UnitedHealthcare Community Plan	DEPARTMENT: Case Management
LOCAL HEALTH PLAN: Louisiana	LINE OF BUSINESS: Medicaid
TITLE: Case Management Process	NUMBER: NCM 002 RIDER LA 002
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I. PURPOSE/SCOPE

This document describes the process UnitedHealthcareUnited Healthcare Community & State Louisiana (UHC C&S LA) Health Plan uses to deliver case management based on Federal and State contractual requirements to:

- Support Enrollees, regardless of age, based on an individualized assessment of care needs.
- Defines procedure for completion of Health Needs Assessment (HNA)
- Establish a consistent process for assessment and the development of an evidence based, person centered plan of care (POC) for individuals identified and enrolled in case management
- Outline process for monitoring, reassessment, and ongoing management of the POC
- Define criteria for case closure and process to measure satisfaction with case management services
- Outline documentation and monitoring requirements for the case management process

- Define levels of tiered case management

II. DEFINITIONS

Refer to UnitedHealthcare Community and State Louisiana Standard Definitions

III. POLICY

UnitedHealthcare Community and State Louisiana (UHC C&S LA) Health Plan will implement case management processes that are has implemented a comprehensive care management program to support Enrollees of all age, which is based on principles of recovery and resiliency.an individualized assessment of care needs. (2.7.1) These processes will beare compliant with State, Federalstate, federal, regulatory, and accreditation requirements (6.19.4.2). The . UHC C&S LA implements a tiered Case Management program that provides different levels of Case Management based on the individual Enrollee's needs. (2.7.5) UHC C&S LA has implemented three (3) levels of Case Management and Transitional Case Management for individuals as they move between care settings. (2.7.5) This population included in case management will be based on clinical model design and regulatory requirements. Included in the population areincludes individuals defined by the State as having special health care needs. The case management staff will (SHCN). (2.7.3) A POD Care Team approach will be utilized for Enrollee outreach in which

multiple factors are considered when determining the staffing mix for each Pod. This includes Enrollee volume, utilization, member demographics, prevalent conditions in area, rural vs urban, network strength, and community organizations/resources. These elements will enable decisions determining how Pods across the state will to be staffed. (2.7.1)

IV. POLICY PROVISIONS[KF1]

A. Health Needs Assessment (HNA): (2.7.2.4.1)

The HNA Is a common survey-based instrument, developed by LDH, which will be utilized by UHC C&S LA Health Plan to conduct Enrollee Health Needs Assessments (HNA) as part of the Enrollee welcome call. The HNA identifies health and functional needs of Enrollees and screens for needs relevant to priority social determinants of health (SDOH). (2.7.2.4.3) The HNA also identifies Enrollees requiring short-term care coordination or case management for medical and behavioral needs. UHC C&S LA Health Plan has developed, implemented, and maintained procedures for completing an initial HNA for each Enrollee, and will make best efforts to complete assessment within ninety (90) Calendar Days of the Enrollee's effective date of enrollment. (2.7.2)

1. HNA may be conducted with the consent of the enrollee. When enrollee is a child, consent shall be obtained by the enrollee's parent or legal guardian, and the HNA shall be completed. (2.7.2.1)
2. Will be available to Enrollees in multiple formats including web- based, print, and telephone. (2.7.2.4.2)
3. If the initial HNA attempt is unsuccessful, UHC C&S LA Health Plan staff will attempt to conduct and document efforts to conduct the HNA on at least three (3) different occasions, at different times of the day and on different days of the week. (2.7.2.2, 2.7.10.2)
4. UHC C&S LA Health Plan will provide HNA data to the enrollee's assigned Primary Care Provider (PCP), and to Louisiana Department of Health (LDH) as requested. (2.7.2.3)
5. HNA identifies individuals for referral to Case Management, with more in-depth assessment to occur as part of the POC. (2.7.2.4.4, 2.7.10.2)
6. HNA Screens for needs relevant to priority social determinants of health (SDOH). (2.7.2.4.5)
7. HNA includes disclosures of how information will be used. (2.7.2.4.6)

B. Enrollees with Special Health Care Needs (SHCN) (2.7.3)

UHC C&S LA Health Plan has implemented mechanisms to provide each Enrollee identified as having SHCNs with a comprehensive assessment conducted by a case manager to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring. (2.7.2.1)

