Potential Implementation of Mandatory Case Management in Medicaid

Report Prepared in Response to HCR 65 of the 2018 Regular Legislative Session

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LOUISIANA DEPARTMENT OF HEALTH

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Executive Summary

This report is submitted in response to House Concurrent Resolution 65 (HCR 65) of the 2018 Regular Legislative Session, which requires the Louisiana Department of Health (LDH) to study potential implementation of mandatory case management for Medicaid enrollees identified as high-risk due to either health status or socioeconomic factors, for the purpose of improving health outcomes and lowering healthcare costs. Specifically, HCR 65 requests LDH to do the following:

- Study the potential implementation of mandatory case management for Medicaid enrollees identified as high-risk;
- Communicate with the Centers for Medicare and Medicaid Services (CMS) to determine the feasibility of mandatory case management and strategies for implementing such a program;
- Examine the potential submission of a waiver application to CMS in which Louisiana would request an exemption to the federal rule requiring that case management be voluntary; and
- Issue the findings and recommendations from this study in a report to the legislative committees on health and welfare on or before January 1, 2019.

HCR 65 asserts that case management is an "evidence-based method of improving health outcomes and making that service mandatory could lower healthcare costs and significantly improve the health status of many Medicaid recipients." The full text of the resolution can be found in Appendix A and also at www.legis.la.gov.

As the resolution notes, case management is currently a voluntary service. In fact, CMS regulations explicitly prohibit making case management mandatory as a condition of program participation. In LDH's correspondence with CMS Regional and Central offices in response to this resolution, CMS confirmed its standing rule against mandatory case management and that no authorities exist to waive the requirements to permit mandatory case management. Our findings further suggest that such an approach would negate any potential positive impacts of case management identified in literature.

The following report examines existing case management practices in Medicaid, further details CMS' rules around case management as a component of a state's Medicaid program and explores alternative options for improving case management opportunities for Louisiana's Medicaid enrollees.

Section 1 – Case Management in Medicaid

Case management refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health-related needs through communication and available resources to promote quality and cost-effective outcomes. Case management can enhance health care coordination through the designation of a case manager whose responsibility is to oversee and coordinate access and care delivery targeted to high-risk patients with diverse combinations of health, functional and social needs.

As defined by CMS, case management services are those that assist eligible individuals in gaining access to needed medical, social, educational and other services, including housing and transportation.[1] Congress first amended the Social Security Act to authorize Medicaid coverage of case management services in 1981.[2] Subsequent changes and additions have been made to CMS regulations on case management, including adding case management to the list of optional services a state may include in its Medicaid State Plan, allowing states to target specific groups or geographic areas for case management, and requiring that state Medicaid agencies provide enrollees with freedom of choice for their case management provider.

CMS describes case management services to include:

1) A comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services;
2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment;
3) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services in order to achieve goals specified in the care plan; and
4) Monitoring and follow-up, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual.

Case management is defined in the Louisiana Administrative Code as services provided to individuals to assist them in gaining access to the full range of needed services including medical, social, educational and other support services.[3]

It is easy to confuse the various terms describing case management-like activities in the health care system. HCR 65 focuses on the term "case management;" however, for the purpose of this report, LDH includes studies and references that use this and similar terms including disease management, care management and care coordination. Even though these terms have nuanced meanings, they are included in order to remain consistent with what LDH believes is the HCR author's intent of providing enrollees with assistance in accessing health care services and improving their health outcomes. Please

[1] Medicaid Program; Optional State Plan Case Management Services, 72 Fed. Reg. 232. (December 4, 2007). *Federal Register: The Daily Journal of the United States*. Web. 6 November 2018.
[2] ibid.
[3] Louisiana Administrative Code 50:10101

see Exhibit 1 for further explanation of these additional terms, some of which may be used in subsequent sections of this report.

Exhibit 1. Various Terms for Case Management.

