2.10.6.1 Case 1: A 38-year-old enrollee resides in St. Helena Parish and has multiple health issues…

Monica, age 38
Our approach to Monica's case emphasizes management of her chronic pain through coordination of non-pharmacological methods of pain management, education to support self-management of her chronic conditions, and linkage with resources to address her social determinants of health (SDOH) needs. Monica receives support from a Humana Registered Nurse (RN) Case Manager (CM) to clarify health information, coordinate care between her providers, and help Monica realize her goals.

This scenario begins when Humana receives a prior authorization (PA) request for Monica's back surgery. As Monica's case does not meet all clinical indications for approval, we route it to a Humana Louisiana Medicaid Medical Director. Our Medical Director contacts the ordering physician to offer a peer-to-peer review and gather additional information to supplement the PA request. Monica's requesting surgeon informs the Medical Director that her primary care provider (PCP) has been treating her pain for several years. To understand her pain management history further, our Medical Director reviews Monica's physical health, behavioral health (BH), and pharmacy claims using our integrated clinical platform, Clinical Guidance eXchange (CGX), and contacts her PCP to determine if there have been any non-covered services provided that do not appear in Monica's case file.

Through her discussions with Monica's PCP and surgeon, our Medical Director concludes that Monica has not exhausted all non-surgical options for relief of back pain. During their peer-to-peer review, Humana's Medical Director and Monica's surgeon agree that a trial of non-surgical options for relieving her back pain is warranted before pursuing surgery. The Medical Director then discusses alternative treatment paths with Monica's PCP, including physical therapy (PT) and one of **Humana's value-added benefits (VAB), such as acupuncture, massage therapy, chiropractic care, or a free gym membership to encourage physical activity**. The Medical Director also suggests that Monica participate in Humana's case management program, which will assist with coordination of her pain management services and support Monica's control of her other conditions.

[redacted]

Had Monica been engaged in Humana case management, her comprehensive assessment or a multi-disciplinary care team (MDT) meeting would have revealed her pain management history prior to the submission of the PA request for surgery. As we did not note Monica's receipt of pain management support from her PCP until the review of the surgery request, she likely has not been engaged in Humana case management to date. This prompts a review of our identification methodologies to determine how we can better engage enrollees with significant pain management needs like Monica. We regularly review our case management algorithms (including predictive models) to ensure accuracy. In this case, we consider how to refine these models to better highlight enrollees such as Monica. [redacted] In the case that we identified Monica for case management but were unable to engage her, we would review our unable-to-contact and engagement procedures (as detailed in our response to Section 2.10.5 of the RFP) to determine strategies for improvement.

In addition to improving our case management identification procedures, this scenario also presents an opportunity for Humana to more deeply engage a potentially less engaged provider. Our Medical Director asks the Provider Relations (PR) representative assigned to Monica's PCP to provide refresher training on case management referrals to the provider. We also direct the provider to the **courses on pain management** that will be accessible to all of our network providers through our website, including three courses approved by Louisiana's Addictive Disorder Regulatory Authority (ADRA): "The Treatment of Chronic Pain;" "Controlled Substances: Implications for Drug Diversion, SUD, and Pain Management;" and "Marijuana and Cannabinoids, Pain and the Brain." In addition, our PR representative educates Monica's PCP on our **value-based purchasing (VBP) offerings**, as a pathway to further engagement with Humana. Her PCP can choose to participate in entry-level programs on our VBP continuum, with the

opportunity to move to upside-only quality bonus contracts and eventually risk-bearing arrangements when or if they feel prepared to do so.

Monica's Engagement in Humana Case Management

We share case management criteria with associates across our organization to support internal referrals for case management. Based on these criteria and their review of Monica's case, our Louisiana Medicaid Utilization Management (UM) team and Medical Director task Humana's case management team to contact Monica. During their call with Monica, they educate her about case management and administer the Health Needs Assessment (HNA), if not yet complete, and with her consent. If we do not successfully reach Monica via telephonic methods, we will dispatch a local Humana Community Health Worker (CHW) to conduct research and in-person outreach. Applying our stratification methodology (described in our response to Section 2.10.5 of the RFP), we stratify Monica to Tier 3 case management. This takes into account Monica's complex needs and history of non-emergent emergency department (ED) visits. After Monica agrees to engage in case management, Chris (Monica's assigned RN CM) calls to introduce himself and schedule a date and time for their first in-person meeting. As needed, Chris will consult with a BH CM on his **Comprehensive Care Support (CCS) team** to inform Monica's care plan and ongoing interventions, including pain management support. To the extent possible, we recruit our associates from the community, so they can contribute their knowledge and understanding of local services and needs to better support our Louisiana Medicaid enrollees.