1. UHC C&S LA Health Plan case managers will complete a comprehensive assessment for at least ninety percent (90%) of Enrollees that UHC C&S LA Health Plan is able to contact and are willing to engage within ninety (90) Calendar Days of being identified as having SHCN. (2.7.3.2)
2. UHC C&S LA Health Plan offers Case Management to all Enrollees with SHCN regardless of information gathered through the comprehensive assessment or the HNA. (2.7.3.3)

C. Referral to Case Management: (2.7.4)

1. UHC C&S LA Health Plan receives referrals to Case Management through the HNA, identification of individuals with SHCN, as well as referral sources, including, but not limited to: (2.7.4.1)
    a. Enrollee services and self-referral (including Enrollee Grievances); (2.7.4.1.1)
    b. Providers (including primary care behavioral health and specialist providers); and (2.7.4.1.2)
    c. State staff including Bureau of Health Services Financing (BHSF), Office of Behavioral Health (OBH), Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), Office of Public Health (OPH), and Department of Children and Family Services (DCFS). (2.7.4.1.3)
2. UHC C&S LA Health Plan provides guidelines to determine circumstances Enrollees are enrolled for potential engagement in Case Management in a manner and format that is readily accessible to providers. (2.7.4.2)
3. UHC C&S LA Health Plan provides guidelines to Enrollees in the Member Handbook to determine circumstances Enrollees may engage in Case Management. (2.7.4.3)
4. UHC C&S LA Health Plan considers all referred Enrollees for engagement in Case Management. (2.7.4.4)

D. Integrated Care Model Pods

1. Integrated pods help enrollees with the highest need by engaging and strengthening informal support including family, friends, and cultural or spiritual communities. Care Model Pods provide personalized outreach to Enrollees by meeting them where they are and not relying on telephonic outreach. Pod approach also allows for the Enrollee to have

a single point of contact and empowers the Enrollee to choose how they want to work with designated care manager, including modality and frequency of outreach.

2. The Care Model program goals include:
    a. Reducing the use of emergency department visits and inpatient hospitalizations due to unmanaged health issues.
    b. Improve Quality Outcomes through Healthcare Effectiveness Data and Information Set (HEDIS) reporting;
    c. Improve transition of care from inpatient and skilled nursing facilities to the community with supports;
    d. Improve health outcomes by meeting the Enrollees social determinants through robust community partnerships; and
    e. Engage and provide care management for those Enrollees where we can make an impact in their overall healthcare through the lens of quality and affordability.
3. Registered Nurses (RN), Community Health Workers (CHW) and Licensed Behavioral Health Specialists (BHS) work collaboratively in team-based care approach. Pods will include a regional Clinical Administrative Coordinator (CAC), Manager, and will roll up to the Health Services Director (HSD). Staffing mix for each Pod is determined by membership volume, utilization, demographics, and prevalent conditions in area, rural vs urban, network strength, community organizations, and resources.
4. Staff assignments are based on clinical needs and are 50:1 for CHWs and 25:1 for Registered Nurse (RN) Case Managers and Behavioral Health Specialists (BHS).
5. Outreach attempts may be telephonic, telehealth, in person, or mail. The primary Pod care staff will clearly document all outreach attempts within the Enrollee record and may request other Pod care staff assist with outreach attempts. Additionally, Enrollees may be identified through a variety of sources including medical management program referrals, discharge planner referrals, Enrollee or caregiver referrals, and practitioner referrals.
6. Evidence of a good faith effort to reach the Enrollee by leveraging community partners shall be documented. Community partners include but are not limited to pharmacies, providers, and hospitals.
7. To meet National Committee for Quality ~~Assurrance~~Assurance (NCQA) standards, the Pod care staff will make three (3) direct outreach attempts in a ~~consectutive~~consecutive [KF2]two (2) week period within the first 30 calendar days of stratification. Enrollee follow ~~standard outreach processes to engage members identified for case management. Once~~-up outreach expectations are one (1) attempt every two (2) weeks, based on Enrollee need, preference, and modality preference. Unable to reach letter shall be mailed after three (3) other attempts have been made.

