SOMOS Your Health, LLC ("MSO")
Department Care Management
Policy Number 101.2

Title

Case Management Care Plans and Assessment

Review Procedure

No less than annually and as needed as determined by ongoing monitoring and evaluation of the Case Management (CM) process that include continued risk stratification and reassessment, the Director of Care Management will review and ensure compliance with all applicable state and federal laws and regulations. The policy will be reviewed and approved by the Quality Management (QM) Committee.

REVIEW AND APPROVAL HISTORY						
VERSION	**AUTHOR**	**REVIEWED BY**	**REVIEW DATE**	**APPROVED BY**	**APPROVAL DATE**	**DESCRIPTION OF CHANGE**
1.0	**Richard Petrucci, MD**	**Quality Committee**	**03/28/23**	**Quality Committee**	**03/28/23**	

General Statement of Policy

SOMOS Your Health LLC (the "MSO") is a management services organization that has contracted with managed care companies ("MCOs") to provide certain services on behalf of the MCO. SOMOS will provide available services to members managed by SOMOS and is not required to provide coverage for benefits not otherwise covered. This policy describes the SOMOS Care Management (CM) Department's policy for providing case management services for SOMOS managed members in accordance with 18 CRR-NY 505.16 of the New York Codes, Rules and Regulations, 42 CFR §438.208 of Title 42 of the Code of Federal Regulations and 15.6 of Section 15.6 in the New York Managed Medicaid Contract.

Contacts/Scope

Policy CM 101.2 is intended to provide guidance on risk stratification and assessment requirements to healthcare providers, SOMOS CM Department and to current and future eligible SOMOS managed members. The Chief Medical Officer (CMO) and the Director of Care Management provide oversight of the CM Department's process.

This policy applies to the following populations:

I. Members newly enrolled in Medicaid to be managed by SOMOS.
II. Members whose healthcare provider leaves the SOMOS network.
III. Members who were previously enrolled in a Medicaid managed care plan and receiving Long Term Support Services (LTSS).
IV. Members with chronic illnesses and physical or developmental disabilities.

V. Transition of care between care settings including appropriate discharge planning for short term and long-term hospital and institutional stays.
VI. Members who are identified as persons who need LTSS or persons with special health care needs.

Glossary/Definitions

Case Manager (CM): An individual with two years' experience in a substantial number of activities including the performance of assessments and development of case management plans.[1]

Case Management: Collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet comprehensive medical, behavioral, and social needs of patients and their families while promoting quality, cost-effective outcomes.[2]

Complex Case Management: Case Management program aimed at patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services[3].

Critical Incidents: Event or occurrence that causes harm to an individual or LTSS provider or serves as an indicator of risk to a patient or LTSS provider's health or welfare, such as abuse, neglect, and exploitation.[4]

Health Risk Assessment: Screening tool to help identify and evaluate health risks and provide individual health promotion interventions.

Individualized Care Plan (ICP)/Individualized case management plan: Plan of care developed by a member and/or a member's ICT or health plan that includes prioritized goals that considers the patient's and caregiver's goals, preferences and desired level of involvement in the case management plan, time frame for reevaluation, resources to be utilized, including the appropriate level of care, planning for continuity of care including transition of care and transfer between settings and collaborative approaches to be used, including family participation.[5]

Interdisciplinary Care Team (ICT): Participation of the PCP and support staff along with the member's family in maintaining the member's ICP.

Long Term Services and Supports (LTSS): Provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility or other institutional setting.[6]

[1] N.Y. Comp, Codes R. & Regs. Tit. 18 § 505.16
[2] NCQA 2020 CM Standards and Guidelines, Appendix 4 Glossary
[3] NCQA 2020 CM Standards and Guidelines, Appendix 4 Glossary
[4] NCQA 2020 CM Standards and Guidelines, Appendix 4 Glossary
[5] NCQA CM 3, Element A
[6] 42 CFR § 438.2

Procedures

Members may be referred for evaluation of Case Management Program through discharge planning and care transitions, MCO referral(s), physicians, members' caregivers, and families and from data sources such as claims or encounter data, pharmacy data, lab data or hospital discharge data.

To ensure that risk stratification and assessment requirements are provided according to best practice standards, SOMOS develops and implements written policies and procedures, consistent with best practices and that comply with state and federal law as well as SOMOS's contractual obligations.

SOMOS stratifies the population into subgroups based on data extracted from the health risk assessments, completed care management plans, and using the proprietary algorithms of Health Catalyst. The data is analyzed to determine service options that would best contribute to the desired outcomes of the population.

