Department of Justice Agreement Compliance Guide

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LOUISIANA DEPARTMENT OF HEALTH

I. Definitions

My Choice Louisiana: Transition Coordination initiative operated through OBH and OAAS in which individuals who meet the target population of the DOJ agreement are provided support to transition into the community from nursing facilities.

Olmstead: Olmstead v. L.C. is a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.

Transition Assessment: Assessment developed by the Transition Coordinator as a precursor to the transition process. The assessment is developed in an effort to identify strengths, status, and needs for transition.

Transition Coordinator: Employed by OBH or OAAS, the Transition Coordinator will work with individuals identified as being part of the DOJ Target Population residing in nursing facilities and facilitating transition activities including: conducting assessments, developing transition plans, and further providing ongoing follow up, ensuring the enrollee's needs in the community are met.

Transition Plan: Plan developed through the transition process led by the Transition Coordinator, in collaboration with the MCO and community case manager, to facilitate and operationalize items needed to ensure the enrollee's successful transition into the community.

II. General Information

In 2014, the Department of Justice (DOJ) initiated an investigation of the state's mental health service system to assess compliance with Title II of the American with Disabilities Act (ADA). The DOJ published the findings of their investigation in 2016, in which they concluded that the State unnecessarily relies on nursing facilities to serve adults with serious mental illness instead of serving them in the most integrated setting appropriate to their needs as required by the ADA. The Louisiana Department of Health (LDH) begin working with DOJ on a mitigation plan, and a formal agreement was entered into on June 6, 2018. LDH and DOJ are committed to achieving compliance with Title II of the ADA, which requires that the State's services to individuals with mental illness be provided in the most integrated setting appropriate to their needs. This agreement has the following goals: (1) divert individuals with serious mental illness away from inappropriate nursing facility placements by requiring comprehensive evaluations and services designed to enable them to live in community-based settings; and (2) identify people with serious mental illness who have been admitted to nursing facilities but are able to and would like to transition to the community, and provide them with transition and discharge planning and community-based services sufficient to meet their needs. With this Agreement, LDH intends to achieve the goals of serving individuals with serious mental illness in the most integrated setting appropriate to their needs, to honor the principles of self-determination and choice, and to provide quality services in integrated settings to achieve these goals.

The duration of the Agreement is for five (5) years, culminating on June 6, 2023. However, LDH must have implemented and demonstrated substantial compliance with the terms of the Agreement for at least one (1) year prior to its formal termination.

Given the broad reach of the Agreement and the implications for the Medicaid population, the MCOs shall comply with the terms of the Louisiana Department of Justice (DOJ) Agreement (Case 3:18-cv-00608, Middle District of Louisiana), subsequent implementation plans, the LDH Diversion Plan, and other activities required in order to implement this agreement as directed by LDH.

III. DOJ Target Population

The DOJ target population includes:

1. Medicaid-eligible individuals over 18 with SMI currently residing in a nursing facility and those individuals who have transitioned from a nursing facility and are referred for case management by a My Choice Louisiana transition coordinator.
2. Individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement during the course of this Agreement, or have been referred within two years prior to the effective date of this Agreement, and were diverted from nursing facility placement.
3. Excludes those individuals with co-occurring SMI and dementia where dementia is the primary diagnosis

The MCO shall ensure members who meet the definition of the DOJ target population are referred for community case management within one (1) business day following the request from the Transition Coordinator or the PASRR decision date for those members diverted from nursing facility placement.

IV. At-Risk Population

The MCO shall identify members who are considered at-risk of nursing facility placement and provide case management in accordance with the requirements set forth in the Healthy Louisiana contract/statement of work and the DOJ Agreement Compliance Guide.

Members shall be considered at-risk when the following criteria is met:

- Member has full benefits with the MCO (P-linkage) and is not residing in a nursing facility; and
- Member is 18 – 79 years of age; and
- Member has a qualifying primary mental health condition including F20-24, F25.0, F25.1, F25.8, F25.9, F28-33, F41-42, F43.1, F43.10, F43.11, F43.12, F60); and
- Member has at least two (2) chronic conditions based on the CMS Chronic Condition Warehouse Algorithm within a one year look-back period to include Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease and Bronchiectasis, Diabetes and Heart Disease or Stroke (note: Heart Disease or Stroke is defined as any of the 5 CCW conditions – acute myocardial infarction, atrial fibrillation, heart failure, ischemic heart disease, and/or stroke/transient ischemic attack); and
- Member has 6 or more all-cause emergency department and/or inpatient hospitalizations within a 1 year look-back period (an ED visit which results in an inpatient hospitalization should be considered 1 visit as opposed to 2 visits).

Given the at-risk criteria has been modified, the MCO shall ensure that members previously considered at-risk, using the criteria established in 2021, who were receiving MCO case management in December 2022 continue to receive MCO case management unless the member declines, disengages from case management, or no longer needs case management after being enrolled in case management for at least 6 consecutive months.

V. PASRR

The MCO shall comply with all portions of the statement of work as they relate to implementation of PASRR activities. This includes requirements associated with staffing and completion of Independent Evaluations for PASRR Level II. Additionally, the MCO shall:

A. Review all Level II evaluations prior to submission to OBH, ensuring the evaluations are accurate, thorough, and free from contradictory information, include all mandatory supporting documentation, include recommendations for nursing facility placement, and services.
B. Ensure that PASRR Level II evaluators are familiar with the complete array of home and community-based services available to members (including the community case management program) and offer community options in a meaningful way to members, providing education about the services available to them as an alternate to nursing home placement.

C. The MCO shall actively link the member to alternate services individualized to their needs and necessary to maintain them in the community through the PASRR Level II process. This includes:
    1. Those services needed to address the member's physical and behavioral healthcare needs;
    2. Community resources necessary to ensure their social needs are met; and
    3. Referrals to home and community-based supports intended to assist the member with their activities for daily living (ADL) and instrumental activities for daily living (IADL) needs.

D. For individuals authorized for nursing facility placement, the MCO shall link and enroll members in specialized behavioral health services necessary to meet their needs. Through this process, the MCO shall report to OBH if barriers in doing so arise, while actively working with nursing facilities and providers to improve service linkages. For individuals referred for nursing facility placement through the PASRR Level II process and therefore considered part of the special healthcare needs population, the MCO shall ensure enrollees are referred to MCO Case Management in accordance with the requirements specified in the Healthy Louisiana contract as it pertains to tiered case management.

E. For individuals denied nursing facility placement through the pre-admission PASRR process, and therefore considered part of the diverted population within the DOJ Agreement, the MCO shall ensure enrollees are referred for community case management within one (1) business day of the decision date.