Chris reviews all available information in CGX to obtain a preliminary assessment of Monica's clinical needs, including her past claims, utilization, and gaps in care. Chris also speaks with our Medical Director to get more details about Monica's case and the outcomes of the peer-to-peer review. During their first face-to-face meeting, Chris administers the comprehensive case management assessment, including an evaluation of Monica's home environment and a review of unmet SDOH needs. Following the tenets of **person-centered planning** covered in his CM training, Chris reviews Monica's medical and psychosocial needs, recent appointments, medications, and other treatments in order to evaluate her knowledge of her conditions and understand her approach to condition management. In addition, Chris and Monica discuss her preferences, needs, strengths, and goals in relation to her health and her overall well-being. In shaping Monica's care plan and delivering ongoing education and other interventions, Chris applies motivational interviewing and empathy skills, which is part of our CM training, and tailors interventions to Monica's stage of change, in accordance with the **Transtheoretical Model of behavior change**.

Chris also ensures that Monica understands the decision to deny the surgery request and next steps, including those services recommended by our Medical Director and her PCP. Chris educates Monica on her appeal rights and guides her through the process of filing an appeal of the adverse benefit determination, if desired.

Arranging Physical Therapy

Chris reviews Monica's surgery request, including the current treatment plan submitted by her PCP to support the request. He also looks at Monica's case file in CGX to confirm that she has received an authorization for physical therapy that includes the approved number of visits. Using Humana's physician finder, Chris notes that Monica does not have a physical therapist in her area. After locating network providers across the border in Pike County, Mississippi, and in neighboring Tangipahoa Parish that meet time and distance standards, Chris helps Monica select the provider who will best meet her needs and discusses her preferences for travel. Chris then facilitates the submission of a physical therapist order to that provider, helps Monica schedule the first appointment, and teaches Monica how to submit a request to [redacted], our non-emergency medical transportation (NEMT) partner, for transportation to her appointments.

Our network development process includes identifying and contracting with providers in bordering states who routinely accept Louisiana Medicaid patients. If Chris were to locate a non-network provider closer to Monica, he would ask our provider contracting team to negotiate a single case agreement (SCA) to cover Monica's approved PT services. Our local contracting team regularly reviews providers with whom we have SCAs to attempt contracting and leverages the provider relationships we have built while serving more than [redacted] **Louisianans** to improve access to care.

Monica's MDT Meeting

During Monica's initial case management meeting, Chris explains the function of the MDT and asks for her input on MDT participants. With Monica's agreement, her MDT includes Monica, her partner, Chris, her PCP, and any other identified providers. If Monica receives care management from her PCP or BH provider, Chris supports that individual as the lead CM on Monica's MDT. At each meeting, the MDT reviews Monica's assessments and care plan, provides feedback, and builds consensus on her care goals and next steps.

Recognizing that Monica has a variety of complex conditions including Hepatitis C (HCV), diabetes, hypertension, and back problems, as well as the possible added responsibilities of caring for her family, Chris works with Monica to prioritize goals on her care plan, taking into account information from the assessment and Monica's own preferences. Monica states that relief from her back pain is her primary goal, as her back pain is negatively impacting her ability to manage her other health conditions, maintain employment, and be active with her family. Table 2.10.6.1-A summarizes Monica's goals, priority needs, and interventions, including input from Monica's MDT.

Table 2.10.6.1-A: Monica's Goals, Priority Needs, and Interventions

Goals	Priority Needs	Interventions
Reduce her pain levels	Monica has identified her back pain as her overarching concern. Chris facilitates a supplemental pain assessment to better understand Monica's pain history and those interventions that have and have not worked in the past to control her pain.	If recommended by her MDT upon review of the initial assessment, Chris arranges for Monica to receive a comprehensive assessment for pain from a specialist. Chris helps Monica access those pain management services suggested by our Medical Director and agreed upon by her MDT by obtaining necessary orders from her PCP, finding providers, and arranging transportation as needed. These services include PT, other pain management interventions covered by Humana's VAB, and cognitive behavioral therapy.