8. Ensure regular contacts between CM staff, the Enrollee's PCP, Enrollee's primary Behavioral Health Provider as applicable, and the Enrollee are documented appropriately. (2.7.10.11)
9. Priority conditions (e.g., diabetes, CHF, COPD, OUD/SUD, and SMI) are addressed through evidence-based pathways based upon readiness to change.

E. Tiered Case Management (2.7.5) [KF3]

1. UHC C&S LA Health Plan has implemented a tiered Case Management program which provides for different levels of Case Management based on an individual Enrollee's needs. Enrollees, parent, or legal guardian are engaged ~~the member will be assessed and a person centered POC will be developed~~, as appropriate in a level of Case Management commensurate with Enrollee's risk score as identified through predictive modeling and the inclusion of different tiers of Case Management including how the HNA and comprehensive assessments are utilized. (2.7.10.6) ~~.~~ This is combined with the care needs identified in the Enrollee's POC and HNA. (2.7.10.6.2) If requested by the Enrollee, or the Enrollee's parent or legal guardian, the frequency, or method of engagement may be increased, reduced, substituted, or declined. UHC C&S LA Health Plan retains documentation of these requests. Where the Enrollee's PCP or behavioral health provider offers Case Management, UHC C&S LA Health Plan will support the provider as the lead case manager on the multi-disciplinary care team. UHC C&S LA Health Plan maintains three (3) levels of Case Management and Transitional Case Management for individuals as they move between care settings. (2.7.10.5) Process of Case Management effectiveness is measured by the expected outcomes of tiers including impact analysis on the use of the emergency room, inpatient admissions and follow up care. (–2.7.10.6.3) It is also measured by expected rates of engagement, measurement of processes and outcomes and using valid quantitate methods to measure performance goals. (2.7.6.5, 2.7.6.6) The data will be analyzed and opportunities for improvement will be identified based on these outcomes.

1. **Intensive Case Management for High-Risk Enrollees (High) (Tier 3)**
   Enrollees engaged in intensive Case Management are of the highest need and require the most focused attention to support their clinical care needs and to address ~~the members' unique needs identified through the assessment~~ SDOH (Social Determinants of Health). A POC is completed in person within thirty (30) Calendar Days of identification and includes assessment of the home environment and priority SDOH. Case Management meetings occur at least monthly, in person, in the Enrollee's preferred setting such as

enrolleesenrollees' home, shelter or other enrollee preference, or more as required within the Enrollee's POC. Monthly updates are made to the POC and formal in person re-assessments occur quarterly. (2.7.10.7) Staffing for these High-Risk Enrollees will be maintained at a ratio of 25 to 1 RN Case Manager and BHS. Community health worker support is integrated as necessary. Attestations of monthly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider will be completed. Case managers serving Tier 3 Enrollees focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting care goals, including self-management. Behavioral health case managers lead when Enrollee has primary behavioral health needs. (2.7.5.1)

i. Enrollees may include the following:

1. Individuals identified with multiple chronic conditions, need for uninterrupted care, pattern of emergency and hospital admissions
2. High Risk Pregnancies, for example women with substance use, sickle cell, or severe physical or behavioral health conditions
3. Serious Mental Illness (SMI), serious emotional disturbance (SED), and/or presented to the Emergency Department for suicide attempt
4. Substance Use Disorder (SUD) and presented to ED for overdose treatment
5. Experiencing homelessness per Section 330(h)(5)(A) of the Public Health Services Act

2. **Case Management (Medium) (Tier 2)**

Enrollees engaged in the medium level of Case Management are typically of rising risk and need focused attention to support clinical care needs and to address SDOH. A POC is completed in person within thirty (30) Calendar Days of identification and include assessment of the home environment and priority SDOH. Case Management meetings will occur at least monthly. Updates to the POC and formal in-person reassessments will occur quarterly. Case Management may integrate CHW support. Attestations of quarterly updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider will be completed. Case managers serving Tier 2 Enrollees focus on implementation of the Enrollee's POC, preventing institutionalization and other adverse outcomes, and supporting the Enrollee in meeting care goals such as self-management. Behavioral Health Specialists lead whenever there is an Enrollee with primary behavioral health needs. (2.7.5.2)

i. Enrollees may include the following:

1. Emerging Risk factors with a chronic condition but not engaging with the health care system at appropriate levels for their condition or no routine monitoring or testing
2. Diagnosed with post-acute sequalae of COVID-19 (PASC or "Long Haul COVID")
3. Pregnant enrollees with minor complications such as stable chronic conditions, mild depression or who have a history of miscarriage
4. Experiencing housing insecurity or two or more SDOH needs that put them at risk
5. DOJ My Choice "At Risk" population PASSR Population

3. **Case Management (Low) (Tier 1)**
   Enrollees engaged in this level of Case Management are of the lowest level of risk within the Case Management program and require support in care coordination and in addressing SDOH. A POC is completed in person within ninety (90) Calendar Days of identification and includes assessment of the home environment and priority SDOH. Case Management meetings are scheduled at least quarterly, within the Enrollee's POC. Updates to the POC and formal in-person re-assessments will occur annually. Attestations of annual updates to the POC and communication of POC to the Enrollee and the Enrollee's primary care provider are completed. (2.7.5.3)
   i. Enrollees may include the following:
      1. Seeking new providers (e.g., care settings that offer multiple services/specialties
      2. Experiencing lower intensity SDOH needs (e.g., transportation barriers, need for smartphone)

F. Case Management Documentation

1. All documentation will be entered into the case management system.
2. The case management system will auto document the staff Enrollee's name, date, and time of interaction for each entry in the Enrollee's record. The time of interaction will be manually entered by the clinician in narrative case notes if not captured by the system.
3. All interactions with Enrollees, providers, and medical directors will be documented within 24 hours of the interaction.
4. Documentation should reflect the case management process ~~(6.19.4.4/6.30.2.). The POC is a strength based, goal oriented, dynamic tool, that will be used to manage the members' care needs. The POC will be monitored, evaluated and updated at least every~~

12 months and as the members' care needs change through case closure (6.19.4.3; 6.39.2.9). The memberas outlined in the health plans policies.

5. The Enrollee case management record will be maintained in the care management system following established documentation standards (6.39.1). and will be monitored for accuracy, quality and effectiveness through monthly reporting and chart audits. (2.7.10.6, 2.7.10.6.1)
6. Ensure that the case management activities that each enrollee is receiving are appropriately documented. (2.7.10.10)

I. POLICY PROVISIONS

A.G. Assessment

2.1. The Case Manager (CM) will complete the initial comprehensive assessment as expeditiously as the member'sEnrollee's condition requires within the timeframes established by regulatory requirements, but no later than 30 calendar days from identification of the memberEnrollee as appropriate for high-risk case management and is completed within 60 days of identification. The assessment will be completed telephonically or face to face based on member condition and regulatory guidance (6.30.1; 6.39.2.16).

0. Prior to initiating contact with the member, the CM will review the referral source and risk stratification data to identify complex or special needs, current and/or future risks as well as the utilization history of member (6.30.2.5). If the member is transitioning from another health plan or FFS Medicaid, and has been previously engaged in case management, the CM will also request and review information provided by the previous health plan, as available, to support the transition of case management services. This will include notifying the physical health or behavioral health primary care provider of the change in health plan and case management contact.

2. Assessments will by completed in person, telehealth, or telephonically and will based on Enrollee condition, Enrollee request, and regulatory guidance.
4.3. The CMcase manager will make a minimum of three (3) telephonic attempts to contact the memberEnrollee on different days of the week at different times of the day. If unsuccessful, the member will be sent an unable to reach letter which outlineswill be mailed to Enrollee outlining the case management program and how to contact the CM to

enroll. Additionally, they maycase manager for enrollment. Enrollee may also be referred to field-based staff to seek and locate the memberEnrollee in the community.

6.4. If the memberEnrollee is successfully engaged, the CM will provide education on the services available through Case Management.case management. The education will include information regarding theirEnrollee rights, including enrollment, and disenrollment from the program. ThisEducation may also includesinclude how to access services, how they are eligibleeligibility to participate in case management, and how to opt out of the program.