F. The MCO shall assist in linking with services and/or evaluations necessary to support the determination of SMI and/or an appropriate diagnosis related to an Alzheimer's or dementia-related disorder.

G. The MCO shall have a process for collecting and tracking service referrals and service utilization for this population, reporting this information as directed by LDH.

VI. Community Case Management Program

For the DOJ target population, defined in Section III, the MCO shall develop and implement a specialized community case management (CCM) program consistent with the DOJ Agreement and LDH-issued guidance using subcontracted community case managers who meet the qualifications established by LDH. The MCO shall maintain ultimate responsibility for ensuring case management needs of the target population are met by community case managers/agencies and community case managers satisfactorily complete required activities.

- The community case management program will ensure each member identified by OBH or OAAS as included in the target population, is assigned and has access to a qualified community case manager in the member's region of residence that will help divert the identified member from the nursing facility or facilitate the transition from nursing facility to the community, as well as provide ongoing case management for at least one full year after successful transition or diversion.
- Case management services and processes shall be individualized and person-centered, reflecting the member's unique strengths, needs, preferences, experiences and cultural background.

- Services will be comprehensive, culturally competent and of sufficient intensity to ensure community case managers are able to identify and coordinate services and supports to assist members with obtaining good health outcomes, achieve the greatest possible degree of self-management of disability and life challenges, prevent avoidable institutionalization or hospitalizations, and connect members with resources that are based on their desires and hopes that build stability and enable them to recover and thrive.
- Services will include assuring access to all medically necessary services covered under the State's Medicaid program and addressing social determinants of health which serve as barriers to good health outcomes, including but not limited to behavioral and physical health services, specialty services, and referrals to community resources.

Part A - Agency Qualifications & Selection Process

1. The MCO shall ensure statewide coverage of community case management services to meet the requirements specified in this guidance. The MCO shall contract with no more than two (2) community case management agencies, which meet the qualifications prescribed by LDH, to provide statewide access to community case management services in accordance with the requirements set forth in this guide.

    a. Each selected community case management agency (CCMA) must have substantial experience providing case management services to members with serious mental illness under Medicaid home and community-based programs, while successfully meeting programmatic requirements and quality standards.

    b. The agency shall demonstrate capacity to provide 24/7 access to case management activities for the target population.

    c. The MCO shall ensure the community case management agency and community case managers do not have a conflict of interest between any direct care activities and community case management responsibilities.

2. The MCO shall provide verification to LDH that the proposed community case management agencies meet the established qualifications for review and approval by **October 1, 2021.** In the event a new community case management agency is considered/recommended, the MCO shall provide verification to LDH that the proposed case management agency meets the established requirements at least 90 days prior to the proposed contract date.

3. The MCO shall collaborate with other MCOs to jointly develop and update the standard operating procedures and monitoring strategy/tools to ensure standardization across community case management agencies for all fundamental activities. In addition, it is highly recommended that the MCOs collaborate to develop the training plan and curriculum for community case management activities and staff.

4. The MCO shall execute a contract with the LDH-approved community case management agencies by **November 12, 2021, with community case management services provided to DOJ Agreement Target Population members beginning January 17, 2022.** Following initial implementation, the MCO shall ensure the contract with the approved community case management agency remains current unless otherwise approved by LDH-OBH.

5. The MCO shall ensure there is an adequate number of trained community case managers and supervisors employed by each agency to ensure access and face-to-face engagement of the target

population to community case managers in accordance with the minimum contact requirements , the ability to provide same day responses or next business day responses during weekends and holidays by the assigned community case manager, timely completion of community case management assessments and plans of care, and with no more than a 1:15 ratio of trained community case managers to members in each region. In addition, the MCO shall ensure there is an adequate number of community case managers and supervisors on a statewide and regional basis to ensure referrals are accepted by the CCMA within 3 business days of receipt and to prevent any referral holds.

6. The MCO shall ensure each contracted community case management agencies include the following staff:

    a. An adequate number of supervisors who shall be available at all times to provide monitoring, back up, coaching, support and/or consultation to community case managers. Supervisors shall be a licensed mental health professional (LMHP).

    b. Adequate number of community case managers in each region of the State who meet the requirements outlined in this guide, and

    c. A registered nurse consultant with adequate expertise to address the medical, behavioral and social needs of the members assigned to the community case managers within the agency.

Part B - Single Point of Contact

1. The MCO shall provide a single point of contact, who has direct access to an MCO LMHP or psychiatrist experienced working with the SMI population for clinical questions, for each community case management agency to coordinate the overall case management activities provided to the target population. The MCO point of contact requirements include, but are not limited to:
    a. Review and approve the initial and ongoing assessment and plan of care to ensure all requirements are satisfactorily met.
    b. Coordinate service request/authorizations with UM section and ensure service authorizations, consistent with the plan of care that is agreed upon by the member, the community case manager, and the MCO are issued to the appropriate providers and authorization information is shared with the community case manager to facilitate monitoring of plan of care implementation. The MCO also has the obligation of performing utilization management on the services authorized and provided to ensure the services rendered are appropriate and necessary to achieve the goals and to meet the needs of the member.
    c. Secure service providers and linkages to other necessary community and social supports to the extent the community case manager is unable to find a service provider or needs assistance.
    d. Assist with arranging for transportation to healthcare appointments to the extent the community case manager needs assistance.
    e. Inform community case managers of the health status and other factors that contribute to the successful community living of the member that can be determined from available and current MCO data, including but not limited to hospitalizations, all-cause emergency

department visits, and pharmacy fills. At a minimum, the MCO shall conduct a monthly all claims surveillance or provide for an alternate method that provides for near real-time surveillance of services, and provide the results to the community case manager on a monthly basis, highlighting any care gaps, uncoordinated services, or missed linkages.

2. The MCO single point of contact shall provide prompt response and assistance to the CCMA; the single point of contact shall respond to CCMA requests within 1 business day of the inquiry.

