Covered Service or services otherwise available to the Beneficiary at no cost.

See the Optum BH Government National Policy, *Medicaid and CHIP Managed Care – Policy Definitions List*.

See also the Optum BH All Lines of Business National Policy, *National Policy Definitions List*.

**~~III~~IV POLICY[1]:**

A General Provisions

[1] Except where noted, policy provisions come from Attachment A the Contract.

1 When an accrediting organization provides guidance that differs from State requirements, UHCCP LA may apply the accrediting organization's guidance when it is beneficial and/or less restrictive to the member[2].

2 Mental illness and addiction are healthcare issues and are integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings.

3 UHCCP LA recognizes that many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions.

4 UHCCP LA facilitates the integration of physical and behavioral health and provides for the appropriate continuity of care across programs.

~~3~~5 The member's Primary Care Providers (PCP) shall provide Basic Behavioral health services and refer the member to the appropriate health care specialist SBHS.

~~4~~6 UHCCP LA's system of care is accessible and comprehensive, and fully integrates an array of prevention and treatment services for all age groups. It is designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement.

~~5~~7 Relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

~~6~~8 Staff are responsible for complying with the relevant expectations included in the ~~Department of Justice~~ (DOJ) Agreement Compliance Guide of June 1, 2022.

B Care Coordination and Continuity of Care

1 UHCCP LA has a process to coordinate the delivery of Managed Care Organization (MCO) Covered Services for which it is responsible with services that are provided through fee-for-service (FFS) another LDH contractor or provided by community and social support providers as required by 42 CFR §438.208(b)(2)(iv). UHCCP LA ensures appropriate provider choice within UHCCP LA network and coordination ~~–~~with out of Network Providers, as needed for continuity of care. Please refer to separate procedural type documentation to review details regarding processes and procedures.

2 UHCCP LA is responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208 which describes care and coordination of services for all ~~Managed Care Organizations (~~MCO~~s~~).

[2] UHCCP Standard

3 UHCCP LA is responsible for coordinating with the Office of Citizens with Developmental Disabilities (OCDD) and the Office of Aging and Adult Services (OAAS), to ensure integrated support across behavioral health services and long-term supports and services.

4 UHCCP LA ensures that each member has an ongoing source of preventive and primary care appropriate to their needs.

5 UHCCP LA ensures that each member is provided with information on how to contact the person designated to coordinate the services the member accesses.

6 UHCCP LA coordinates care between network ~~Primary Care Providers (~~PCP~~)~~ and specialists, including specialized behavioral health providers.

7 UHCCP LA coordinates care for out-of-network services, including specialty care services.

8 UHCCP LA coordinates services provided by UHCCP LA with services the member may receive from other health care providers.

9 UHCCP LA, upon written request, shares with LDH or other health care entities serving the member with ~~special health care needs~~SHCN the results and identification and assessment of that member's needs to prevent duplication of those activities.

10 UHCCP LA ensures that each provider furnishing services to the member maintains and shares the member's health record in accordance with professional standards.

11 UHCCP LA documents authorized referrals in its utilization management system.

12 UHCCP LA provides active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with UHCCP LA. UHCCPLA provides continuation of such services for up to 90 calendar days or until the member is reasonably transferred without interruption of care, whichever is less.

13 Where a new member with ~~special health care needs (~~SHCN~~)~~ is actively receiving medically necessary MCO Covered Services at the time of enrollment, UHCCP LA provides continuation/coordination of such services up to 90 calendar days or until the member may be reasonably transferred to a network provider without disruption, whichever is less. UHCCPLA may require prior authorization for continuation of services beyond 30 calendar days; however UHCCP LA does not deny authorization solely on the basis that the provider is a non-contract provider.

~~14~~1 ~~UHCCP LA coordinates with the court system and State child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the request of LDH when there~~

~~is a need to inform the court of available services and limitations, and participating in cross-agency staffing[OJA7].~~

~~15~~14 UHCCP LA ~~C~~continues the behavioral health therapeutic classes (including long-acting injectable antipsychotics) and other medication assisted treatment (including buprenorphine/naloxone and naloxone products) prescribed to the member in a mental health treatment facility for at least 60 calendar days after the facility discharges the member, unless UHCCP LA's psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications are:

a Not medically necessary; or

b Potentially harmful to the member.