8.5. If the memberEnrollee agrees to participate, the CM completes the initial comprehensive assessment. The assessment is completed based on information provided by the member and/or theirEnrollee, caregiver (with the member'sEnrollee's consent), the member'sEnrollee's PCP, other medical and behavioral health providers including external case managers involved in the membersEnrollee's care (6.28.2.1/6.39.). (2.7.2).10.3)

0. Elements in the assessment (including for High Risk) may include but are not limited to the following (6.39.2.5):

- Initial assessment of members' health status, including condition specific issues
- Event or diagnosis that identified member for complex case management
- Documentation of clinical history, including dates (e.g., disease onset, recent inpatient admissions, and ER visits, and past relevant medications and allergies
- Screening for the presence or absence of comorbidities and their current status
- Member's self-reported health status
- Documentation of current medications, including schedule and dosage

- Evaluation of current treatment including preventive care, medications, treating physicians, self-care and understanding of self-management of condition
- Identification of Special Needs, i.e., need for extended nursing hours, ventilator dependence, development delay, specialized medical condition
- Adherence to current treatment, including barriers to adherence
- Assessment of activities of daily and instrumental activities of daily living including bathing, dressing, going to the toilet, transferring, feeding and continence.
- Initial assessment of behavioral health status, including mental health and substance use symptoms and conditions
- Evaluation of cognitive function including the ability to communicate and understand instructions and process information about their condition
- Evaluation of Speech, Vision or Hearing needs, preferences or limitations
- Evaluation of physical disability, needs preferences or limitations
- Evaluation of cultural, spiritual, and linguistic needs, preferences or limitations
- Evaluation of living arrangement and identification of environmental needs
- Evaluation of caregiver resources and involvement
- Evaluation of at least two social determinants such as housing, income, transportation and food.
- Evaluation of health service utilization, i.e., inpatient care, outpatient care DME, home care and emergency department.
- Evaluation of life planning activities
- Detection of safety issues
- Evaluation of the member's available benefits within the organization and eligibility for community resources that supplement their benefits including community mental health, transportation, wellness organizations, palliative care programs and nutritional support.

36.6. After the initial assessment is completed, the CM will document a summary of the meaning and the implications of the assessment so it can be used in the development of a member-Enrollee-centered case management plan. A single comprehensive summary or a combination of summaries that addresses each factor in the assessment is permissible.

A.H. **Individual Plan of Care** Plan Development **(2.7.8)**

0. A person centered POC is developed by the CM in collaboration with the member, caregiver/family (with member's consent), and the interdisciplinary care team, including the member's PCP, other medical and behavioral health providers as appropriate and external case managers involved in the members care (6.28.2.1/6.39.2.7.2; 6.39.3).

0. The POC will focus on the actual/potential gaps in care and service needs identified through the assessment process (6.39.2.14). The CM will work with the interdisciplinary care team to assure that the POC is person centered and addresses medical, behavioral, and social/environmental needs focused on optimal health outcomes (6.28.2.3; 6:30.2.4; 6.39.2.7.3; 6.39.3).

0. The POC is evidence based and goals are measurable, time bound, and prioritized to meet the needs identified in the assessment. The POC is individualized in alignment with the member's strengths, wishes and preferences (6.39.2.7.4).

0. The POC will include the development and communication of member self-management goals. The POC will be recovery based and will include the identification of "warning signs" that a condition or situation is worsening and actions the member can take to regain and maintain stabilization.

0. The POC is entered into the case management system. As the member case management record is updated, the case management system automatically documents the username and the date and time the information is updated. This process also includes identification of the member's/responsible party's priorities and preferences and the barriers that would prevent the success of the goals (6.39.2.7.6).

0. Member contact frequency for follow-up is established based on member's preference for level of engagement, acuity level, and their medical/psychosocial status/needs (6.39.2.15). The CM will assign follow up tasks in the case management system that will prompt interventions as outlined in the POC. This includes the identification of a process for communicating member self-management plans (6.39.2.7.11).

