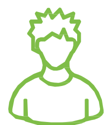
2.10.6.2 Case 2: The Proposer has an enrollee who is 11-years-old and presents at the ER…



Benny, age 11

Our first concern is interrupting the escalating crisis for Benny and his family and ensuring he is in a safe setting where he can be evaluated, treated, and triaged to an inpatient or other safe level of care. As we learn more and Benny stabilizes, we will work with the hospital and our network providers to develop and implement a treatment plan that addresses his and his family's needs. As he responds to treatment, Benny's multi-disciplinary care team (MDT) ensures that Benny is engaged with covered services, community resources, and LDH agency supports (including the Coordinated System of Care) that can help him achieve his goals.

Benny is back in the emergency department (ED) after being released just 48 hours ago. Our Utilization Management (UM) Coordinator is alerted to Benny's ED visit through one of several means, including a notification through our planned linkage with Louisiana Health Information Exchanges (HIE), including the Louisiana Health Information Network and the Greater New Orleans HIE; submission of an authorization to move Benny to another level of care; direct notification by the ED; or notification from Benny's family through his licensed mental health professional (LMHP) Case Manager (CM), Julie. Based on the complex behavioral health (BH) needs noted in his enrollment file and Health Needs Assessment (HNA) conducted upon his enrollment in Humana, we identified Benny as an enrollee with special health care needs (SHCN) and placed him in Tier 3 case management. During their previous assessment and care planning session, Julie met face-to-face with Benny and his father (whom we confirmed is his guardian) and provided her phone number so that Benny and his father could reach her if a clinical or social need arises or when an adverse event occurs. Noting Benny's history of abuse, Julie also discussed the appropriate level of involvement for Benny's stepmother and mother in his care plan and ensured that Benny was living in a safe home and was receiving appropriate trauma-informed care. Leveraging the cultural sensitivity and motivational interviewing skills taught in her CM training, Julie worked to understand and appreciate the circumstances of the family and applied these to discussions. She spoke with the family about the services and supports needed to help Benny stabilize his health. Julie actively sought to build a connection with Benny and his father to support their relationship. In this case, Julie connected over their shared heritage and nearby hometowns.

Upon notification of Benny's current ED visit, our UM Coordinator works with Benny's family, the ED staff, and Julie to discuss the appropriate level of care given Benny's recent ED visits, including two visits within two days. If it is determined that Benny requires an inpatient level of care, our UM Coordinator helps to identify a facility with an available bed and coordinates the submission of a prior authorization (PA) request. We use MCG® guidelines for both physical health and BH determinations to ensure consistent decision-making and compliance with mental health parity regulations and to ensure the most appropriate level of care for Benny's needs. If a bed is not available at a Humana network facility, our UM Coordinator looks for psychiatric beds at in-state, out-of-network facilities as well as out-of-state facilities, arranging transportation as appropriate. If we cannot locate a psychiatric bed in a timely manner, we also consider moving Benny to a medical-surgical unit with psychiatric support offered by a community provider. While we work to find Benny a psychiatric bed, our UM Coordinator arranges an assessment by an LMHP to evaluate and stabilize Benny while he is in the ED, in observation, or in a step-down bed. This evaluation may occur in person if the ED is affiliated with a psychiatric unit; may be arranged with a community provider; or may be delivered via Humana's partnerships with local and national companies, including Ochsner's CareConnect 360 platform, to provide real-time ED psychiatric consultations (as available) for facilities without an affiliated psychiatric unit.

As an added benefit, Humana will cover transportation for Benny's parents to attend family sessions while he is inpatient or in a residential facility.

Julie stays in close contact with Benny, his family, and our UM Coordinator to confirm he is still in the ED and has not been inappropriately discharged. She also confirms that he is receiving appropriate treatment to stabilize him while waiting for an open bed. In keeping with our commitment to coordinating with all of those who care for our enrollees, Julie notifies Benny's CM at the Office for Citizens with Developmental Disabilities (OCDD) and Benny's current providers within 24 hours of his admission to an inpatient facility. She also talks with Benny's father to see how he is

responding to Benny's latest ED visit, including impacts on his own BH needs; answers questions; addresses any concerns; and begins discharge planning. To ensure a return to a safe and supportive setting, we begin discharge planning upon admission for all enrollees.