C Additional Continuity for Behavioral Health Care Requirements

1 UHCCP LA's continuity of care activities ensure that Network Providers and UHCCP LA staff are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care activities provide processes to support effective interactions between members and providers, and to identify and address interactions that are not effective. UHCCP LA monitors service delivery through member surveys, medical and treatment record reviews, and Explanations of Benefits ~~(EOBs)~~ to identify and overcome barriers to primary and preventive care that an UHCCP LA may experience.

2 In any instance when a member presents to UHCCP LA, including calling UHCCP LA's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, UHCCP LA instructs the member to seek help from the nearest emergency medical provider. UHCCP LA initiates follow-up with the member within 48 hours for follow-up to establish that appropriate services were accessed.

3 UHCCP LA complies with all post-stabilization care service requirements found at 42 ~~Code of Federal Regulations (~~CFR~~)~~ §438.114 which describes emergency and poststabilization services.

4 UHCCP LA includes documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health and primary care provider(s).

5 UHCCP LA provides procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity of care.

6 UHCCP LA's procedures address members with co-occurring medical and behavioral conditions, including children with ~~special health care needs~~SHCN, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.

7 UHCCP LA provides or arranges for training of providers and other individuals involved in care management activities on identification and screening of behavioral health conditions and referral procedures.

8 Please refer to separate procedural type documentation and to review details regarding criteria, processes and procedures.

D Comprehensive Care Management Program

1 UHCCP LA offers a comprehensive care management program to support members, regardless of age, based on an individualized assessment of care needs.

a Health Needs Assessment (HNA)

i UHCCP LA attempts to conduct member HNA as part of the member welcome call to identify health and functional needs of members, and to identify members who require short-term care coordination or Case Management for medical, behavioral or social needs. When the member is a child, the HNA is completed by the member's parent or legal guardian.

ii UHCCP LA has developed, implemented, and maintains procedures for completing an initial HNA for each member, and makes best efforts to complete such screening within 90 calendar days of the members effective date of enrollment [42 CFR §438.208(b)]. If the initial HNA attempt is unsuccessful, UHCCP LA attempts to conduct, and document its efforts to conduct, the HNA on at least 3 different occasions, at different time of the day and on different days of the week.

iii UHCCP LA provides HNA data to the member's assigned PCP, and to LDH as requested.

iv UHCCP LA's HNA:

a) Utilizes a common survey-based instrument, which shall be developed by LDH as described in the Contract Part 3: State Responsibilities;

b) Is made available to members in multiple formats including web-based, print, and telephone;

c) Is conducted with the consent of the member;

d) Identifies individuals for referral to Case Management; ~~with more in-depth assessment to occur as part of the POC;~~ [KF8][OJA9]

e) Screens for needs relevant to priority SDOH as described in the *Population Health and Social Determinants of Health* section of the Contract; and

f) Includes disclosures of how information will be used.

E Case Management Assessment

1 ~~UHC shall~~UHCCP LA uses Claims data and other available data to identify ~~Enrollees~~members who meet the SHCN criteria on at least a monthly basis. ~~The Contractor shall implement~~UHCCP LA has mechanisms to provide each ~~Enrollee~~member identified as having SHCN with a comprehensive Case Management assessment conducted by a qualified healthcare professional to identify any ongoing special conditions of the ~~Enrollee~~member that require a course of treatment or regular care monitoring.

2 ~~The Contractor shall implement~~UHCCP LA has mechanisms to provide other ~~Enrollees~~ members referred to Case Management with a Case Management assessment to identify any needs or conditions of the ~~Enrollee~~member that require intervention by ~~the MCO~~UCHCP LA, a course of treatment, or regular care monitoring.

3 ~~The Contractor shall~~UHCCP LA completes the required assessment for at least ~~ninety percent (~~90%~~)~~ of those ~~Enrollees~~members that UHCCP LA ~~the Contractor~~ is able to contact and are willing to engage within ~~ninety (~~90~~)~~ ~~C~~calendar Days of being identified as having SHCN or of being referred to Case Management.

4 ~~The Contractor shall~~UHCCP LA offers Case Management to all ~~Enrollees~~members with SHCN regardless of information gathered through this comprehensive assessment or the HNA. [KF10] [OJA11]

F Individual Plan of Care (POC)

1 UHCCP LA has a comprehensive individualized, person-centered POC for all members who are found eligible for case management.

a When a member receives services from UHCCP LA only for SBHS, the POC focuses on coordination and integration, as appropriate.

b When a member receives services requiring a POC from LDH, such as Home and Community Based Waiver services or services through the OPH, UHCCP LA collaborates with LDH or its designee in developing the POC.