1. The memberUHC C&S LA Health Plan POC is a comprehensive, individualized, goal oriented, and person- centered tool used to manage the Enrollee's care needs through case closure. The POC is completed
for all Enrollees who are found eligible for Case Management. When an
Enrollee receives services only for Specialized Behavioral Health Services (SBHS), the POC will focus on coordination and integration as appropriate. When an Enrollee receives services requiring a POC from LDH, such as Home and Community Based Services (HCBS) waiver or services through OPH, UHC C&S LA Health Plan will collaborate with LDH or its designee in developing the POC. (2.7.8.1)
2. The person-centered process is led by the Enrollee and case manager with significant input from Enrollees and the Enrollee's interdisciplinary care team. When an Enrollee

receives SBHS and has treatment plans developed through their behavioral health providers, UHC C&S LA Health Plan collaborates with the Enrollee's behavioral health providers to incorporate the treatment plans into the Enrollee's overall POC and to support the Enrollee and the provider in efforts to implement the treatment plan. (2.7.8.2)

3. The POC is based on the principles of self-determination and recovery and includes all medically necessary services identified by the Enrollee's providers as well as the care coordination and other supports to be provided by UHC C&S LA Health Plan. (2.7.8.3)
4. The POC is reviewed at least monthly and revised upon reassessment of functional needs. The POC revisions may also occur at the frequency required in the Tiered Case Management. Plan of care revisions are based on need, when the Enrollee's circumstances change significantly, or at the request of the Enrollee, parent or legal guardian, or the multi-disciplinary care team. (2.7.8.4)
~~14.~~5. The Enrollee and/or primary care provider are supplied with a copy of the POC based on health plan ~~specific~~case management program requirements ~~and upon request.~~. The POC will be shared with ~~all DSNP/MMP members, their PCP and other members of their care team upon creation and when updated.~~Enrollees as requested. The POC ~~will~~may be shared ~~using a variety of methods which may include the following:~~via mail, fax, verbally, ~~by mail, by fax~~ or electronically. Plan of care may also be shared with PCP via provider portal. If the ~~member~~Enrollee is receiving behavioral health services, the ~~member's~~Enrollee's primary ~~BH~~behavioral health provider is also provided a copy within the same parameters as the PCP.

~~1.~~ Services and referrals to providers and community resources to support the POC are documented in the case management system ~~(6.28.2.3).~~. The CM will follow up on referrals to providers and community resources to assure appropriate care and services are in place ~~(6.39.2.11; 6.39.2.14).~~. This coordination will be documented in the POC and will include Enrollee follow-up on counseling, referrals to Disease Management (DM) programs, referrals to health resources, Enrollee education and self-management support. The CM will determine in conjunction with the Enrollee and document when follow-up is not appropriate. This includes criteria and protocols regarding documentation of follow -through with identification and successful linkage to community resources.

~~1.~~ (2.7.10.8)

member follow-up on counseling, referrals to DM programs, referrals to health resources, member education and self-management support (6.39.2.7.8; 6.39.2.7.11; 6.39.2.8; 6.30.2.14; 6.39.2.18; 6.39.3). The CM will determine in conjunction with the member and document when follow-up is not appropriate.

9.6. For membersEnrollees receiving services from state or community programs, (i.e., early intervention, school-based programs for children and/or specialized services for individuals with physical disabilities or behavioral health needs;), the Case Manager will be responsible for collaborating with the interdisciplinary care team to prevent duplication of interventions and assure coordination (6.30.2.7).

B. Member Engagement

0. The CM and member will modify and re-evaluate goals and the POC based on the member's accomplishments and progress (6.39.2.9). The CM will update the interdisciplinary care team with revisions to the POC as appropriate.

0. The CM and member will monitor adherence to the POC and the member's progress in self-management of his/her condition (6.39.2.9). The CM will provide coaching to promote member interaction/communication with his/her PCP and care providers.

0. The CM will communicate with the PCP, specialists, and care providers to coordinate care needs outlined in the POC (6.39.2.7.2). In the event the member changes PCP, the CM will contact the new PCP as soon as they are aware of the change. The current POC will be shared with the new PCP or care provider to assure continued work toward the goals on the POC (6.30).

0. The CM will collaborate with the interdisciplinary care team (i.e., PCP, pharmacy, medical director, behavioral health, social work, health home, external case manager), as appropriate to address and coordinate care needs of the member across the continuum (6.30.2.4; 6.39.2.7.2). When appropriate the member will be presented at interdisciplinary case conference for an interdisciplinary review of the member needs. The CM will be responsible for implementation of recommendations and follow up from the case conference. The case conference participants and outcome will be documented in the case management system.

0. In the event that available benefits are exhausted for necessary services the CM will provide the member with information on alternate resources for continuing care and how to obtain

them (6.30.2.6). This includes children or adolescents that may have a change in benefits or

coverage as they transition to adulthood. For DSNP members this will include researching Medicaid benefits that may be available to cover needed care and facilitating access to these services.