Risk levels include:

1) High Risk:
    a) Program/Service: **Complex Case Management**
    b) Goal: Maximize the ability of the population to return or remain in the community setting, assess polypharmacy and medication management, reduce preventable readmissions, coordinate benefits and services
2) Moderate Risk:
    a) Program/Service: **Essential Case Management, Transition of Care Services, Social Services**
    b) Goal: Maximize the ability of population to remain in the community through the use of evidenced based self-management tools designed to address Members with multiple chronic conditions, transitions of care, multiple social needs, and identified care gaps.
3) Emerging Risk:
    a) Program/Services: **Care Coordination, Condition-specific Quality Campaigns**
    b) Goal**:** Maximize the ability of the population to remain at current level of functioning by implementing care Coordination interventions designed to focus on chronic condition management, promoting health, and reducing risk.
4) Low Risk:
    a) Program/Service: **Health and Wellness, Care Coordination, Provider Interventions**
    b) Goal: Maximize the ability of the population to remain at current level of functioning and low risk identification using Provider and payor collaboration to address preventative health needs through self-management.

Case management functions and services are determined by the member's circumstances and therefore must be determined specifically in each case and with the member's agreement and involvement. Case

management services should not be duplicated with other agencies and should not be implemented for the purpose of creating a demand for unnecessary services or programs. A separate case record must be established for each member receiving case management services and must document each case management function provided.

(1) Intake and screening.
This function consists of the following activities:

(i) The initial contact with the member.
(ii) Provide information concerning case management.
(iii) Explore the member's interest in the case management process.
(iv) Determine if the member is included in the provider's targeted population.
(v) Identify potential payors for services.
(vi) Identify potential duplication of case management services with other agencies/programs (e.g., medical assistance program, Federal home, and community-based waiver)
(vi) Initiate a health risk assessment screening.

(2) Assessment.
A health risk assessment screening must be completed by a case manager within 15 days of the date of the referral. An assessment requires the case manager to draw and document conclusions from the information collected. The case manager, with the member's permission be able to obtain additional information from various sources:

(i) Assess member's service needs including past hospitalizations and major procedures and surgeries, significant past illnesses and treatment history, and relevant past and present medications.
(ii) Activities of daily living (must include at least six (6) ADLs (i.e., bathing, dressing, transferring, feeding, continence, going to the toilet).
(iii) Mental health status to include substance use disorders, member's ability to communicate and understand instructions and ability to process information about their illness.
(iv) Cultural and spiritual beliefs (health beliefs and practices), linguistic (preferred languages, healthy literacy), and socioeconomic needs (i.e., SDOH such as housing, transportation, financial barriers, domestic violence, etc.).
(v) Visual and hearing needs.
(vi) Need to assess adequacy, availability, and skills of caregivers' involvement (paid or unpaid).
(vii) Needs for referrals to appropriate community resources and other agencies for services outside the scope of responsibility of SOMOS. Determine member's eligibility for and assess availability of community resources to include at a minimum community mental health, transportation, wellness organization, nutritional support, and palliative care programs.
(viii) Information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the member.
(viii) Needs for facilitation of timely access to primary care, specialty care, durable medical equipment (DME), medications and other health services needed by the member.
(ix) Needs for communication among member's health care providers.
(x) Needs for coordination of care across all settings.
(xi) Needs for providing other activities or services, such as LTSS services to assist the member in optimizing their health status.

(xii) Life-planning activities such wills, living wills or advance directives, healthcare powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment forms.

(a) The case manager will document whether the member has in place or has considered the need for wills, living wills or advance directives, Medical or Physician Orders of Life Sustaining Treatment forms and health care powers of attorney.
(b) If the activities are determined to be appropriate, the case manager will document what activities the patient has performed and what documents are in place. If the life-planning activities are deemed not to be appropriate, the reason(s) will be documented in the care plan.
(c) SOMOS will make available and provide the member with written material regarding advance care planning via fax or postal mail.

(3) Case management plan, implementation, and coordination.

A written individualized case management plan for each member must be completed and implemented within 30 days of the date of referral. The written care plan shall incorporate summarized findings from the assessment. The case management activities required to establish a comprehensive individualized written case management plan and to affect the coordination of services include:

(i) Identify the nature, amount, frequency, and duration of the case management services required by the member.
(ii) Select the nature, amount, type, frequency, and duration of services to be provided to the member, with the participation of the member, the member's informal support network, and providers of services.
(iii) Specify realistic and comprehensive long-term and short-term goals to be achieved through the case management process.
(iv) Identify participants in the member's interdisciplinary care team to include at minimum health care providers such as PCP, specialty care, family member(s), caregivers as appropriate, through case conferences to encourage exchange of clinical information and to assure:

(a) The integration of clinical care plans throughout the case management process.
(b) The continuity of service.
(c) The avoidance of duplication of service (including case management services); and
(d) The establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational, and financial needs of the member.