2 Development of the POC is a person-centered process led by the member and their case manager with significant input from members of the member's interdisciplinary care team. When a member receives SBHS and has treatment plans developed through their behavioral health providers, UHCCP LA works with the member's behavioral health providers in order to incorporate the treatment plans into the member's overall POC and to support the member and the provider in their efforts to implement the treatment plan.

3 The POC is based on the principles of self-determination and recovery, and includes all medically necessary services identified by the member's providers as well as the care coordination and other supports to be provided by UHCCP LA.

4 The POC is reviewed and revised upon reassessment of functional need. The POC revisions occur at least at the frequency required in the *Tiered Case Management Based on Need* section of this policy/the Contract, or when the member's circumstances or needs change significantly, or at the request of the member, their parent(s) or legal guardian(s), or a member of the multi-disciplinary team.

G Referral to Case Management

1 UHCCP LA receives referrals to Case Management through the HNA, identification of individuals with SHCN, as well as referral sources, including, but not limited to:

a Enrollee services and self-referral (including Enrollee Grievances);

b Providers (including primary care, behavioral health and specialist providers); and

c State staff, including the Office of Behavioral Health, BHSF, OAAS, OCDD, OPH, and DCFS.

2 UHCCP LA provides 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.

3 UHCCP LA provides guidelines to Enrollees in the Member Handbook on how and in what circumstances Enrollees may engage in Case Management.

4 UHCCP LA considers all referred Enrollees for engagement in Case Management.

H Tiered Case Management Based on Need[KF12][OJA13]

1 UHCCP LA implements a tiered case management program that provides for differing levels of case management based on an individual member's needs. UHCCP LA engages members, or their parent(s) or legal guardian(s), 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 members POC and HNA. If requested by the member, or the member's parent(s) or legal guardian(s), the frequency and/or method of engagement may be increased, reduced, or substituted or declined. UHCCP LA retains documentation of such requests. Where the members PCP or behavioral health provider offers case management, UHCCP LA supports the provider as the lead case manager on the multi-disciplinary care team.

2 UHCCP LA maintains 3 levels of Case Management and Transitional Case Management for individuals as they move between care settings.

a Intensive Case Management for High Risk Members (High) (Tier 3)

i Members engaged in intensive case management are of the highest need and require the most focused attention to support their clinical care needs and to address SDOH.

ii A POC ~~shall be~~is completed in person within ~~thirty (~~30~~)~~ c~~C~~alendar ~~D~~days of the Case Management assessment being completed and ~~shall~~ includes assessment of the home environment and priority SDOH[KF14][OJA15]~~A POC is completed in person within 30 calendar days of identification and includes assessment of the home environment and priority SDOH~~.

iii Case management meetings occur at least monthly, in person, in the member's preferred setting, or more as required within the member's POC, or as needed to coordinate the services that it furnishes to the ~~Enrollee~~member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i)[KF16][OJA17], with monthly updates to the POC and formal in person re-assessment quarterly.

iv Case management may integrate community health worker support.

v Attestations of monthly updates to the POC and communication of POC to the member and the member's PCP are completed.

vi Case managers serving Tier 3 members focus on implementation of the member's POC, preventing institutionalization and other adverse outcomes, and supporting the member in meeting his or her care goals, including self-management.

vii Behavioral health case managers are the lead whenever there is a member with primarily behavioral health needs.

b Case Management (Medium) (Tier 2)

i Members 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.

ii A POC is completed in person within 30 calendar days of the Case Management assessment being completed[OJA18] and includes assessment of the home environment and priority SDOH.

iii Case management meetings occur at least monthly, with quarterly updates to the POC or as needed to coordinate the services that it furnishes to the member between

settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i[OJA19]) and formal in-person re-assessment quarterly.

iv Case management may integrate community health worker support.

v Attestations of monthly updates to the POC and communication of POC to the member and the member's PCP are completed.

vi Case managers serving Tier 2 members focus on implementation of the member's POC, preventing institutionalization and other adverse outcomes, and supporting the member in meeting his or her care goals, including self-management.

vii Behavioral health case managers are the lead whenever there is a member with primarily behavioral health needs.

c Case Management (Low) (Tier 1)

i Members 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.

ii A POC is completed in person within 90 calendar days of the Case Management assessment being completed[OJA20] and includes assessment of the home environment and priority SDOH.

iii Case management meetings occur at least quarterly, or more as required with in the member's POC or as needed to coordinate the services that it furnishes to the member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2(i[OJA21]), with annual updates to the POC and formal in-person re-assessment annually.

iv Attestations of annual updates to the POC and communication of POC to the member and the member's PCP are completed.