Part C – Community Case Management Activities

1. Engagement

a. Members Residing in Nursing Facilities: For those members residing in a nursing facility, community case management activities will begin at least 60 days prior to the member's discharge from the nursing facility, with an option to engage earlier if recommended by the LDH transition coordinator, in order to plan for an effective and successful transition to a community living setting.
    i. The LDH transition coordinator leads the development of the transition assessment and transition plan, with support from the community case manager and MCO, for the purpose of securing providers, resources, and supports in the community that will begin immediately upon the member's transition to the community.
    ii. The community case manager shall attend transition planning meetings with the transition coordinator and member, including the discharge planning meeting which is typically held 10 days prior to the member's transition from the nursing facility. At a minimum, the community case manager shall have at least four (4) face-to-face contacts in the 60-day period prior to the member's transition from the nursing facility, with at least two (2) of these face-to-face contacts occurring in the last 30 days prior to the member's transition from the nursing facility.
    iii. The MCO shall ensure each transitioning member has all services, including prescription medication and durable medical equipment, in place necessary to transition the member at the appropriate time, with necessary services authorized at the point of transition to the community.
b. Community Members Who Are Admitted or Readmitted to Nursing Facilities: The community case manager shall meet with transitioned and diverted members, who are admitted/readmitted to a nursing facility, the member's TC if available, member's service providers, and others the member wishes to include in the meeting to determine the approximate length of time the member is expected to reside in the nursing facility, any changes to the member's needs and functioning, and changes in the member's desire to reside in the community. The meeting shall occur within 5 days following the member's admission/readmission to the nursing facility.
    i. Following the meeting with the member, the community case manager shall consult with the MCO and TC, if applicable, to determine if community case management shall continue given the length of time the member is expected to reside in the nursing facility and member preferences.
        a. If the stay is expected to be short-term (approximately 30 days or less), community case management services shall continue unless the member declines.

b. If community case management services will be discontinued, the community case manager shall meet with the member to develop the discharge plan prior to the member's discharge from community case management services.

c. The CCMA shall outreach to members within 3 business days of receiving the referral to begin community case management related activities.

3. *Comprehensive Needs Assessment*

a. The community case manager shall conduct an initial community case management assessment within 14 days of the transition date for transitioned members and within 14 days of the consent/enrollment date for diverted members. For transitioned members who are not connected with a CCM prior to transition from a NF, the community case manager shall conduct the initial community case management assessment within 14 days of consent/enrollment date.

   i. The community case manager shall assess the member's needs on at least a monthly basis, or more often following a significant change (e.g., unplanned hospitalization, reduction in primary caregiver, change in living situation), in consultation with the CCMA's LMHP, to determine if the member's needs and/or functioning has changed since the initial assessment and to guide care planning, service coordination, and monitoring activities.

   ii. A formal reassessment shall be conducted at least 60 days prior to the member's proposed discharge date from community case management following at least 365 days of continuous enrollment to determine if continuation of community case management services is needed.

b. The initial assessment and periodic reassessments of member's needs shall identify the need for medical, behavioral health, social/recreational, educational/vocational and other services and supports to meet the daily needs and preferences of members. These other services and supports include, but are not limited to: housing and housing supports, employment, health/wellness, safety, transportation, health care services and adaptive equipment, nutrition and dental services.

c. The assessment shall be conducted using a team-based approach and include the community case manager, community case management agency LMHP, member, and his/her family/natural supports as available and desired by the member. The assessment shall also include inputs medical providers, behavioral health providers (including peers), and others important to the member who are identified by the member prior to assessment. Assessments shall gather information from the member across several dimensions to identify gaps in care and proactively address such gaps in care to reduce risk of readmission or other negative outcomes including:

   - Functional status: The degree to which a person is able to fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care.
   - Co-morbidities: Identifies potential complications in the course of illness due to level of acuity or disability related to co-occurring medical illness, substance use disorder and/or intellectual/developmental disability. This includes an assessment for information and education needed for management of these co-morbidities.
   - Physical health needs.

- Recovery environment: This dimension considers factors in the environment, the social and interpersonal determinants of health and wellbeing that may support efforts to achieve or maintain mental health and/or abstinence.
- Family and/or natural support system.
- Purpose and productivity: Includes queries about the person's interests, concerns, perceived barriers and preferences about work and education.
- Housing preferences: Identification of feelings, choices and supports needed for people to be successful in living independently. This can include choice of living arrangement, neighborhood and other aspects that are important to the person for their housing environment.
- Community inclusion and engagement: Identifies the opportunities for low demand social engagement, such as settings the public at large uses (i.e., libraries, senior centers, recreation centers, park programs etc.) as desired by the member.
- Risk of harm: This dimension of the assessment considers a person's potential to cause significant harm to self or others.
- Treatment and recovery history: Past experience may be one predictor of future engagement and response to treatment and supports and shall be taken into account in determining service needs and related person centered plan of care.
- Crisis and relapse triggers: Some situations or behaviors, called triggers, can lead to a relapse. Identifying triggers through the assessment process will allow the development of strategies to deal with them and reduce the risk of crisis or relapse.

3. *Person-Centered Plan of Care Development*

a. The community case manager shall develop the person-centered plan of care, based on the principles of self-determination and recovery, that will assist the member in achieving outcomes that promote the member's social, professional and educational growth and independence in the most integrated settings using a strengths-based approach and in collaboration with the member.
b. The person-centered plan of care shall reflect the member's needs, strengths, preferences, choices and goals as identified in the assessment process. (Note: the plan of care is to be developed following the CCM assessment). The goals included on the plan shall be member-centered and include short and/or long-term goals, specific actionable objectives, and measurable outcomes.
c. The development of a plan of care shall include the community case manager, member, his/her family/natural supports if available and desired by the member, and others important to the member for whom the member requests to be part of the planning process; in addition, service providers shall be invited to participate as available and desired by the member. The community case manager shall provide timely notice (at least 7 days prior to the proposed meeting date) of planning meetings to all individuals the member identifies and requests to be a part of the planning process (Note: Community case managers may engage providers via telehealth modalities for the development of the plan of care/planning meetings).
d. At a minimum, the person-centered plan of care shall include the following:
    - Member's goals, desired outcomes (as stated in the member's own words), needs (including health care and other needs), strengths, and preferences.
    - Services and supports to achieve these goals and meet member's needs (formal and informal). This should include medical, behavioral health, housing, social,

educational/vocational, durable medical equipment, transportation and other services requested by the member or identified as part of the assessment or planning process.
- Type, amount, duration, and frequency of services, including service providers.
- Strategies to address identified barriers.
- Crisis plan, which includes potential causes and strategies for recognizing and addressing crisis.
- Emergency preparedness and backup plan.
- Documentation the member participated in the planning process and was offered freedom of choice of services and providers.

e. The community case manager shall develop the plan of care within 14 days following the community case management assessment for transitioned and diverted members. For diverted members, the community case manager shall connect members with service providers to respond to urgent needs within 7 days following the member's consent to enroll in the community case management program. The plan of care shall include services and supports to address the member's assessed needs or any documented barriers.

f. The community case manager shall review the services included in the plan of care with the member at least monthly, or more often if needed and following a significant change (e.g., unplanned hospitalization, reduction in primary caregiver, change in living situation), to determine if the member is receiving all needed services, if there are additional services/supports needed, if there are any unmet needs, and to resolve any identified issues. The plan of care shall updated when there are changes in the member's needs or circumstances, goals, services or providers.

g. The MCO shall collaborate with other MCOs to jointly develop the plan of care tool, instructions, and associated forms (e.g., emergency back-up plan, freedom of choice form) and submit to LDH for review and approval as a part of the CCM standard operating procedures unless LDH-OBH prescribes the use of a specific assessment, plan of care, and associated forms

h. The community case manager shall provide a copy of the plan of care to the member and his/her caregiver if applicable, and to providers/organizations delivering care (with appropriate consent). The community case manager shall exchange information with providers/organizations delivering care, including cross sharing of plans during team meetings, to ensure the plan remains current and to determine if the members' needs are being met and if there is progress towards goals.