Case Management versus Disease Management, Care Management and Care Coordination
Case management in health care is often associated with health episodes, meaning that it only spans the amount of time when specific interventions are needed or until certain goals are met, or until a patient is transitioned from one level of care to another. The timing and length of a case management intervention can vary according to the patient's needs and program design. ***Care management*** and ***care coordination*** are often used interchangeably, and are considered to describe managing individuals beyond a specific episode or situation. Care management seeks to provide individuals with a wide spectrum of services directed at behavioral change, creating healthier lifestyles and achieving optimal outcomes that last beyond the episodic nature of the specific health encounter. Care management differs from case management in that it is typically continuous and that it can occur in any care setting and for all individuals regardless of program or payment source. ***Disease management*** typically consists of multiple interventions to prevent or manage one or more chronic conditions. The goal of disease management is to identify persons at risk for one chronic condition, to promote self-management by patients and caregivers and to achieve the best clinical outcomes. Disease management interventions are generally targeted toward specific diseases, whereas case management, care management and care coordination activities are condition agnostic.
Source: Ahmed, Osman I. "Disease Management, Case Management, Care Management and Care Coordination: A Framework and a Brief Manual for Care Programs and Staff" Professional Case Management, Vol. 21, No. 3 (2016): Pages 137-146. Ovid. Web. 10 Nov. 2018.

Eligibility for case management services is determined by the Medicaid State Plan, which is the agreement between a state and the federal government describing how that state administers its Medicaid program. The State Plan establishes the groups of individuals eligible for case management and the types of case management services to be provided.

LDH utilizes a broker model of case management in which enrollees are referred to other agencies for the specific services they need. Needed services are determined by individualized planning with the recipient's family and other persons/professionals deemed appropriate. Services are provided in accordance with a written comprehensive plan of care which includes measurable person-centered outcomes.[4]

Subsection 1.1 Case Management Evidence Base

Case management is widely used in Medicaid because of its perceived value in assisting individuals with making decisions about their care and locating service providers; however, research has found mixed

[4] Louisiana Administrative Code 50: 10101

results of case management in Medicaid populations.[5] There is limited evidence of positive effects on utilization of other services, like reductions in inpatient hospitalizations and emergency department visits, and limited evidence of cost savings, but not all studies witness these same effects.

A literature review of case management programs in Medicaid produced only one example of a mandatory case management program, Philadelphia's HealthPASS program in 1988. One study analyzed its impact on adequacy of prenatal care and birth outcomes among enrollees and found no statistically significant differences between HealthPASS participants and comparable non-HealthPASS Medicaid enrollees in terms of adequacy of prenatal care and birth outcomes, suggesting that the mandatory program neither improved nor impeded access to needed services. While aligning enrollees with primary care providers through HealthPASS may have stimulated earlier diagnoses of pregnancy and referral to obstetrics, HealthPASS' administrative requirements may have created real or perceived barriers to care. Authors suggest that the results were not surprising, considering that the mandatory HealthPASS program did little to actually change patient or provider behavior.[6]

There is wide variability in the available evidence on the relationship between case management and health outcomes in general, and there is no consensus on when and how case management should be used, nor on the proper intensity or frequency necessary to achieve desired outcomes. Alternatively there are examples of successful *care* management programs yielding outcomes for specific interventions like patient education or telephonic care management; however, success can vary in terms of how effective a care management program is overall and which outcomes it impacts, depending on factors such as the specific disease, patient population or payer involved. For example, the Agency for Healthcare Research and Quality (AHRQ) found that patient education and telephonic care management were much more effective interventions for patients with asthma than for patients with diabetes.[7] In-person care management appears to be one of the more consistently successful case management interventions in terms of impacts on clinical outcomes and process measures, but to varying degrees in different groups and with inconsistent cost savings.