~~Members with Special Health Care Needs (SHCN)~~

~~UHCCP LA has mechanisms to provide each member identified as having SHCN with a comprehensive assessment conducted by a qualified healthcare professional to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.~~

~~UHCCP LA completes this comprehensive assessment for at least 90% of those members that UHCCP LA is able to contact and are willing to engage with 90 calendar days of being identified of having SHCN.~~

~~UHCCP LA offers case management to all members with SHCN regardless of information gathered through this comprehensive assessment of the HNA.~~[KF22][OJA23]

I Transitional Case Management

1 UHCCP LA coordinates the services that it furnishes to the member between setting of care including appropriate discharge planning for short-term and long-term hospital and institutional stays as required by 42 CFR §438.208(b)(2)(i). UHCCP LA provides Transitional Case Management for members not already enrolled in Case Management Tiers 1, 2, or 3 [KF24][OJA25]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 treatment facilities (PRTFs), therapeutic group homes (TGHs), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IDDs), residential substance use disorder treatment settings, and incarceration and transitions to permanent supportive housing.

2 Transitional Case Management includes:

a Development of a transition POC in coordination with the care setting, the member, and other key members of a member's multi-disciplinary team prior to the transition which is provided in writing to the member upon discharge, includes post discharge care appointments and linkages as appropriate, medication reconciliation, patient education and self-management strategies, and addresses Prior Authorization needs. The member is provided the case manager's name and contact information prior to discharge.

b The POC also identifies circumstances in which the follow-up includes a face-to-face visit.

c For members preparing for discharge for a PRTF, TGH, or ICF/IDD, aftercare services are in place 30 calendar days prior to discharge.

d Ensuring that the setting from which the member is transitioning is sharing information with the member's PCP and behavioral health providers regarding the treatment received and contact information.

e Follow up with members within 7 calendar days following discharge/transition to ensure that services are being provided as detailed within the member's transition POC.

f Additional follow-up as detailed in the discharge plan.

g Coordination across the multi-disciplinary team involved in Transitional Case Management for members.

h For members identified as homeless at the time of care transition, the care management team includes a housing specialist, as described in the *Individual Plan of Care* subsection

of the Contract, on the multi-disciplinary care team Housing specialists are also used to ensure members transitioning from facility to community are connected to appropriate housing resources, including, but not limited to, referral of potential members to UHCCP LA's Permanent supportive Housing Liaison for application to the Louisiana permanent Supportive Housing program.

J Case Management for Individuals in DOJ Agreement Target Population (Case 3:18-cv-00608, Middle District of Louisiana)

1 UHCCP LA has 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. UHCCP LA makes a referral to a community Case Management agency within 1 Business Day of receipt of a referral from LDH. UHCCP LA maintains 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.

~~J~~K Care Transition Between Managed Care Organizations (MCOs)

1 UHCCP LA provides active assistance to members when transitioning to/from another MCO or FFS in accordance with this policy that ensures continued access to services during the transition.

2 When UHCCP LA is the receiving MCO it is responsible for activities that include, but are not limited to:

a Ensuring the member has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in UHCCP LA's network;

b Coordinating care with the relinquishing MCO so services are not interrupted;

c Arranging for continuity of necessary care such as by making referrals to appropriate providers of services that are in network;

d Adhering to the Service Authorization requirements as described under the *Service Authorization Requirements for New Enrollees* section of the C~~c~~ontract;

e Initiation of the request of transfer for the member's health record to the receiving MCO and the new PCP, if necessary. The cost of reproducing and forwarding the health record to the receiving MCO is the responsibility of the relinquishing MCO; and

f Any other necessary procedures as specified by LDH in writing to ensure continued access to services to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.

3 When UHCCP LA is the relinquishing MCO it is responsible for activities that include, but are not limited to:

a Ensuring timely notification to the receiving MCO regarding pertinent information related to any health needs of transitioning members;

b Fully and timely complying with requests for historical utilization data from the receiving MCO in compliance with Federal and State laws, regulations, rules, policies, procedures, and manuals.

c Consistent with Federal and State laws, regulations, rules, policies, procedures, and manuals, allowing the member's new provider(s) to obtain copies of the member's health record, as appropriate; and

4 Any other necessary procedures as specified by LDH in writing to ensure continued access to services to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization. Special consideration is given to, but not limited to, the following:

a Members with significant conditions or treatments or who are hospitalized at the time of transition;

b Members who have received prior authorization for services such as therapies to be provided after transition or out-of-area specialty services;

c Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels.