Community Integration

The focus of community integration is to ensure individuals with disabilities have access to the same social, educational, and professional opportunities as others. Community integration contributes to the overall well-being of individuals; without it, individuals may feel isolated and experience a decline in physical and mental health. Peer support services may assist and provide support to the member in participating in community activities.

To support community integration, the community case manager shall meet with the member and the member's team (e.g., main providers, including peers if applicable, and natural supports) to explore the member's interests/hobbies (including volunteering/employment or social interests) within 60-90 days of the initial plan of care development; for other members, the community integration meeting should occur at the next scheduled team meeting. During the meeting, the member's unique interests and preferences (e.g., arts/crafts, games, cooking, hiking, reading) should be considered, along with activities available in

the member's community (e.g., game clubs, book clubs, library), access to the community (e.g., transportation, and who will accompany the member to community activities/events).

As a part of this discussion, the community case manager shall update the plan of care, as necessary, to reflect any new goals or interests identified, including action steps, person who will assist with each step, and anticipated completion dates.

Discharge Planning

When the member has been enrolled in the community case management program for ten (10) consecutive months, the community case manager shall conduct a formal re-assessment to determine if continuation of community case management services is warranted. As a part of the discharge planning process, the community case manager shall meet with the member and the member's team (e.g., natural supports, main providers, TC if applicable) to determine if there are any extenuating needs that warrant continuation in the community case management program considering the criteria outlined in the CCM standard operating procedures.

If it is determined the member will be discharged from the program, the community case manager shall work with the member and his/her authorized representative to develop a discharge plan at least 30 days from the planned discharge date (which must allow for at least 365 days of continuous enrollment in CCM program) to include the services and supports that will remain in place following discontinuation of community case management services, contact information for each service provider, and contact information for the MCO. As a part of this process, the CCM shall provide information to the member on the benefits and availability of MCO case management services, and if accepted, the CCM shall initiate a warm hand-off to the MCO case manager. In the event, the member has unplanned hospitalizations or critical incidents following the formal re-assessment, the community case manager shall meet with the member and the member's team to determine if the continuation in the community case management services is warranted.

A discharge plan is not required for unplanned discharges such as a member's death or disengagement from community case management services.

4. *Referral and Linkage*

a. The community case manager shall refer and link members with necessary services and supports identified in the plan of care, including, but not limited to: primary care and specialty healthcare services, medications, substance use detoxification/treatment, mental health treatment, local housing authorities, supportive employment, education, home health care, personal care, and coordination to ensure enrollment in benefit programs needed by the member.
b. The community case manager shall conduct the following activities with support from the MCO as needed:
    i. Inform the member of available supports and services, and provide choice of services and service providers.
    ii. Actively assist the member with locating and arranging for services and supports, scheduling appointments, and arranging for transportation.

iii. Actively assist the member with contacting and accessing community resources as needed, including scheduling appointments for the member.
iv. Prepare members for appointments, including but not limited to providing education on transportation system and health care related processes, and assisting the member to develop questions to ask the care provider as needed.
v. Attend appointments with the member, as desired by the member, to assist the member in navigating the healthcare system.
vi. Ensure services and supports are coordinated between all service providers/agencies that provide services to the member, including the MCO, through routine sharing of information to assess members' needs, members' progress towards goals/objectives, detect/address barriers to care, assist with transitions of care, and to ensure the plan of care remains current.
vii. Exchange relevant information with agencies or professionals to whom the referral is being made in a manner consistent with confidentiality regulations and professional standards of care.

5. *Monitoring and Follow-Up*

a. The community case manager shall monitor and follow up on the services and supports provided to the member through both member and provider contacts to ensure the plan of care is effectively implemented, addresses the needs of the member, and that the member is actively engaged. The community case manager shall resolve identified issues in a timely and appropriate manner.
b. The community case manager shall conduct follow-up with the member, member's providers (based on member's consent), and natural supports (if available and based on member's consent) during the implementation of the plan of care and as needed to ensure the member is sufficiently engaged in the delivery of services as per the plan of care and treatment plan.
    i. If the community case manager determines the member is not engaged or accessing support services, the community case manager works with the member and supports to update the plan of care to address individualized needs, preferences, and goals.
    ii. Community case managers advocate for the member and assist the member in achieving the goals in their plan of care and with removing barriers to services/care.
c. Community case managers are responsible for responding to the community living needs of members on their caseload. This could include, but not be limited to: providing instruction and direction to individuals during contacts (on site and remotely) regarding use of appliances, equipment, financial questions and other activities. These should support but not supplant instruction and directions provided by other providers (e.g., providers rendering PSH, psychosocial rehabilitation, personal care services, or community psychiatric support and treatment).
d. Ongoing contact is made with the member at least monthly or more frequently as indicated to monitor the member's needs, status, and risk factors and to ensure:
    i. Member is receiving needed services, in accordance with the member's plan of care and assessed needs. If this is not the case, the community care manager should follow up with

the member and provider to gather information, work to resolve identified issues, and update the plan or care if needed.

ii. Individual preferences continue to be sufficiently reflected in current plan of care and the plan of care meets the member's changing needs.

iii. Member is making progress towards his/her desired goals.

iv. Member is satisfied with services and providers (including health, behavioral health and other supports) rendering such services, and if not, the community case manager takes immediate action to discuss other options with the member for alternative services or providers.

v. Member has good access to health care including primary and specialty healthcare and pharmacies for prescription drugs.

vi. Member does not feel isolated, and if so, ensure steps to promote better social opportunities and other efforts to promote community inclusion.

vii. Current living setting is safe, stable and healthy and whether the member is satisfied with the current living arrangement or is interested in changing such arrangements.

viii. Immediate issues are resolved before they become overwhelming and severely impair the members' ability to function or maintain in the community (e.g., housing eviction). For a mental health crisis, help the member connect with an appropriate treatment provider or crisis center.

