SOMOS Your Health, LLC (“MSO”)
Department Care Management
Policy Number 101.8

Title

Complex Case Management

Review Procedure

No less than annually and as needed as determined by ongoing monitoring and evaluation of the complex Case Management Program, 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 the 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 complex case management services and for SOMOS managed members to prevent the delay, or interruption, of medically necessary covered services 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 101.8 is intended to provide guidance on complex case management 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.

The areas of focus in complex case management include:

I. Members with frequent emergency room utilization defined as 3 or more visits for the same reason, in a 3-month span.
II. Members with multiple chronic illnesses and comorbidities.
III. Members requiring assistance to navigate the healthcare system and resources for appropriate delivery of care and services.

IV. Members identified as persons utilizing Long Term Services and Supports (LTSS) resources.

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]

Procedures

[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

To ensure that complex case management is 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.

Complex 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. There is no requirement for members to be enrolled in any other programs to qualify for complex case management.

Complex case management is made available to members who have been placed in the "High Risk" category through stratification processes, assessment activities and direct referral activities. Members that fall into the "High Risk" category have chronic illness with multiple co-morbidities, 3 or moreER Visits, 2-3 Hospitalization in the last 6 months and 7+Prescribed medication. The goal of case management is to assist members in regaining optimum health and/or improved functional capability, in the right setting and in a cost-effective manner through active management of disease and social factors affecting health, assess polypharmacy and medication management, reduce preventable readmissions or emergency room use, coordinate benefits and services, and ensure safe transitions and coordination through the continuum of care.

Members may be referred for evaluation of Complex Case Management Program through discharge planning and care transitions, MCO referral(s), physicians, completion of the initial health risk assessment conducted by SOMOS's general case management program or members' caregivers and families. Members referred to the Complex Case Management Program would require completion of an initial health risk assessment tool and care plans (refer to Policy Number CM 101.2 Care Management Care Plans and Assessment).

The developed care plans are specific to the needs identified and ranked by priority during the assessment and include goals and level of involvement discussed with the member and/or families or caregivers. Each of the ranked issues will indicate a target completion date and will identify any known barriers to achieving the goal within the targeted completion timeframe. The care plan will outline the actions the member and/or families or caregivers have agreed to take in managing the condition(s) and issues. A reassessment of the member's need for continued complex case management and other services must be completed every six (6) months, or sooner if required by changes in the member's condition or circumstances (refer to Policy Number CM 101.2 Care Management Care Plans and Assessment). As part of the assessment and reassessment process, discussions about life planning activities and use of LTSS resources are included.

Remediation

The Complex Case Management Program is monitored and evaluated on a continuous basis to ensure compliance with all applicable state and federal laws and regulations. Progress and outcomes of the complex 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 CMO 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
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 G
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