Section 2 – CMS Rules on Case Management

As HCR 65 acknowledges, the existing regulations providing for case management in Medicaid clearly prohibit forcing individuals to receive case management, and prohibit limiting any Medicaid services on the basis of receiving case management services. Also, receipt of case management services cannot in any way alter an individual's eligibility to receive other services under the State Plan.[8] According to the

[5] Sabik, Lindsay M. et al. "The Impact of Integrated Case Management on Health Services Use and Spending Among Nonelderly Adult Medicaid Enrollees." Medical Care, Vol. 54, No. 8, August 2016. www.lww-medicalcare.com, Accessed October 26, 2018.
[6] Goldfarb, Neil I. et al. "Impact of a Mandatory Medicaid Case Management Program on Prenatal Care and Birth Outcomes: a Retrospective Analysis." Medical Care, Vol. 29, No. 1 (1991). Pages 64-71. Jstor. Web. 29 October 2018.
[7] Arora R, et al. Designing and Implementing Medicaid Disease and Care Management Programs: A User's Guide. (Prepared by The Lewin Group under Contract No. 290-04-0011.) AHRQ Publication No. 07-0063. Rockville, MD: Agency for Healthcare Research and Quality; February 2008.
[8] Medicaid Program; Optional State Plan Case Management Services, 72 Fed. Reg. 232. (December 4, 2007). *Federal Register: The Daily Journal of the United States*. Web. 6 November 2018.

Code of Federal Regulations, if a Medicaid State Plan provides for case management, the state must meet the following requirements (see Appendix B for the full text):

1) Allow individuals the free choice of any qualified Medicaid provider within the specified geographic area identified in the plan when obtaining case management services, except as specified;
2) Not use case management (including targeted case management) services to restrict an individual's access to other services under the plan;
3) Not compel an individual to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
4) Prohibit providers of case management services from exercising the agency's authority to authorize or deny the provision of other services under the plan.[9]

Subsection 2.1 – Using a waiver to mandate case management

HCR 65 requests that LDH examine the potential submission of a waiver application to CMS whereby Louisiana would request an exemption to the federal rule requiring that case management be voluntary. A Medicaid waiver is a provision in Medicaid law that allows the federal government to waive certain rules and requirements that normally apply to the Medicaid program. There are several types of Medicaid waivers. Appendix C, adapted from the AHRQ guide, "Designing and Implementing Medicaid Disease and Care Management Programs," describes ways to secure CMS approval through these waivers, state plan amendments (SPAs) and the Deficit Reduction Act.

Although many states have proposed and implemented different versions of care management programs, there is considerable variability in how states designed their programs and in the Federal authorities used to implement the programs. CMS' approval procedures are generally individualized, usually dependent on the particular care management model proposed.[10] According to Medicaid.gov, "CMS performs a case-by-case review of each proposal to determine whether its stated objectives are aligned with those of Medicaid. CMS also considers whether proposed waiver expenditures are appropriate and consistent with federal policies…."[11]

In accordance with HCR 65, LDH reached out to CMS Regional and Central Offices to request guidance on how a state could potentially secure an exemption to the rule prohibiting mandatory case management for high-risk Medicaid enrollees. CMS representatives from the 1115 Waiver Division, Managed Care Division and the State Plan Division in the CMS Central Office confirmed a CMS standing rule against mandatory case management and expressed their awareness that no authorities exist to waive the requirements in order to permit mandatory case management. They reiterated existing law, stating that under State Plan 1905(a) Case Management, states cannot condition the receipt of any

[9] Case management services, 42 CFR §441.18.
[10] Arora R, et al. Designing and Implementing Medicaid Disease and Care Management Programs: A User's Guide. (Prepared by The Lewin Group under Contract No. 290-04-0011.) AHRQ Publication No. 07-0063. Rockville, MD: Agency for Healthcare Research and Quality; February 2008.
[11] Centers for Medicare and Medicaid Services. About Section 1115 Demonstrations. https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html. Accessed October 30, 2018.

Medicaid services on the receipt of case management per 42 CFR 441.18(a)(2) and (a)(3), or mandate the receipt of case management per 441.18(a)(3).[12]

CMS also confirmed that no other states have requested to mandate that a Medicaid enrollee receive case management via a demonstration.