5 If a member is to be transferred between MCOs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving MCO. However, the relinquishing MCO is responsible for the member's hospitalization until the member is discharged. The receiving MCO is responsible for all other care.

a In the event that the relinquishing MCO's contract is terminated prior to the member's discharge, responsibility for the remainder of the hospitalization charges revert to the receiving MCO, effective at 12:01 am on the day after the prior MCO's contract ends.

L Collaboration

1 UHCCP LA collaborates with:

a The ~~Office of Juvenile Justice (~~OJJ~~)~~, the ~~Department of Children and Family Services (~~DCFS~~)~~ and Department of Education ~~(DOE)~~ to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a Wraparound Agency ~~(WAA)~~ if indicated;

b Nursing facilities and ~~Intermediate Care Facility for Individuals with Intellectual Disabilities (~~ICF/IDDs~~)~~ to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;

c Hospitals, residential facilities, and inpatient facilities require collaboration to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers and after-care appointments; and

d The Department of Corrections and criminal justice system in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services prior to reentry into the community, including referral to community providers prior to reentry into the community including, but not limited to, members in the Louisiana Medicaid Program pre-release program.

e ~~UHCCP LA coordinates with t~~The court system and State child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the request of LDH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffing[OJA26].

~~d~~f Please refer to separate procedural type documentation to review details regarding processes and procedures.[KF27]

## VI RELATED POLICIES AND MATERIALS:

- 42 CFR §438.208 and §438.114
- Medicaid Managed Care Organization Contract between State of Louisiana Department of Health, Bureau of Health Services Financing and UnitedHealthcare of Louisiana, Inc., Effective 01/01/2023, Attachment A: Model Contract.
- Louisiana Department of Health, Department of Justice Agreement Compliance Guide, Published 06/01/2022
- Optum BH All Lines of Business National Policy, *Coordination of Behavioral Healthcare*
- Optum BH All Lines of Business National Policy, *National Policy Definitions List*

- Optum BH All Lines of Business National Policy, *Transition of Care for Members Receiving Behavioral Health Services*
- Optum BH All Lines of Business National Policy, *Transition of Members – Pediatric to Adult Treatment or to another MBHO*
- Optum BH Government National Policy, *Medicaid and CHIP Managed Care – Policy Definitions List*
- Optum BH National Medicaid policy *Transition and Coordination of Care Addendum*
- Optum BH UHC C&S States Specific Policy, *Utilization Management of Behavioral Health Benefits Addendum*
- Procedural type documentation describing how the requirements outline within this policy are met as well as monitoring reports, analysis documentation, actions taken to demonstrate compliance, etc.

**VI APPROVED BY:**

~~12/12/2022~~

**Jose Calderon-Abbo, M.D.**
**UnitedHealthcare Community Plan Louisiana**
**Behavioral Health Medical Director**

**Date**

**VII Policy Revision Control Log**

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|---|---|
| **UnitedHealthcare Community Plan of Louisiana, Inc.** | DEPARTMENT:<br>**Clinical Operations – Behavioral Health** |
| | LINE OF BUSINESS:<br>**UHC C&S Louisiana** |
| POLICY TITLE:<br>**Coordination, Continuity and Transition of Behavioral Health Care Addendum** | POLICY NUMBER: |
| EFFECTIVE DATE: | PAGE:<br>**Page 18 of 18** |
| REVIEW DATE: | REVISION DATE: |
| REPLACES POLICY# / DATED: | AUTHORIZED BY: |

| Optum BH OPS Committee Approval Date | Summary of Revision(s) | Reason(s) for Revision |
|---|---|---|
| 07/27/2022 | Policy created – SUBJECT TO CUSTOMER AND STATE APPROVAL | |
| 12/20/2022 | Updated for new contract requirements effective 01/01/2023. Customer approval received 12/19/2022. | Annual Review and Contractual Changes |
| 12/22/2023 | No material changes | Annual Review |
| 01/24/2024 | Removed State Approval Tag. State approval received 01/09/2024. | Mid-Term Review |
| | Added definitions and sections for Comprehensive Case Management Program, Individual Plan of Care, Referral to Case Management, Tiered Case Management Based on Need, Members with Special Health Care Needs, Transition Case Management, and Case Management for Individuals in DOJ Agreement Target Population. | |