ix. Member health and welfare in the community, including reporting of designated critical incidents (identified in the CCM reporting template) to the appropriate agencies and follow-up activities to ensure the member is protected from harm and prevent similar incidents from reoccurring. The community case manager shall report deaths to the MCO single point of contact and LDH-OBH (Cynthia.Bennett@LA.GOV) within one (1) business day of discovery. Notification shall include the following:

    i. Member's name, date of birth/age, race/ethnicity;
    ii. Member's date of transition, if applicable ad known;
    iii. City and region where the member resided;
    iv. Date and approximate time of death, if known;
    v. Reported or suspected cause of death, if known;
    vi. Member's location at the time of death, if known;
    vii. Date of community case manager's last contact with the member;
    viii. Person(s) with the member at the time of death and their relationship with the member, if known; and
    ix. Date community case manager was informed of the member's death and by whom.

e. The MCO shall collaborate with other MCOs to jointly develop monitoring forms/processes which include the information to be collected on a monthly basis by community case managers when contacting members and providers, and submit such forms/documents to LDH for review and approval as part of the CCM standard operating procedures unless a specific monitoring form is prescribed by LDH-OBH.

Part D – Community Case Management Contacts

Community case managers are expected to have frequent and ongoing contacts with the members who have transitioned or are diverted from a nursing facility stay. At the point of transition or diversion, community case managers should meet with members and service/support providers as follows:

- First 60 days:
  - Four contacts per week with the member, with one face-to-face visit with the member.
  - One contact with each service/support provider within the first two weeks.
  - One team meeting in the first 30 days and subsequent 30 days (by day 60) to include the member, member's natural supports, CCM, transition coordinator if applicable, and member's main providers (e.g., behavioral health provider, personal care service provider) for the purpose of cross sharing of plans of care, revising interventions if needed, identifying service gaps and developing strategies to address gaps, and determining any additional actions steps and responsible party. If emergent issues (e.g., unplanned hospitalization, psychiatric admission, NF admission) arise prior to a scheduled meeting, the team should schedule a meeting within 5 days of the hospitalization/admission.
- 61 – 180 days:
  - Two contacts per month with the member, with two face to face visits with the member.
  - One contact with each service/support provider each 60 days.
  - One team meeting by day 90 and day 180. If emergent issues (e.g., unplanned hospitalization, psychiatric admission, NF admission) arise prior to a scheduled meeting, the team should schedule a meeting within 5 days of the hospitalization/admission.
- 181 – 365 days:
  - Two contacts per month with the member, with one face to face visit with the member.
  - One contact with each service/support provider each 60 days.
  - At least one team meeting, and more often as the member's needs dictate. If emergent issues (e.g., unplanned hospitalization, psychiatric admission, NF admission) arise prior to a scheduled meeting, the team should schedule a meeting within 5 days of the hospitalization/admission.
- 365+ days: Based on assessment to determine ongoing need and desire for case management. A minimum of two contacts per month with the member, with one face-to-face contact with the member. One contact with each service/support provider each quarter.

If the member is receiving Assertive Community Treatment (ACT), the community case manager should meet with members and ACT providers as follows:

- First 30 days: Meet with both the member and ACT provider once per week, with at least one face-to-face meeting during the month.
- From 31-60 days: Meet with both the member and ACT provider at least twice per month, with at least one face-to-face meeting.
- 61 – 365 days: At least one face-to-face meeting with the member and ACT provider each month.
- 365+ days: Based on assessment to determine ongoing need and desire for case management. At least one face-to-face meeting with the member and ACT provider each month.

The type and frequency of community case management contacts shall be based on the individual member's needs and preferences.

VII. Community Case Manager & Staff Qualifications

The MCO shall ensure contracted community case management agencies employ only qualified case managers and staff.

- Satisfactory completion of criminal background checks pursuant to La. R.S. 40:1203.1 et seq., La. R.S. 15:587 (as applicable), and any applicable state or federal law or regulation.
- Not excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Office of Inspector General.
- Does not have a finding on the Louisiana State Adverse Action List;
- Pass a TB test;
- Pass a motor vehicle screen if duties include transporting members;
- Pass drug screening test, as required by the MCO's policies and procedures;
- Successful completion of First Aid and CPR training with a curriculum based on guidelines published by the American Heart Association (AHA). (Note: psychiatrists, APRNs/PAs, RNs, LPNs, and non-direct care staff are exempt from this training).

In addition, case managers must have a bachelor's-level degree in a human services field OR a bachelor's-level degree in any field with a minimum of two years of full-time experience working with the SMI population or providing case management to other populations (elders, adults with physical disabilities, or individuals with developmental disabilities).

VIII. Community Case Manager Training Requirements

Each case manager and supervisor must have at least 24 hours of training in the first year, including 16 hours of training before providing direct services (*denotes training that must occur prior to providing direct services). At a minimum, the training will include:

- Overview of required case management activities, including associated timeframes, processes and procedures, and documentation requirements*
- Overview of serious mental illnesses, including symptoms, signs someone is doing well/not doing well* NOTE: LMHPs are exempt from this training.
- Recognizing signs of abuse, neglect, extortion or exploitation, and critical incident reporting requirements*
- Cultural competency and social determinants of health*
- Principles of and approach to person-centered planning using a strength-based approach*
- Motivational interviewing and successful engagement strategies*
- Identifying and cultivating relationships with formal providers in the community and other community resources*
- Benefits of community integration/inclusion and strategies for discussing, identifying and assisting members to develop employment/educational goals and other community integration activities*
- Strategies for identifying and addressing crisis*
- Common physical health conditions impacting the SMI population, including overview of the condition, healthy ranges, modifiable risk factors, and strategies

for supporting healthy behavior changes. Strategies to identify co-morbid conditions and likely medical services needed to address such conditions*

- Benefits and services for adults, including home and community-based services provided the Office of Aging and Adult Services and the Office of Citizens with Developmental Disabilities and MCO-covered services (including in-lieu of services and value add services). For MCO-covered services, training must cover member eligibility criteria, service goals if applicable and process for identifying and linking to qualified providers*
- Quality improvement expectations for target population and related reporting responsibilities*

In addition, community case managers and their supervisors shall meet any certification or other standards required for using the LDH-prescribed or approved assessment tool. The MCOs shall ensure case managers receive training on an annual basis which addresses at a minimum critical incident management and reporting, strategies for addressing crisis, and other areas determined by the MCO or LDH to address programmatic changes or areas of need. LDH may require the MCOs to provide additional training to community case managers based on identified needs, programmatic/operational changes, best practices, or areas of concern.