Address any identified BH needs	As a routine part of our assessment process, Chris administers the Patient Health Questionnaire (PHQ-2) and the CAGE-AID to screen for alcohol and drug use. If the PHQ-2 is positive, Chris administers the PHQ-9 to evaluate Monica's symptoms of depression. Chris recognizes Monica's risk for substance use disorder (SUD) given her struggle with chronic pain and her HCV diagnosis, as SUD can be a contributing factor for HCV.	If Monica is diagnosed with SUD or another BH need, Chris works with her MDT to determine and coordinate needed services. These may include:
		• **Medication-assisted therapy (MAT):** Chris locates MAT providers in East Feliciana and Tangipahoa Parishes and arranges transportation as needed
		• **Outpatient therapy:** Depending on the severity of her BH needs, the input of her MDT, and her preferences, Monica may:
		  ○ Receive BH treatment from her PCP, with the support of our psychiatric consultation line
		  ○ Visit a local BH provider for in-person treatment
		  ○ Be linked with **telebehavioral health services**, either using our direct-to-consumer platform or our PCP-led option

Better management of her chronic conditions	As part of the comprehensive assessment, Chris identifies Monica's barriers to chronic condition management, such as lack of education on her conditions, inability to be physically active due to safety or other concerns, lack of access to healthy food, and/or tobacco use.	As recommended by her MDT and with Monica's input and full agreement, Chris coordinates the following interventions to support Monica's management of her chronic conditions: • Maintaining regular PCP appointments • Disease management (DM) interventions, provided by Chris and tailored to Monica's health literacy level and interests • Access to Humana's added benefits and community resources, including **transportation to SDOH-related services** and food assistance and tobacco cessation support (as needed) • Medication therapy management (MTM)

Table 2.10.6.1-A: Monica's Goals, Priority Needs, and Interventions		
Goals	Priority Needs	Interventions
Successfully complete treatment for HCV	Chris asks questions to better understand Monica's HCV diagnosis, including when she was diagnosed, if she knows how she contracted the virus, if she has ever engaged in risky behaviors, if she has any symptoms of HCV, and if she is receiving treatment.	If Monica is receiving HCV treatment, Chris performs weekly follow-up calls to monitor adherence as part of Humana's HCV program. If Monica is not receiving HCV treatment or is ineligible due to risky behaviors, Chris discusses next steps with Monica and her PCP. These may include initiation of HCV treatment (if eligible), or taking action to make her eligible (e.g., SUD treatment or intervention from a Humana peer support specialist to eliminate risky behaviors).
Maintain a healthy environment for her family and caring for her children	Monica and Chris discuss her support system and family dynamics, including whether she has children, their ages, where they currently live, and who generally cares for them. Chris evaluates how a lack of child care may impact Monica's ability to seek care. During the assessment, Chris evaluates possible physical hazards inside the home and SDOH needs to determine how these factors impact her well-being.	Issues in Monica's home (as well as any health-related SDOH needs she reports) guide Chris in his resource referrals. Chris provides Monica resources that can help her achieve her goals for her family, including but not limited to: • Child care options such as the Child Care Assistance Program (CCAP) or Head Start • Community events for enrollees and their families supported by our Louisiana Medicaid Community Engagement team • Food assistance through the Supplemental Nutrition Assistance Program (SNAP) or the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) To empower Monica to take increased control over her needs and circumstances, Chris teaches Monica how to use the [redacted] and encourages her to contact agencies directly.
Seek gainful employment	Monica expresses interest in finding better employment once her back pain improves. Chris evaluates Monica's education level, employment status, interest in seeking employment, and any barriers she faces to maintaining employment (e.g., child care).	If Monica does not have her high school diploma but expresses interest in completing her schooling, Chris helps her access our **GEDWorks™ benefit**, which provides test preparation assistance and covers the cost of the exam. He also refers her to Vocational Rehabilitation or a nearby office of the Louisiana Workforce Commission for job-seeking support, and links her to child care resources and other supports that can help her maintain employment.