0. In the event the member transitions from pediatric to adult care, the Case Manager will support this transition to ensure the member's needs are met (6.30; 6.30.2.12). See Policy NCM 024 RIDER LA 024 Children and Youth with Special Healthcare Needs Care Coordination and Transition Planning.

0. Member reassessments will be completed, at a minimum, annually, or with significant change in condition as per contractual requirements (6.39.2.9; 6.39.3). The POC and member goals will be revised to reflect member preferences/goals of care and the needs identified via reassessment (6.39.2.9; 6.39.2.7.4; 6.39.3).

I. Multi-Disciplinary Care Team

1. UHC C&S LA Health Plan implements a multi-disciplinary care team to serve each Enrollee based on individual need for all Enrollees in Case Management Tiers 2 and 3 and Transitional Case Management. UHC C&S LA Health Plan assigns lead case managers based on an Enrollee's priority care needs, as identified through the POC. When behavioral health is the Enrollee's primary health issue, a behavioral health case manager will manage Enrollee's case. As needed, case managers with expertise in physical or behavioral health care will support lead case managers where there are secondary diagnoses. If the Enrollee is under the age of six (6), the lead case manager will have expertise in early childhood mental health or access to a consultant with expertise in infant and early childhood mental health. (2.7.9.1)
2. Physical and behavioral health case managers are located and based in Louisiana to allow for integration of Case Management for Enrollees with both physical and behavioral health care needs. UHC C&S LA Health Plan may request exceptions in writing to this requirement for individual case managers. (2.7.9.2)
3. Care team may include other Enrollees according to Enrollee's specific care needs and goals identified in the POC. Team Enrollees may include:

    - Primary care provider; (2.7.9.3.1)
    - Behavioral health providers; (2.7.9.3.2)
    - Specialists; (2.7.9.3.3)
    - Pharmacists; (2.7.9.3.4)
    - Community health workers; (2.7.9.3.5)
    - Home and community-based service providers and managers; (2.7.9.3.6)

- Housing Specialists if the Enrollee is identified as homeless; and (2.7.9.3.7)
- State staff, including transition coordinators. (2.7.9.3.8)

4. Multi-disciplinary teams meet at regular intervals as identified in the POC, based on the individual's care needs. Multi-disciplinary teams meet at least monthly for Enrollees in Tier 3 Case Management and quarterly for Enrollees in Tier 2 Case Management. (2.7.9.4)
5. When possible, the team will meet in person but, when necessary, team Enrollees may participate in telehealth or telephonic meetings.

J. Transitioning Between Tiers

Inclusion of a process for graduation from Tiers 2 or 3 of Case Management to a lower tier, as an enrollees ongoing Case Management needs are reduced bases on the Enrollee's POC; Case managers will continuously monitor the enrollee's health status, reassessments, and POC updates during regular touch points. Case managers works with the enrollee and the multi-disciplinary team to look for indications the enrollee can move to a lower tier of case management or that a higher level is needed. Indications that an enrollee may be ready to move to a lower level of care management include evidence that the drivers of utilization, such as homelessness, have been addressed, goals in their POC are achieved, adherence to treatment plans, and resources have been accessed (e.g., transportation). Enrollees who could benefit from tier escalation can be identified by changes to their living situation, recent acute events such as hospitalization or surgery, or emerging SDOH needs. (2.7.10.12)

B.K. Case Closure

2.1. Case Management cases will be evaluated for closure when the following criteria and protocols are met (2.7.10.9):

- b. Completion of goals as defined in the POC;
- c. Transfer to a long-term care facility, loss of eligibility/, change in health plan, Fee-For-Service (FFS or another Managed Care Organization),), transition to other MCO, death, or disenrollment;
- d. Member declinesEnrollees decline participation or requests to withdraw from case management for any reason;
- e. Unable to reach memberEnrollee as defined by contact/, unable to contact process, contract and/or after not less than three consecutive telephonic and/or one written attempt over a two-week period.; and
- f. Unsafe environment and or circumstances for the CMCase Manager not due to psychiatric condition requiring treatment services.