The MCO shall develop a training plan and curriculum for addressing the training needs of community case managers and supervisors, and provide plan and curriculum to LDH by August 2, 2021. The training plan shall specify the trainings to be offered and required, training dates, training goals/objectives, methods to evaluate community case managers and supervisors' proficiency, and person/entity conducting each specific training including a summary of qualifications. It is recommended the MCOs jointly develop the training plan and curriculum to reduce administrative burden on the community case management agencies/staff. The training plan and curriculum shall be reviewed by the MCOs on an annual basis, with updates to the plan and curriculum as needed based on changes in policy/procedures or best practices. The MCO shall provide the updated training plan and curriculum to LDH-OBH for approval within 60 days of the proposed effective date.

IX. Community Case Management Agency Requirements

The MCO shall ensure community case management agencies complete the following requirements:

- Arrange for and maintains documentation that all persons, prior to employment, pass criminal background checks and a search of the U.S. Department of Justice National Sex Offender Registry. If the results of any criminal background check reveal that the potential employee (or contractor) was convicted of any offenses against a child/youth or an elderly or disabled person, the community case management agency shall not hire and/or shall terminate the employment (or contract) of such individual. The community case management agency shall not hire an individual with a record as a sex offender nor permit these individuals to work for the agency as a subcontractor. Criminal background checks must be performed as required by La. R.S. 40:1203.1 et seq., and in accordance with La. R.S. 15:587 et seq.
- Not hire individuals failing to meet criminal background check requirements and regulations. Individuals not in compliance with criminal background check requirements and regulations shall not be utilized on an employment, contract nor volunteer basis. Criminal background checks

performed over 30 days prior to the date of employment will not be accepted as meeting the criminal background check requirement. The community case management agency shall maintain the results of an individual's criminal background check in the individual's personnel record and comply with the confidentiality requirements of La. R.S. 40:1203.4.

- Review the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds, including but not limited to licensed and unlicensed staff, interns and contractors. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The OIG maintains the LEIE on the OIG website (https://exclusions.oig.hhs.gov) and the LDH Adverse Action website is located at https://adverseactions.ldh.la.gov/SelSearch.
- The community case management agency is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. The agency shall maintain the results of completed searches in the LEIE and LDH State Adverse Action databases in the individual's personnel record.
- Arranges for and maintains documentation that all persons, prior to employment, are free from tuberculosis (TB) in a communicable state via skin testing to reduce the risk of such infections in recipients and staff. Results from testing performed over 30 days prior to date of employment will not be accepted as meeting this requirement.
- Establishes and maintains written policies and procedures inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use.
- Ensure and maintains documentation that all unlicensed persons employed by the organization complete training in a recognized crisis intervention curriculum prior to handling or managing crisis calls, which shall be updated annually.
- Maintains documentation of verification of staff meeting educational and professional requirements, as well as completion of required trainings for all staff.
- Ensure supervisors adequately monitor community case managers to ensure requirements are met and community case managers are competent, and document said monitoring activities and findings. At a minimum, the supervisor shall observe community case managers providing services to members as follows:
    - Three meetings within the first month of hire, during which time the supervisor shall attest if the community case manager is performing adequately.
    - Continued monitoring to ensure the community case manager is competent to perform required activities, which shall include observation of at least one meeting six months following hire or more frequent observations based on the needs/competency of the community case manager and review of plans of care developed by community case managers to ensure it adequately addresses members' assessed needs, preferences, and goals.

- Do not steer members to services, including Medicaid-funded or non-Medicaid funded services, provided by the agency or staff.
- Abide by record-keeping requirements pertaining to retention of records, confidentiality and protection of records, and review by state and federal agencies, as specified in the Behavioral Health Provider Manual. In addition, community case management agencies must ensure staff document all case management activities and maintain such documentation in accordance with LDH requirements.

X. Standard Operating Procedures

The MCO shall collaborate with other MCOs to jointly develop standard operating procedures for the community case management program, which addresses the following minimum components including any associated timeframes:

a. Referral processes and documentation requirements should a member or a member's authorized representative reject community case management services, including processes to connect the member to other supports, services, and care coordination.
    i. Internal protocols to link members diverted from nursing facility care immediately to community case management agencies and for ensuring the PASRR II evaluators make an immediate referral for community case management services.
    ii. Procedures for community case managers to attempt successful contact and engagement with newly referred members, who have not declined services, before the member is discharged from the community case management program. This shall consider reasonable timeframes, of at least 1 month, for the community case manager to attempt successful contact with the member.
    iii. Procedures for the MCO or the CCMA, as designated by the MCO, to follow-up with transitioned and diverted members who initially declined community case management services. The MCO or CCMA, if designated by the MCO, shall attempt outreach to these members to offer community case management services between 60-90 days following the member's discharge date. If the member declines or is unable to be reached, another attempt shall be made within 180-210 days following the member's discharge date.
b. Intake procedures, including obtaining member permission to coordinate care and obtain healthcare records in accordance with the privacy requirements at 45 CFR, parts 160 and 164, subparts A and E, to the extent they are applicable.
c. Transition protocols and criteria for referral to MCO traditional case management when specialized community case management is no longer needed and transfer procedures if the member moves to another region or enrolls with another MCO.
d. Assessment and reassessment process, including timelines and methods/criteria for determining when a reassessment may be needed sooner than the established due date, assessment tools and instructions, training/certification requirements and processes, documentation of member outcomes, and standardized process to determine when a member no longer requires community case management and member feedback into the process.
e. Standards for development and documentation of the plan of care, including development of back-up plans and crisis plan, updating the plan of care, and community case manager coordination with

the MCO to ensure services are authorized consistent with the member's needs and MCO prior authorization requirements.

f. Procedures for offering freedom of choice of services and providers, and freedom of choice form completion.
g. Process for referring and linking members to service providers that are qualified to provide the services defined in the plan of care, exchanging information with providers including timelines, and coordinating care with providers.
h. Process for identifying active, qualified providers within the MCO network by service/provider type
i. Process for service authorization and other MCO coordination procedures, including links to medical necessity criteria so community case managers know how to appropriately document services in the plan of care. This will include, but not be limited to:
    i. Providing a single point of contact at the MCO for the community case managers at an agency to help facilitate service authorization and provider network referrals.
    ii. Providing access to a network directory that is up to date and reflective of provider's current capacity to accept new members.
    iii. Assist the community case manager with provider referrals and linkages to the extent needed and requested if they are unable to locate a provider in the MCO network.
    iv. Assist the community case manager with securing transportation to appointments as necessary.
    v. Process for accessing out-of-network providers.
j. Process and procedures for monitoring implementation of the plan of care to determine if services are being delivered consistent with the plan of care and meeting member's needs and preferences, and access to care (including transportation).
k. Process and procedures for monitoring member health and welfare in the community, degree of community inclusion/autonomy, satisfaction with services and providers, functional status, physical and mental well-being, stability (e.g., housing, providers, caregivers), and service utilization.
l. Procedures for responding to and reporting critical incidents, including reportable critical incidents and definitions.
m. Establishment of minimum contact requirements for the agency case managers based on LDH-established criteria and how those contacts are recorded in the member's record.
n. Procedures for emergency preparedness and response for case management entities, including a plan for case managers to complete and document the following within the member's record:
    i. Contact all members within 24-48 hours prior to a known disaster or emergency to review the member's individualized emergency disaster plan, provide resource information, and to assess and address member needs, with the expectation that at least 85% of members are successfully contacted.
    ii. Contact all members following a disaster or emergency within the timeframe requested by LDH to track the status of each member, including any sustained impacts due to the event, current location if displaced, determine if the current plan of care is meeting the member's needs, and to address any unmet needs, with the expectation that at least 80% of members