Monica's Continued Engagement with Humana Case Management

We will tailor case management contacts to the needs of each individual while complying with Contract minimums. At the beginning of Monica's engagement in Tier 3 case management, Chris visits her face to face each week, with additional calls as needed. As Monica's condition stabilizes, and she demonstrates better self-management of her conditions, Chris may reduce the frequency of his contacts. While Monica is in Tier 3 case management, she receives monthly in-person visits, monthly updates to her care plan (at a minimum), and quarterly re-assessments (in compliance with contractual requirements). During their ongoing contacts, Chris focuses on actions to help Monica reach her goals and maintain compliance with her treatment plan, including:

- Pain Management: Chris continues to monitor Monica's pain level and compliance with her pain management plan. On a quarterly basis at a minimum, Chris reassesses Monica to monitor development of any symptoms of depression or SUD, recognizing their association with chronic pain. If Monica's pain level does not diminish after the approved course of PT, we work with her PCP and a Humana Medical Director to reassess her condition and care plan. If Monica and her care team wish to re-submit a PA request for surgery, we will take updated information about Monica's care into consideration.

- Diabetes and Hypertension: Under our integrated care model, our CMs provide DM supports and education tailored to the enrollee's health literacy level, stage of change, and care plan. Chris offers the following supports to help Monica manage her diabetes and hypertension:
  - *Education:* Chris uses **Healthwise**, our library of health education content, to provide chronic condition education that fits Monica's health literacy level. If she expresses a desire to become pregnant again, Chris explains the importance of managing her conditions prior to pregnancy, particularly given her history of high-risk pregnancy.
  - *Digital Therapeutics:* Humana is partnering with [redacted] to introduce an **innovative digital therapeutic smartphone application,** known as [redacted], to help our enrollees with diabetes better manage their blood sugar levels. Monica can improve self-management of her diabetes through the individualized, real-time feedback that [redacted] provides in response to her reported blood glucose level, activity level, diet, and more. Chris receives a report of Monica's activity on [redacted]. He uses this information to help Monica identify and overcome barriers to glucose control. If Monica does not have a smartphone or has limited data, Chris helps her access our smartphone and/or unlimited data benefits to support use of our digital platforms.
  - *Medication Support:* Monica receives MTM through her local pharmacy for management of her diabetes medications, in addition to targeted medication reviews to manage her hypertension and HCV antiviral therapy (as indicated). Our MTM program aims to increase medication adherence, reduce the risk of adverse drug events, and ensure that medications are appropriately used to enhance therapeutic outcomes. [redacted]
- Reducing Non-Emergent Use of the ED: Chris and Monica collaborate on a plan to reduce her non-emergent use of the ED. To inform this plan, Chris and Monica discuss the reasons behind her use of the ED in the past, such as lack of awareness of ED alternatives, discomfort with using these alternatives, or lack of transportation. Chris encourages her to complete Humana's course on appropriate care-seeking, for which she can receive a monetary incentive. He also notes the locations of our 27 nearby in-network urgent care centers and her PCP's after-hours availability on Monica's care plan and provides a refrigerator magnet that lists the numbers for our [redacted] house calls service, Ochsner's Anywhere Care (for virtual urgent care visits for common illnesses), and our Nurse Advice Line (NAL) and [redacted] BH Crisis Line through [redacted]
- Healthcare for Her Children: If Monica has children in her care, Chris educates her on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) periodicity schedule and teaches her how to access our library of video and written content on pediatric BH and physical health conditions, managed by [redacted]. If Monica's children are Humana enrollees, Chris uses CGX's family unit view to access each child's case file and identify gaps in care. He reminds Monica to schedule visits as needed.
- SDOH Support: Chris continues to monitor Monica's SDOH needs to ensure she connects with the appropriate community resources. For more complex needs or additional assistance in locating the appropriate resources, Chris seeks support from the SDOH coordinator on his CCS team.
- Family Planning (FP): If Monica does not plan to have more children in the near future, Chris helps her make an appointment with a local health parish unit or her PCP to discuss and receive her FP method of choice.

Monica's Graduation from Tier 3 Case Management

Through regular contacts, care plan updates, and quarterly reassessments, Chris continues to monitor Monica's progress and evaluate opportunities to move her to a lower tier of case management. Once Monica attains her goals, including demonstrating control of her chronic conditions, having no inappropriate ED utilization for at least six months, and reporting that her back pain has stabilized, she moves to a lower tier of case management, with the ultimate goal of moving from case management to self-management of her health and wellness.