Section 3 – Considerations for Louisiana

Subsection 3.1 – Types of Case Management Models Currently used in Medicaid

3.1.1 Targeted Case Management

Targeted case management services, as defined by CMS, means case management services furnished to particular defined target groups or in any defined locations of the state without regard to requirements related to statewide provision of services or comparability. The "statewideness" requirement of section 1902(a)(1) of the Social Security Act stipulates that the provisions of a Medicaid State Plan be in effect throughout the state. The comparability provision of section 1902(a)(10)(B) requires states to make Medicaid services available in the same amount, duration and scope to all individuals within the categorically needy group or covered medically needy group.[13]

By removing the statewideness and comparability requirements, states can go beyond traditional Medicaid concepts of eligibility in identifying groups eligible to receive targeted case management services. This allows states to target services by geography, age, type or degree of disability, illness or condition, or any other identifiable characteristic or combination of characteristics.[14] CMS does not impose a limit on the number of groups to whom case management services can be targeted.

3.1.2 Primary Care Case Management

Primary Care Case Management (PCCM) is a model of Medicaid managed care in which state Medicaid agencies contract with primary care providers to provide, locate, coordinate and monitor primary care services for Medicaid enrollees who select them or are assigned to them by the state. The primary care provider may be a physician, physician practice, nurse practitioner, physician assistant or other provider. The provider serves as an enrollee's "medical home" for primary and preventive care. In exchange, the PCCM provider receives a small monthly case management fee in addition to regular fee-for-service payments. Under this model, providers do not assume any financial risk.[15]

3.1.3 Integrated Case Management

Integrated Case Management programs expand beyond basic disease management by including approaches to address medical, social and behavioral health needs. This approach appears to be most

[12] Case management services, 42 CFR §441.18
[13] Social Security Administration, State Plans for Medical Assistance. https://www.ssa.gov/OP_Home/ssact/title19/1902.htm. Accessed November 9, 2018
[14] Medicaid Program; Optional State Plan Case Management Services, 72 Fed. Reg. 232. (December 4, 2007). *Federal Register: The Daily Journal of the United States*. Web. 6 November 2018.
[15] Kaiser Family Foundation "Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts" June 2015. http://files.kff.org/attachment/issue-brief-medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts Accessed November 6, 2018.

popular and most impactful for high-need individuals. One recent study found significant changes in utilization in a high-risk group and little impact on service use for the lower-risk participants. [16]

3.1.4 Enhanced Case Management

Enhanced case management is a model of intensive case management, where the case manager delivers services to the client outside of clinical settings. It is a field-based approach targeted at especially vulnerable populations, like pregnant women or persons who are homeless, bringing the case management into their homes and their neighborhoods.

CMS recently approved a request for North Carolina to address social determinants of health through a pilot for enhanced case management services, where insurers will identify and target populations of high-need Medicaid enrollees and determine a specific package of services tailored to that individual's needs. Those services include several housing-related options, like helping enrollees find a place to live or offering repairs for mold and pest infestation or malfunctioning heating or air conditioning systems. Other enhanced services include providing food after a hospitalization and transportation to pharmacies, grocery stores and social engagement activities such as churches and parks. CMS awarded North Carolina $650 million to pay for enhanced case management services through the year 2024.[17]

Subsection 3.2 – Case Management in Louisiana Medicaid

Managed care organizations (MCOs) in Louisiana are contractually required to develop and implement case management programs for enrollees with special healthcare needs and enrollees who have high risk or unique, chronic or complex needs. The case management programs are required to include the development of an individualized, comprehensive and mutually agreed upon plan of care that meets the medical, functional, social and behavioral health needs of the enrollee, based on the results of the enrollee's individual needs assessment. The plan of care is to be developed and implemented through a person-centered process in which the enrollee has a primary role and which is based on the principles of self-determination and recovery. For enrollees with a behavioral health diagnosis who may experience crisis, these plans must also address crisis events to prevent unnecessary hospitalization or institutionalization. MCOs must have a monitoring process to identify early changes in the health status of enrollees, ensuring enrollees are receiving needed services and supports, and ensuring enrollee safety and progress, and a process for continuity of care, including managing transitions between levels of care. These processes must provide for high-touch, face-to-face engagement for high-risk enrollees, including those who:

- have complex care needs;
- are difficult to engage through telephonic care management;
- are residing in or transitioning from an institution;
- access care primarily through emergency services; or
- are frequently admitted to inpatient settings.

[16] Sabik, Lindsay M. et al. "The Impact of Integrated Case Management on Health Services Use and Spending Among Nonelderly Adult Medicaid Enrollees." Medical Care, Vol. 54, No. 8, August 2016. www.lww-medicalcare.com, Accessed October 26, 2018.

[17] Dickson, Virgil. "CMS denies North Carolina's proposal to pay down docs' debt." Modern Healthcare. October 24, 2018.

Currently, MCOs must also provide a Chronic Care Management Program (CCMP) for enrollees diagnosed with specified chronic conditions, including asthma and diabetes, HIV, Hepatitis C, congestive heart failure, sickle cell anemia and obesity. The programs must include guidelines for treatment plan development, as described in the National Committee for Quality Assurance (NCQA) Disease Management program content; emphasize exacerbation and complication prevention utilizing evidence-based clinical practice guidelines and patient empowerment and activation strategies; address co-morbidities through a whole-person approach; and coordinate CCMP activities for enrollees also identified in the Case Management Program.[18]

For descriptions of additional targeted case management programs currently funded by Louisiana's Medicaid program, see Exhibit 3.2

Subsection 3.3 -- Case Management Lessons from Other States

AHRQ created the Medicaid Care Management Learning Network in 2005 to assist states offering care management to their fee-for-service and primary care case management populations. AHRQ compiled a guide describing best practices in care management using the experiences of the thirteen states in the network. This guide provides a number of useful lessons and recommendations that Louisiana can employ to pursue HCR 65's goals of using case management to improve public health and lower costs, most notably:

- Linking case management to other state initiatives;
- Designing programs as opt-in or opt-out; and
- Engaging the patient community. [19]

Linking case management to other state initiatives: Understanding other programs already operated by the state can ensure that the case management program does not duplicate efforts and encourages sharing of ideas. For instance, LDH's current managed care contract requires MCOs to offer case management to eligible enrollees. As a component of a Medicaid Performance Improvement Project to reduce Healthy Louisiana rates of prematurity, MCOs were required to offer perinatal case management to high-risk pregnant women and, more specifically, women with a history of prior preterm singleton birth. Results of this project will not be available until after this report is published; however, preliminary data provide evidence to support that case management in conjunction with provider education improved rates of evidence-based treatment to prevent preterm birth among Healthy Louisiana enrollees at risk for preterm birth.

Designing programs as opt-in or opt-out: Instead of mandating participation in case management, another option might be to distinguish case management as an opt-out service, where enrollees are enrolled automatically but have the option to disenroll if they choose. Opt-out programs generally have higher enrollment than opt-in programs because they ease the enrollment process for willing enrollees. By contrast, enrollees of opt-in programs, where enrollees are notified of their eligibility but must

[18] Louisiana Department of Health, Provider and Plan Resources. Managed Care Executed Contracts. http://ldh.la.gov/index.cfm/page/1763 Accessed December 4, 2018.
[19] Arora R, et al. Designing and Implementing Medicaid Disease and Care Management Programs: A User's Guide. (Prepared by The Lewin Group under Contract No. 290-04-0011.) AHRQ Publication No. 07-0063. Rockville, MD: Agency for Healthcare Research and Quality; February 2008.