are successfully contacted upon the initial outreach attempts and with 100% of members successfully contacted following the emergency.

o. Procedures for access to language assistance services for any language spoken by the member including ASL.
p. Policies and procedures related to reporting from the community case management agency and documentation requirements.

The MCO shall submit the standard operating procedures to LDH for approval by September 3, 2021, and thereafter within 60 days prior to implementation of a material change. The MCOs shall review the standard operating procedures on an annual basis, and make necessary updates to reflect changes in practices/procedures.

The MCO shall educate community case management agencies, in collaboration with other MCOs, on the LDH-approved standard operating procedures initially and when changes are made to the approved plan. The MCO shall provide a copy of the standard operating procedures to community case management agencies initially and when changes are made.

XI. Monitoring & Reporting

1. The MCO shall conduct at least weekly rounds with community case management agencies to oversee community case management activities, review member status, identify and address member health and safety risks, coordinate members' care, address barriers to care or quality of care, develop engagement strategies, and plan for potential discharges.
2. The MCO shall conduct quality monitoring reviews to ensure community case management agencies and staff adhere to requirements and quality standards, ensure any required remedial actions are completed timely and appropriately, and validate community case management reporting on at least a semi-annual basis (every 180 days). In addition, the MCO shall ensure community case management staff and agencies meet the minimum qualifications and training requirements initially prior to delivering services and on an ongoing basis. The MCO shall collaborate with other MCOs to develop a strategy for monitoring community case management agencies and staff to ensure requirements are satisfactorily met and quality of care which shall include monitoring review elements, scoring criteria, minimum compliance threshold, sample size, number of charts to be reviewed, review period, validation activities, method of review (i.e., desktop, onsite) and monitoring frequency. In addition, the strategy shall detail the qualifications of MCO staff performing monitoring reviews and methods to determine staff competency initially and ongoing, and inter-rater reliability methods including minimum target rate; at a minimum, MCO staff performing monitoring reviews shall have clinical expertise, working knowledge of the DOJ Agreement and community case management activities as described in the Guide and working knowledge of behavioral health services included in the Louisiana Behavioral Health Provider Manual and other services covered by the MCO. The strategy shall be submitted to OBH within 60 days of the publication date and upon material change. The strategy shall address the following standards:

- Agencies not achieving the minimum threshold shall be monitored in a timely manner (not to exceed 60 days) to ensure necessary corrective actions/improvements are implemented until the minimum threshold is met.
- MCOs may conduct less frequent monitoring reviews of community case management agencies who achieve high compliance which greatly exceeds the minimum threshold over 2 consecutive monitoring reviews unless the compliance score drops below the minimum threshold or based on the number and degree of grievances, quality of care concerns, or other reported issues involving the agency or staff.
- The quality monitoring reviews conducted by the MCOs shall focus on:
    - The quality of the assessment and plan of care;
    - Assessment and plan of care completion timelines;
    - Development of crisis plans (to include contact information for crisis resources in members' community);
    - Plans are updated based on the criteria specified in the Guide;
    - Sufficient CCM contacts with members;
    - Proactive monitoring and intervention by the CCM to meet member needs before issues arise;
    - CCM coordination of team meetings to include member, member's natural supports (as requested/desired by member) and member's main provider (e.g., ACT, personal care) based on member consent;
    - CCM has copies of the member's treatment/service plan as developed by their main provider;
    - CCM exploring and documenting efforts to integrate members into the community; and
    - CCM documentation aligns with the information included in the respective 361 report.

3. The MCO shall collect, track, and review member-level data, perform data validation activities, ensure appropriate remedial actions are taken to address any identified issues, and report information to LDH in accordance with LDH-issued reporting templates and instructions. Data elements include but are not limited to housing stability, community integration, assessment and plan of care timeframes, member satisfaction with services and providers, member health and welfare, critical incidents, member outcomes, and member service utilization.
4. LDH may require community case managers to use a centralized database for reporting member specific data and case management activities.

XII. Other Requirements

1. The MCO shall ensure that payment rates to the community case management agency are sufficient to provide ongoing timely access to a sufficient number of community case managers to be able to successfully meet the requirements in this Guide, considering assessment and plan of care timeliness rates, referral response rates, pending referrals and vacancies. The MCOs shall jointly conduct an annual review, or more frequently as warranted by program performance, to ensure adequate payment rates and submit evidence of sufficient payment rates to LDH, upon

request, including a description of improvements or changes to be implemented to ensure timely access if applicable.

2. In the case of a member's death, the MCO shall collect and provide the following information to LDH-OBH (Cynthia.Bennett@LA.GOV) within one (1) month of notification of the member's death:

    - Current plan of care,
    - Current treatment plan from the behavioral health provider(s),
    - Progress notes for 90 days preceding the member's death from the behavioral health provider and community case manager,
    - Hospital and emergency department records, to include discharge summaries and all ancillary department records, from the past year,
    - Medical records in the custody of health care providers from the past 6 months, and
    - Critical incident reports from the past year.