Benny's Inpatient Stay: Two days after Benny's admission and periodically thereafter, our UM Coordinator contacts the facility to conduct a concurrent review. Our UM Coordinator and Julie continue to monitor Benny's care through ongoing chart reviews and communication with the facility to ensure Benny receives high-quality, appropriate care throughout his stay in the inpatient facility. This includes a visit from a facility provider within the first 24 hours after admission to conduct a thorough physical examination, including assessing any effects of his self-induced vomiting, one-to-one observation or a safety check every 15 minutes (depending on facility policies and his assessed risk), family sessions, a daily visit from a psychiatrist, and age-appropriate therapy. Our UM Coordinator raises any concerns about treatment with the facility staff, with the involvement of our Louisiana Medicaid BH Medical Director as needed. To respond to Benny's diagnosis of post-traumatic stress disorder (PTSD), our UM Coordinator works with the attending psychiatrist to ensure trauma-informed care is provided. If the facility does not have access to psychiatry staff trained in trauma-informed care for children, our UM Coordinator arranges a visit from a community provider trained in trauma-informed care who can continue to treat Benny after discharge.

Julie ensures that Benny receives a full assessment for his BH and physical health needs from facility staff prior to discharge. This assessment addresses Benny's anxiety, including the drivers, symptoms, and underlying causes. Benny's anxiety may be linked to his PTSD, but it may also signify an impending psychotic disorder as manifested by his dissociation, unrelenting distressing memories, and self-harm. We provide an assessment for any substance use by Benny to rule out this and any associated behaviors as contributing causative factors. A family history of psychiatric needs places Benny at increased risk for development of a psychotic disorder. Julie ensures the assessment also covers Benny's autism spectrum disorder (ASD) diagnosis, his dissociative symptoms, his self-injurious behavior, and his history of adverse childhood experiences. Results of the assessment are shared with Benny's MDT to assist in treatment and care planning.

Because of Benny's high level of need, he is placed on Humana's priority list for clinical rounds. Through twice weekly or more frequent clinical rounds, we bring together our Louisiana Medicaid UM team, CM team, Medical Directors, and other members of Humana's Comprehensive Care Support (CCS) team to discuss the care of enrollees with complex needs. Julie, our UM Coordinator, and our BH Medical Director discuss Benny's response to treatment and needed treatment adjustments. In addition, this team aligns on a plan for step-down care and reviews the plan for addressing any barriers to a successful discharge, including concerns related to his safety, living environment, or unmet Social Determinants of Health (SDOH) needs. Our integrated clinical platform, Clinical Guidance eXchange (CGX), is used to communicate information between our UM and CM teams and other associates interacting with Benny and his family on an ongoing basis.

CSoC Screening and Referral: Based on Benny's recent history and symptoms, Julie identifies him as a candidate for the Coordinated System of Care (CSoC). With his father's consent, Julie applies the initial risk screen for CSoC eligibility while Benny is in an out-of-home placement and transfers Benny's father to the CSoC administrator for further evaluation, as appropriate. If Benny is deemed eligible for the CSoC program and chooses to participate (with the agreement of his father), Julie helps coordinate the transfer of his specialized BH (SBH) services to the Wraparound Agency (WAA). We will develop procedures in conjunction with the WAA to ensure a smooth transfer of services and case management responsibilities without any interruptions in support for the enrollee and their family. Julie continues to serve as Benny's CM for those services covered by Humana, facilitating regular contact with his Wraparound Facilitator (WF), joining Child and Family Team (CFT) meetings as invited, and coordinating with the WF and the CFT to develop Benny's care plan. Julie will discuss the possibility of merging Benny's MDT with his CSoC CFT, with the aim of reducing duplication of efforts and promoting coordination of all covered services and family supports.

Addressing Long-Term Stays in EDs

Benny's previous long-term stay in the ED when a bed could not be found raises quality of care concerns that Humana takes very seriously. We are committed to working with our providers, community partners, and State agencies to solve this issue, including addressing the shortage of inpatient psychiatric beds for children and adolescents in Louisiana. Our proposed solutions include:

- Investing in the expansion of step-down services, including intensive outpatient therapy (IOP) and partial hospitalization (PHP) in the State
- Partnering with our BH Crisis Line partner and other crisis service providers to support the expansion and development of evidence-based crisis response services, including psychiatric urgent care
- Delivering BH consultations in EDs via our telehealth and/or community providers
- Offering online courses for network ED staff on treating BH in EDs to support proper referrals
- Intervening with EDs that display a pattern of BH-related long-term stays through refresher trainings on our UM processes for psychiatric inpatient admissions, peer-to-peer meetings with our Louisiana Medicaid UM directors and Medical Directors, and the institution of corrective action plans, as necessary

Transitioning Benny to a Lower Level of Care

Julie and our UM Coordinator continue to work with Humana's BH Medical Director, the admitting facility, Benny's support system, Benny's community providers, OCDD, and Benny's WF (as applicable) to transition Benny to a lower level of care and develop a transition plan of care. Our discharge planning process is designed to ensure that our enrollees can go to the least restrictive setting that is most appropriate for their needs. For Benny, these options may include a transition to a residential facility or discharge to home with outpatient services and intensive wraparound support. We will educate our associates on, and will adhere to, all relevant Chisholm Class court-ordered requirements when managing PAs for Benny's services. Within 72 hours of Benny's discharge to either a residential or home setting, Julie follows up to confirm that services on his transition plan of care are in place.