3.2. To ensure continuity of care, if a memberEnrollee transitions to another health plan Managed Care Organization (MCO) or FFS Medicaid), the care manager will facilitate transition with transition coordinator to the new health plan. The CM will share the memberEnrollee's care plan and historical utilization data, upon request, will be shared with the new health plan. as requested. This data will be shared per Health Insurance Portability and Accountability Act (HIPAA) guidelines.

5.3. If the member'sEnrollee's case is closed due to loss of eligibility, the CM will educate the memberEnrollee regarding the existence of community-based organizations or alternate resources for receiving care. This includes children or adolescents that may have a change in benefits or coverage as they transition to adulthood.

~~7.~~4. The ~~member~~Enrollee, providers ~~and~~, or treating specialists will be notified of case closure including the reason for case closure at the time the case is closed.

~~C.~~L. **Satisfaction with Case Management**

2. ~~Members~~Enrollees who accept Case Management Services and are actively engaged in ~~Case Management~~case management will be contacted to complete ~~a member~~an Enrollee satisfaction survey.

~~4.~~3. Responses to the survey will be compiled quarterly and annually. The data will be analyzed and opportunities for improvement will be identified based on ~~member~~Enrollee feedback. A plan will be developed outlining interventions to address areas of identified for improvement. The plan will also include a plan to re-measure the effectiveness of interventions.

4. Overall scores will be provided to the CM and Health Plan Leadership. The overall survey results will be shared with the Case Management Team. Aggregate results will be reviewed and approved by appropriate health plan and national committees.

~~5.~~

~~D. Case Management Documentation~~

~~1. All documentation will occur into the case management system.~~

~~2. The case management system will auto document the staff member's name, date and time of interaction for each entry in the member's record. The time of interaction will be manually entered by the clinician in narrative case notes if not captured by the system.~~

~~All interactions with members, providers, and medical directors will be documented within 24 hours of the interaction.~~

~~3. Documentation should reflect the CM process as outlined in the health plans policies.~~

~~3. Only medically acceptable, uniform abbreviations may be used in documentation.~~

~~II.~~V. **REFERENCES:**

~~1.~~ NCM ~~001 RIDER LA 001 High-Risk~~(Nurse Case ~~Management~~

~~3. NCM 024 RIDER LA 024 Children and Youth with Special Healthcare Needs Care Coordination and Transition Planning~~

~~5.~~1. ~~LA 002.4 Special Health Care Needs Membership~~Manager) Policy Rider 002

~~7. CONTRACT BETWEEN STATE OF LOUISIANA – LOUISIANA DEPARTMENT OF HEALTH Bureau of Health Financing AND UnitedHealthcare of Louisiana, Inc. dba United Healthcare Community Plan Effective 01/01/2020~~

~~9.~~ Model Contract ~~Amendment # 3, Attachment B3 Effective 12/01/2020~~

~~11. Contract Amendment # 5, Attachment B5 Effective 01/01/2021~~

~~13. Contract Amendment # 6, Attachment B6 Effective 01/01/2021~~

~~15.~~2. 2022 ~~NCQA Accreditation Standards, PHM 5: Complex Case Management Element B, C, D, E~~RFP (Request for Proposal)

~~16. Model of Care Scoring Guidelines, MOC 2 Care Coordination Element C and D~~

~~42 CFR 438.208 Coordination and Continuity of Care~~

~~17. 42 CFR 438.62 Continued Services for Enrollees~~

~~III.~~VI. **APPROVED BY:**

Julie Monaco MD ~~March 07, 2022~~

Julie Morial, MD Date
Chief Medical Officer
Louisiana Community and State

~~March 07, 2022~~

~~Nicole Thibodeaux~~

LaMonica Johnson, DNP, MHA, RN ~~BSN CCM~~ Date
Interim Director of Clinical Services
Louisiana Community and State

~~V.~~VI. REVIEW HISTORY:

Effective Date	Key update from Previous Version	Reason for Revision
~~12/29/2021~~ 10/28/2022	~~Revision date update. Format corrections.~~Added contract language for tiered case management process. Added contract language for HNA	~~Annual Review.~~ Contract implementation for 2023
~~02/08/2022~~	~~Reviewed national policy. Removed time frame section E-1. Added reference sources 2 and 8 – 11.~~	~~Periodic Review.~~