Exhibit 3.2 Additional Targeted Case Management Programs Funded by Louisiana's Medicaid Program

Targeted Case Management Programs in Louisiana Medicaid

Louisiana's Medicaid regulations currently allow for the following additional targeted case management programs:

Infants and Toddlers- This is an optional targeted case management service (also referred to as Support Coordination) for Medicaid eligible infants and toddlers who have established medical conditions as defined in the Individuals with Disabilities Education Act. Services must be authorized by the EarlySteps Program, and authorizations are approved through the Individualized Family Service Plan (IFSP) process.

Early, Periodic Screening Diagnosis and Treatment (EPSDT)- The goal of this benefit is to ensure that children under the age of 21 who are enrolled in Medicaid receive age-appropriate screening, preventive services and treatment services that are medically necessary to correct or ameliorate any identified conditions. The point of entry for targeted EPSDT case management services for most eligible children is through the Office of Citizens with Developmental Disabilities regional offices.

Foster Care and Family Support Worker Services- This regulation allows LDH to reimburse the Louisiana Department of Children and Family Services (DCFS) for targeted case management services provided to Medicaid eligible children under the age of 21 by DCFS foster care and family support workers, as specified. Medicaid-reimbursed services can include child safety and risk assessments, trauma screenings, screenings for mental health, domestic violence or substance abuse, and making arrangements for medical, dental and communicable disease screenings upon entry into foster care, among other services.

Louisiana regulations allow for Medicaid reimbursements for targeted case management programs provided through the Nurse Family Partnership Program and to individuals with disabilities resulting from HIV, but Medicaid budget authority was eliminated for these programs effective February 1, 2013. Nurse Family Partnership continues to operate through the Louisiana Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) under the LDH Office of Public Health, but had to forgo growth of the program in order to reach more families due to state budget cuts that effectively eliminated the federal Medicaid match for these services. All families enrolled in MIECHV are eligible for Medicaid.

For more information about these statutes, see Louisiana Administrative Code, Title 50, Part XV, Subpart 7: Targeted Case Management (p 343-352), which can be found at the Louisiana Division of Administration website: https://www.doa.la.gov/Pages/osr/lac/books.aspx.
For information about the programs authorized by these statutes, go to www.ldh.la.gov.

actively choose to enroll, tend to be more engaged in the programs which could lead to better outcomes.

Engaging enrollees: By involving enrollees during the planning, implementation and evaluation stages of a case management program, states will be better able to gauge the possible impact of certain interventions and can design a more effective program. For example, Pennsylvania's Regional Advisory

Committees were created for enrollees and providers to meet and provide feedback to the state on disease management programs and activities.[20] Partnering with patients to ensure their health care needs are effectively coordinated may also increase the likelihood of active patient participation in the program which may yield better health outcomes.

Conclusion

While mandatory case management in the Medicaid program may not be feasible, other opportunities exist to enhance and strengthen the availability of services offered to Louisiana Medicaid enrollees to improve their health and lower costs.

[20] Arora R, et al. Designing and Implementing Medicaid Disease and Care Management Programs: A User's Guide. (Prepared by The Lewin Group under Contract No. 290-04-0011.) AHRQ Publication No. 07-0063. Rockville, MD: Agency for Healthcare Research and Quality; February 2008.

Appendix A – HCR 65

2018 Regular Session

HOUSE CONCURRENT RESOLUTION NO. 65

BY REPRESENTATIVE MCFARLAND

MEDICAID: Requests the La. Department of Health to study and report to the legislature concerning the potential implementation of mandatory case management in the Medicaid program

A CONCURRENT RESOLUTION

To urge and request the Louisiana Department of Health to study the potential implementation of mandatory case management for Medicaid recipients identified as high-risk and to report findings of the study to the legislative committees on health and welfare.