Discharge to Residential Treatment

We may recommend residential treatment if Benny requires longer-term, trauma-informed psychiatric care that includes further assessment and stabilization of his conditions and triggers. This option would also allow more time to identify his needs, refine his treatment plan, and prepare Benny and his family for his return home. As needed, Julie helps Benny's family access our transportation added benefit to attend family therapy sessions while he is in the residential facility. If Benny is placed in a therapeutic group home (TGH), Julie helps to arrange funding for his room and board in coordination with Humana's Housing Specialist. Julie supports transitional case management led by Humana or CSoC (as applicable), including ensuring that aftercare services are in place 30 days prior to discharge.

Discharge to a Home Setting

Our ideal goal is to help Benny return to his family home, but only when it is safe and appropriate to do so. Whether it occurs directly after his inpatient admission or a stay in a residential facility, Benny's discharge to the home he shares with his father and stepmother is contingent upon confirmation that he is returning to a safe environment (without risk of abuse) and to adults who are informed and prepared to resume caring for his BH needs. This includes ensuring we address his parents' own BH needs. Before Benny's return home, Julie conducts an in-person assessment to determine the safety of the home environment. If Julie has concerns that Benny's parents are decompensating to an extent that Benny is placed at risk or that they are abusing him, she reports her concerns to the Department of Children and Family Services (DCFS). If Benny's father and stepmother are not currently receiving treatment for their own BH conditions, Julie helps them locate a provider who accepts their insurance or who can provide low-cost services.

If any member of Benny's household is enrolled in Humana case management, Benny will be assigned to the same CM to facilitate support for the entire family unit.

Benny's transition plan of care for his return to his family home will include the services that can help Benny and his family manage his conditions and avoid a future ED visit or inpatient admission. Overseen and facilitated by Julie and

developed in coordination with his MDT, his OCDD CM, discharging provider, and WF (as appropriate), Benny's transition plan of care includes:

- Outpatient BH Services: Julie documents Benny's scheduled care appointments, including follow-up with an outpatient BH provider. Benny's BH treatment plan may include the following services, none of which will require PA per Humana policy:
  - *Services provided by the CSoC*: If Benny is determined to be eligible for and agrees to participate in CSoC, his WF will organize his SBH services from the package of covered CSoC supports, with Julie's support.
  - *Community Psychiatric Support and Treatment (CPST)*: Through CPST for high-risk populations, Benny and his family can participate in the Functional Family Therapy and/or Homebuilders® Program. These service types are designed to support the entire family and keep Benny in his family home.
  - *Applied Behavioral Analysis (ABA)*: To address Benny's ASD diagnosis, Julie coordinates ABA services (as ordered) and any associated durable medical equipment (DME) required.
  - *Wraparound Supports*: Julie works with OCDD and Benny's providers to arrange other wraparound supports for his family, including center-based respite care, family support, and family training.
  - *IOP and PHP*: Humana intends to cover both IOP and PHP as in lieu of services for our Louisiana Medicaid plan. IOP and PHP can support Benny to live at home and stay connected with his family while receiving a higher level of care.
- Patient Education and Self-Management Strategies: With the consent of Benny's father, Julie invites Carla, a Humana peer support specialist, to join Benny's MDT to provide education and self-management support. We educate Benny and his family on how to access our library of video and written content on a range of BH and physical health conditions, created and managed by [redacted]. Our educational library includes English and Spanish content written for children and adolescents, allowing Benny to directly access age-appropriate material.
- Medication Reconciliation: Julie coordinates with Benny's MDT (including prescribing providers) to perform medication reconciliation after discharge, engaging our Louisiana Medicaid Pharmacy Director as needed. In addition, she educates Benny's family on his medication regimen.
- PA Needs: **Humana will not require PA for the majority of outpatient BH services to ensure access to needed services for our Louisiana Medicaid enrollees, promote administrative simplification, and reduce provider burden**. If an ordered service does require PA, Julie manages the PA process in a manner that minimizes the burden on Benny and the requesting provider.
- SDOH Needs: In preparation for Benny's return home, Julie conducts an in-person assessment of his family's SDOH needs to ensure that Benny is returning to a safe, healthy environment that can provide for his basic needs, including food and electricity. In addition to using her knowledge of available resources as a member of Benny's community, Julie uses our [redacted] as needed, to link the family with appropriate community resources.