XIII. My Choice Louisiana Transition Coordination Program

The MCO shall participate in all coordination activities associated with the My Choice Louisiana program, transitioning individuals from Nursing Facilities into the community. This includes:

A. Provide the MCO point of contact, forms, and processes for linkage to Tiered Case Management initially and prior to making changes.
    1. This information must be provided to LDH along with appropriate training and/or instructions on the designated process and any associated forms.
B. Assigning an MCO Case Manager to work as active participants of the Transition Coordination Team based on member consent.
    1. Case Managers should operate in congruence with the principles and values of the MCL program which is based in the following tenets:
        i. Transition planning begins with the presumption that with sufficient services and supports, individuals can live in the community.
        ii. Transition planning is developed and implemented through a person-centered planning process in which the individual has a primary role and is based on principles of self-determination and recovery.
C. During the transition coordination meetings, providing Transition Coordinators with all completed assessments conducted throughout the case management process, including the Health Needs Assessment and Comprehensive Case Management assessment as well as the Individual Plan of Care.
D. Actively engage in transition coordination meetings; the MCO plays a pivotal role in these meetings, proactively addressing and following up on key action items. This may include but is not limited to:
    1. Coordinate with the goal of establishing necessary services for members.
    2. Providing value-added supports, designed to facilitate a smooth transition.
E. Integration into community services; the MCO is responsible for connecting transitioning members to the spectrum of related services covered by the MCO. This comprehensive approach is aimed at addressing the needs of members in their new community settings. This includes:
    1. Ensuring access to healthcare services, addressing both physical and mental health needs;

2. Connecting members with community resources to meet their social and emotional needs;
3. Referrals to home and community-based supports intended to assist the member with their activities for daily living (ADL) and instrumental activities for daily living (IADL) needs;
4. Providing referrals to Personal Support Services (PSS) or Individual Placement and Support (IPS) for employment opportunities, where appropriate; and
5. Informing members about applicable Value Added Benefits available through the organization

F. In the event of an identified area of concern, actively identify supports and resources which can be implemented to ensure the individual's needs and preferences in the community are maintained.

XIV. Appendix

A. DOJ Agreement Compliance Guide Revision Log

DOJ Agreement Compliance Guide Revision Log

Section	Summary of Change	Effective Date
V. PASRR	Deleted C4 as duplicative of D1.	June 1, 2022
VI. MCO Case Management	Provided timeframe for MCO engagement activities before a member may exit from MCO case management.	June 1, 2022
Part C, 1. Engagement	Added language to denote the TC leads the development of the transition assessment and transition plan; added new section to address community members who are admitted/readmitted to NFs.	June 1, 2022
Part C, 2. Comprehensive Needs Assessment	Revised the initial assessment due date to allow for aligned due dates for both the transition and diverted population. Change the requirement for reassessments every 90 days to reflect a review of member's needs on a monthly basis (or more often is needed) and a formal reassessment for members who have received community case management for at least 10 months.	April 1, 2022
Part C, 3. Person-Centered Plan of Care Development	Revised the initial plan of care due date to allow for aligned due dates for transition and diverted population. Changed requirement for plan of care reviews every 90 days to a monthly plan of care review (or more often if needed), and added criteria for updating the plan. Clarified the 30 day timeframe for developing the discharge plan applies only to members who have received CCM services for at least 365 days.	April 1, 2022
5,d. Monitoring and Follow-Up	Established an LDH point of contact for the CCM to provide notice to following a member's death.	June 1, 2022
X. Community Case Manager Training Requirements	Clarified that LMHPs are exempt from the overview of SMI training.	April 1, 2022
XII. Standard Operating Procedures	Added language to require the MCOs to include reportable critical incidents and definitions as a part of CI procedures.	June 1, 2022
XIV. Other Requirements	Added an LDH point of contact for MCOs to provide required information following notification of a member's death.	June 1, 2022
IV. At. Risk Population	Revised criteria to include focus on SMI members with high rate of hospitalizations in the present period.	February 1, 2023

VI. – VII.	Removed MCO Case Management and MCO Case Manager Staffing and Training sections.	January 1, 2023
V1. Community Case Management Program	Revised Part A. Agency Qualifications & Selection Process to include requirements for maintenance of contract with the CCMA following implementation, procedures for selecting a new CCMA, and access standards for community case managers and supervisors. Revised Part B. Single Point of Contact to include response expectations and requirements. Revised Part C. Community Case Management Activities to include referral response standard. Clarified that a discharge plan is not required for unplanned discharges. Revised Part D. Community Case Management Contacts to include distinct standards for members receiving ACT services.	February 1, 2023
VIII. Community Case Manager Training Requirements	Included requirement for MCO-covered service training to also address the process for identifying and linking to qualified providers. Removed requirement for training to address expected outcomes for services. Added that training shall address service goals if applicable. Included requirement for annual review of the training plan and curriculum and process for submitting the updated plan to LDH-OBH for approval.	February 1, 2023
X. Standard Operating Procedures	Clarified the requirement that the SOP include the process for identifying active, qualified providers within the MCO network by service/provider type. Included requirement for annual SOP review and submission to LDH-OBH when material changes are made.	February 1, 2023
XII. Other Requirements	Clarified access standards and updated payment review timeframe.	February 1, 2023
IV. At-Risk Population	Changed timeframe for which MCOs must offer CM to the at-risk population from 60 to 90 days to align with the timeframes in the contract. Clarified that members who previously met the at-risk criteria and were enrolled in MCO case management shall continue to receive those services unless specific criteria is met.	February 1, 2023
XI. Monitoring & Reporting	Updated the criteria for MCO staff conducting CCM monitoring reviews to include knowledge of CCM and BH services; updated MCO quality monitoring	Upon publication

	implementation date, sample selection criteria, and areas of focus for quality monitoring reviews. Clarified that in the event DOJ reviews are discontinued or suspended, the MCO is responsible for selecting the member sample.	
IV. At-Risk Criteria	Modified the at-risk criteria.	October 1, 2023
VI. Community Case Management Program	Included discharge planning meeting requirements, updated process and timelines for CCM contacts with members admitted/readmitted to NFs; clarified expectations regarding plan of care goals; updated CCM contacts frequency and scope.	Upon publication or effective date of the MCOs' SOP (whichever is the earliest) for CCM contacts; October 1, 2023 for all other changes.
IX. Community Case Management Agency Requirements	Included LMHP supervisor review of CCM plans of care.	October 1, 2023
XIII. My Choice Louisiana Transition Coordination Program	Included section pertaining to MCO role and responsibilities during the MCL transition coordination process.	February 22, 2024
V. PASRR	Clarified language related to linkage to specialized behavioral health services and MCO case management	February 22, 2024
VI. Community Case Management Program	Changes anchor date for assessments from referral date for the diverted and transitioned (not in NF) population to the consent date. Includes new section on Community Integration. Revises Discharge Planning section to include linkage to MCO case managers.	April 1, 2025
X. Standard Operating Procedures	Includes processes/procedures to allow member cases to stay open for at least 1 month to attempt successful outreach for newly referred members who have not declined services; includes processes/procedures to attempt to engage members who initially declined services, along with timeframes.	Revised SOP due to OBH by April 1, 2025.
XI. Other Requirements	Changes payment adequacy review from semi-annual review to annual review.	Upon publication