WHEREAS, case management in health care has proven to be a vital tool in improving the health status and quality of life for individuals identified as high-risk due to either health status or socioeconomic factors; and

WHEREAS, through case management, individuals have opportunities to participate in disease management programs such as diabetes management, smoking cessation, asthma control, medication reminders, and referral to community programs and other evidence-based strategies that assist people in their efforts to improve their health and socioeconomic status; and

WHEREAS, case management in Medicaid is a voluntary service and, by federal rule, individuals can decline the service if they choose; and

WHEREAS, currently, only twenty percent to thirty-five percent of Louisiana Medicaid enrollees identified as high-risk actually receive case management services; and

WHEREAS, roughly one third of Louisiana's approximately four million five hundred thousand residents receive health care through the taxpayer-funded Medicaid program; and

WHEREAS, the overall cost of Louisiana's Medicaid program has increased from approximately six billion dollars in 2012 to more than twelve billion dollars in 2018, and this state's Medicaid spending is anticipated to grow to more than fourteen billion dollars by 2021; and

WHEREAS, state Medicaid programs must be innovative in order to continue to provide quality health services while enrollment growth increases and costs continue to escalate; and

WHEREAS, innovative state Medicaid programs include initiatives that improve both health outcomes and overall quality of life for Medicaid enrollees; and

WHEREAS, in order to achieve the goal of improving public health, Medicaid programs should not just assist participants with health coverage, but should also consider initiatives that provide opportunities for disease management, community engagement, and economic advancement; and

WHEREAS, case management is an evidence-based method of improving health outcomes and making that service mandatory could lower healthcare costs and significantly improve the health status of many Medicaid recipients.

THEREFORE, BE IT RESOLVED that the Legislature of Louisiana does hereby urge and request the Louisiana Department of Health to study the potential implementation of mandatory case management for Medicaid recipients identified as high-risk.

BE IT FURTHER RESOLVED that in conducting the study called for in this Resolution, the Louisiana Department of Health shall do all of the following:

(1) Communicate with the Centers for Medicare and Medicaid Services to determine the feasibility of mandatory case management and strategies for implementing such a program; and

(2) Examine the potential submission of a waiver application to the Centers for Medicare and Medicaid Services through which this state would request an exemption to the federal rule requiring that case management be voluntary.

BE IT FURTHER RESOLVED that the Louisiana Department of Health shall issue findings and recommendations from the study called for in this Resolution in the form of a report to the House Committee on Health and Welfare and the Senate Committee on Health and Welfare on or before January 1, 2019.

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the secretary of the Louisiana Department of Health.

Appendix B – CMS Rules on Case Management in Medicaid

42 CFR § 441.18 Case management services.

(a) If a State plan provides for case management services (including targeted case management services), as defined in § 440.169 of this chapter, the State must meet the following requirements:

(1) Allow individuals the free choice of any qualified Medicaid provider within the specified geographic area identified in the plan when obtaining case management services, in accordance with § 431.51 of this chapter, except as specified in paragraph (b) of this section.

(2) Not use case management (including targeted case management) services to restrict an individual's access to other services under the plan.

(3) Not compel an individual to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services.

(4) Indicate in the plan that case management services provided in accordance with section 1915(g) of the Act will not duplicate payments made to public agencies or private entities under the State plan and other program authorities;

(5) [Reserved]

(6) Prohibit providers of case management services from exercising the agency's authority to authorize or deny the provision of other services under the plan.

(7) Require providers to maintain case records that document for all individuals receiving case management as follows:

(i) The name of the individual.

(ii) The dates of the case management services.

(iii) The name of the provider agency (if relevant) and the person providing the case management service.

(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved.

(v) Whether the individual has declined services in the care plan.

(vi) The need for, and occurrences of, coordination with other case managers.

(vii) A timeline for obtaining needed services.

(viii) A timeline for reevaluation of the plan.

(8) Include a separate plan amendment for each group receiving case management services that includes the following:

(i) Defines the group (and any subgroups within the group) eligible to receive the case management services.

(ii) Identifies the geographic area to be served.

(iii) Describes the case management services furnished, including the types of monitoring.