Benny's Re-Assessment and Revised Care Plan

Upon Benny's return to a home setting, Julie works with Benny, his family, his OCDD CM, his providers, his WF (as engaged), Humana's I/DD Liaison, and other members of his MDT to complete an in-person comprehensive re-assessment, including an updated home environment assessment. In addition, the MDT revises Benny's care plan to accommodate the change in Benny's condition and his new services, including those services offered by OCDD and CSoC. Assessment results and the revised care plan are shared with Benny's care team through our provider portal, Availity, and are securely disseminated to his OCDD CM and his WF. Table 2.10.6.2-A summarizes Benny's identified goals, priority needs, and planned interventions for his home setting.

Table 2.10.6.2-A: Benny's Goals, Priority Needs, and Interventions

Goals	Priority Needs	Interventions
Avoid BH crises	Julie and Benny's family discuss events that precipitated his previous crises (e.g., a fight with a sibling) and interventions that have and have not helped to mitigate past crises.	Julie, Benny's family, and the rest of his MDT work together to formulate his crisis plan, including signs and symptoms of a crisis; actions to mitigate identified triggers; and interventions his family and school can undertake when a crisis begins, including contacting our Louisiana-based BH Crisis Line, contacting his CPST provider, going to an identified facility (if needed), and/or using

Table 2.10.6.2-A: Benny's Goals, Priority Needs, and Interventions		
Goals	Priority Needs	Interventions
		those crisis supports provided by OCDD. With his father's permission, the crisis plan is shared with our BH Crisis Line to support their response in the event of a crisis.
Manage Benny's BH and physical health needs	With Benny's father's permission, Julie requests his treatment plan from his BH provider and any records or provider information not previously obtained. Julie also reviews Benny's physical health needs and history, including his compliance with recommended well-child visits and immunization schedule.	Julie identifies and documents his CSoC services (if enrolled); ABA; trauma-informed BH care; services provided by OCDD; early and periodic screening, diagnosis, and treatment services (EPSDT) including immunizations provided by his primary care provider (PCP); and other needed physical health services. The MDT provides a forum for Benny's BH providers and PCP to exchange information about his care. Julie ensures that all his providers have access to his care plan and assessments.
Improve the family's well-being	Benny and his family have experienced stress from his recent admissions, along with his parents' ongoing challenges with their own BH needs. Julie evaluates how SDOH or other needs may be compounding the family's stress through motivational interviewing and an environmental assessment.	Julie and Carla (Benny's assigned peer support specialist) use the [redacted] – as well as their own knowledge of available community resources – to link Benny and his family with agencies to address SDOH needs, including those related to food insecurity, housing, transportation, and physical safety. Julie and Carla also connect Benny's parents with child care support such as the Child Care Assistance Program to ensure stability of their own health, well-being, and any current employment. In addition, we identify those added benefits that can support Benny and his family. For example, Carla will link Benny with a discounted YMCA membership to provide a safe space to spend time together as a family and engage in fitness activities.
Succeed in school	Benny's inpatient admissions and recent behaviors have likely contributed to school absences. Julie and Benny's family discuss his performance in school, as well as those services that Benny receives from his school.	Carla will help advocate for needed services with Benny's school, including requesting an individualized education program (IEP), modifications to an existing IEP, and/or attending IEP meetings upon invitation from Benny's father.

Julie continues to conduct in-person meetings with Benny for the duration of his enrollment in Tier 3 case management in accordance with his acuity level and the preferences of Benny and his father. In addition, Carla visits or contacts Benny and his family as needed to answer questions, assist in navigation of the health care system, support condition self-management, and connect them with needed community resources. With permission, Benny's crisis plan is shared with his school to help Benny manage his behaviors in an educational setting.

Benny's complex conditions require a team-based approach to care. Working with OCDD, Benny's BH and physical health providers, and Carla, Julie coordinates among providers to reduce fragmentation and duplication and to ensure that Benny receives care that addresses his needs and contributes to positive outcomes. Benny's MDT continues to meet monthly to monitor his progress with his care plan and resolve any additional needs. As Benny demonstrates increased control over his conditions, including an extended period without an ED visit or inpatient admission, he is graduated to Tier 2 case management. Humana continues to work with Benny and his family to support self-management of Benny's conditions, help them advocate for the services and supports they require, and ultimately, graduate from case management.