(v) Secure services determined in the case management plan to be appropriate for the member through referral to those agencies or persons who are qualified to provide the identified services.
(vi) Assist the member with referral and/or application forms required for the acquisition of services.
(vii) Being an advocate and mediate for the member with all providers of services.
(viii) Develop alternative services to ensure continuity in the event of service disruption.
(ix) In addition to conducting an assessment and creating an individualized case management plan, the case management staff may visit the member at home or in other community settings for interim reassessments as deemed necessary.
(x) Identify and prioritize crisis incidents and implement crisis intervention with appropriate staff and agencies, when necessary, to include at minimum:

(i) Assess the nature of the member's circumstances (e.g., physical abuse, attempted suicide, sexual abuse or exploited)
(ii) Determine the member's emergency service needs.
(iii) Revise the case management plan, including any changes in activities or objectives required to achieve the established goal.
(iv) Track the critical incident from the initial report through follow-up.

(4) Reassessment of case management services.
A reassessment of the member's need for continued case management and other services must be completed by the case manager every six months, or sooner if required by changes in the member's condition or circumstances to include:

(i) Verifying that quality services, as identified in the case management plan, are being received by the member, and are being delivered by providers in a cost-conscious manner.
(ii) Assuring that the member is adhering to the case management plan.
(iii) Ascertaining the member's satisfaction with the services provided and advising the preparer of the case management plan of the findings if the plan has been formulated by a practitioner.
(iv) Collecting data and documenting in the case record the member's progress.
(v) Ascertaining whether the services to which the member has been referred are and continue to be appropriate to the member's needs and making necessary revisions to the case management plan.
(vi) Making alternate arrangements when services have been denied or are unavailable to the member.
(vii) Assisting the member and/or provider of services to resolve disagreements, questions, or problems with implementation of the case management plan.
(viii) Changes in the member's health status may trigger a reassessment. Triggers for reassessment may include, but not limited to:

a) An inpatient hospital admission
b) An emergency room visit
c) Change in medications
d) Change in health condition/medical treatments
e) Change in the member's living situation
f) Request for additional services.

(5) Continuity of service.

(i) Case management services must be ongoing from the time the member is accepted by the case management agent for services to the time when:

(a) The coordination of services provided through case management is not required or is no longer required by the member.
(b) The member moves from the social services district.
(c) The long-term goal has been reached.
(d) The member refuses to accept case management services.
(e) The member requests that his/her case be closed.
(f) The member is no longer eligible for services.
(g) The member's case is appropriately transferred to another case manager with another organization or service area.

(ii) Contact with the member or with a collateral source on the member's behalf must be maintained by the case manager at least monthly, or more frequently.

(6) Monitoring and Evaluation

The individualized care plan is monitored and evaluated on a continuous basis and progress towards goals is evaluated and measured. The risk stratification process and corresponding care plans are modified accordingly, to provide the member with the skills and strategies for self-care and to help the member achieve the optimum level of health and function by preventing chronic disease, stabilizing current chronic conditions, and preventing acceleration to a higher risk category with higher costs.

Remediation

Case management services is monitored and evaluated on a continuous basis to ensure compliance with all applicable state and federal laws and regulations. Progress and outcomes of case management services received are reviewed and discussed in the QM Committee on a quarterly basis. Program quality is monitored through monthly case audits on randomly selected cases to ensure compliance with program guidelines. In the event non-compliance is discovered, immediate investigation of the root cause commences and is reported to the Director of Care Management and Chief Medical Officer and shared with the QM Committee. Audit findings are used to share with the individual and is used as training and guidance for the CM staff.

Documentation/Attachments

Checklists or monitoring tools—If the SOP is overseen with a checklist or some other tool, reference it in the SOP and/or attach it. This may include an ongoing monitoring tool as well as an annual audit tool.

Governance

N.Y. Comp, Codes R. & Regs. Tit. 18 § 505.16
42 CFR §438.208
15.6 Service Continuation of Section 15 in the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract
21.10 Provider Status Changes in the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract
N.Y. PHL § 4403(6)(e)
NCQA 2020 CM Standards: CM 2, Element D
NCQA 2020 CM Standards: CM 3, Element A
NCQA 2022 HP Standards: LTSS 1, Element C
NCQA 2022 HP Standards: LTSS 1, Element H
NCQA 2022 PHM Standards: PHM 5, Element C

Whom Do I Contact with Further Questions?

Chief Executive Officer
Chief Compliance Officer
General Counsel
Chief Medical Officer
Director of Care Management