(iv) Specifies the frequency of assessments and monitoring and provides a justification for those frequencies.

(v) Specifies provider qualifications that are reasonably related to the population being served and the case management services furnished.

(vi) [Reserved]

(vii) Specifies if case management services are being provided to Medicaid-eligible individuals who are in institutions (except individuals between ages 22 and 64 who are served in IMDs or individuals who are inmates of public institutions).

(9) Include a separate plan amendment for each subgroup within a group if any of the following differs among the subgroups:

(i) The case management services to be furnished;

(ii) The qualifications of case management providers; or

(iii) The methodology under which case management providers will be paid.

https://www.law.cornell.edu/cfr/text/42/441.18 Accessed November 12, 2018.

Appendix C – Federal Authority Options for Operating a Disease Management or Care Management Program

Waiver Type	Description
Research and Demonstration Projects Section 1115	Section 1115 provides the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further Medicaid program objectives. Demonstrations must be "budget neutral" over the life of the project, meaning they cannot be expected to cost the Federal Government more than it would cost without the waiver.
Managed Care/Freedom of Choice Section 1915(b)	This section provides the Secretary of Health and Human Services authority to grant waivers that allow States to implement managed care delivery systems or limit individuals' choice of provider under Medicaid. States may request Section 1915(b) waiver authority to operate programs that impact the delivery system of some or all of the individuals eligible for Medicaid in a State by: Mandatory enrollment of enrollees into managed care programs (although States have the option, through the Balanced Budget Act of 1997, to enroll certain enrollees into mandatory managed care via an SPA), or Creation of a "carve out" delivery system for specialty care, such as behavioral health care. Section 1915(b) waiver programs need not be operated statewide. They may not be used to expand eligibility to individuals ineligible under the approved Medicaid State plan. Four types of authorities exist under Section 1915(b) that States may request: **1915(b)(1):** Mandates Medicaid enrollment into managed care. **1915(b)(2):** Uses a "central broker" to help individuals select among competing health plans. **1915(b)(3):** Uses cost savings resulting from enrollee use of more cost-effective medical care to provide additional services. **1915(b)(4):** Limits the number of providers from which enrollees can obtain services.

State Plan Amendment	The State Medicaid plan is a document that defines how the State will operate its Medicaid program. The plan addresses the areas of administration, eligibility, service coverage, and provider reimbursement. After approval of the original State plan, program staff must submit to CMS all relevant changes (required by new statutes, rules, regulations, interpretations, and court decisions) to determine whether the plan continues to meet Federal requirements and policies. An SPA authorized under section 1932(a) of the Social Security Act provides much of the same flexibility available under waivers and also does not require the periodic renewals associated with programs operating under waiver authority. Created by the Balanced Budget Act of 1997, this SPA authority to mandate enrollment applies to primary care case management or MCO-model disease management programs. Similar to waivers, a section 1932(a) SPA authority provides flexibility with respect to limiting providers, eligible populations, and geographic areas that normally is unavailable under traditional SPAs. An SPA may authorize disease management activities through expansions of the covered benefits for "other licensed practitioners" or "preventive services," as appropriate. A disease management SPA must meet the requirements of section 1902(a) of the Social Security Act, including statewideness, comparability, and freedom of choice. These requirements apply to both capitated and fee-for-service disease management providers.
Deficit Reduction Act	The Deficit Reduction Act (DRA), passed in 2007, provides States additional flexibility to make changes to their Medicaid programs. Mandatory requirements include an increase of the look-back period for long-term care enrollees to 5 years and proof of citizenship for all new Medicaid applicants and current Medicaid enrollees. Specifically, among other requirements, the DRA allows States to impose cost-sharing requirements on services such as prescriptions, increase copayments on emergency services, and alter existing Medicaid benefits packages to mirror certain commercial insurance packages through use of "benchmark" plans. Some States are using DRA-related SPAs to provide targeted disease management for conditions such as chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, pediatric obesity, and pediatric asthma.

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