SOMOS Your Health, LLC ("MSO")
Department Care Management
Policy Number 101.9

Title

Behavioral Health Case Management & Health Home Services

Review Procedure

No less than annually and as needed as determined by ongoing monitoring and evaluation of Behavioral Health Case Management & Health Home Services, 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 continuity of care 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 101.9 is intended to provide guidance on behavioral health (BH) case management and health home services 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 who have had three (3) admissions in a 2-month span for any of the following BH conditions:
   a. Substance use disorders (SUD)
   b. Alcohol abuse
   c. Major depression

d. Psychotic break for Schizophrenia

II. Members experiencing homelessness.

III. Members who have had their first break – first episode psychosis (FEP).

IV. Members who are transitioning from foster care or aging out of the children's system – transition age youth (TAY).

V. Members who provide consent to meeting eligibility criteria for the BH Case Management Program and are referred to a Health Home for additional care coordination.
   a. New York State's Health Home Program for Medicaid requires members to have one (1) or more of the following in order to be eligible to be enrolled in a Health Home:
      i. Two (2) or more chronic conditions (e.g., mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25 or other chronic conditions).
      ii. One (1) qualifying chronic condition (e.g., HIV/AIDS) and the risk of developing another.
      iii. One (1) serious mental illness.

VI. Members who are identified as persons who need Long Term Services Support (LTSS) or persons with special health care needs.

Glossary/Definitions

Case Manager: 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 (CM): 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.

Health Home: A 'Health Home' is not a physical place; it is a group of health care and service providers working together and communicating with each other to make sure members receive the care and

[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

services to stay healthy. The coordination of a member's care is done through a dedicated care manager who oversees and coordinate access to all of the services a member requires.[5][6]

Individualized Care Plan (ICP)/Individualized case management plan/person-centered plan: Plan of care developed by a member and/or a member's ICT or health plan that includes member's strengths, abilities and preferences, 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.[7] [8]

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.[9]

Procedures

To ensure that behavioral health case management and health home services 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.

New York State's Health Home Program requires at a minimum the provision of coordinating services with health care providers, mental health, and substance abuse providers, need for medications including refills, assist with housing and social service programs (i.e., food, benefits, transportation).[10] Providers can refer members who meet the eligibility criteria that may benefit from case management to SOMOS. Additionally, consenting members meeting eligibility criteria will be referred to a Health Home for additional care coordination. If a patient is in need of case management and is enrolled in a Health Home, SOMOS will link the member to the Health Home or will work with the provider to ensure this happens. If the provider is unable to link members to these supports directly, the provider is expected to reach out to SOMOS to ensure member needs are met.

SOMOS's Health Home At-Risk Project utilizes the behavioral health complex case management functions and services to address the complex needs of members who do not meet New York State

[5] New York State Medicaid Program, Comprehensive Medicaid Case Management Policy Guidelines, January 11, 2019, Version 2019-1
[6] Health.ny.gov/health_care/Medicaid/program/Medicaid_Health_homes
[7] NCQA CM 3, Element A
[8] NCQA LTSS 1, Element E
[9] 42 CFR § 438.2
[10] Health.ny.gov/health_care/Medicaid/program/Medicaid_Health_homes

eligibility requirements for Health Home participation but do meet federal eligibility participation criteria. Such members show patterns of repeated hospital and emergency department (ED) utilization that often reflect the effects of social determinants of health (SDOH), medical and behavioral health needs not being met, including substance abuse issues. In the absence of a formal health home to provide supportive services, the project brings an array of integrated care management support services to address the needs.

The project addresses the high-risk population that have:

- One (1) chronic condition and are at risk for a second, or
- One (1) serious and persistent mental health condition

Members are identified through various sources such as:

- Diagnosis codes recorded in the PCP's Electronic Health Record (EHR)
- Disease registries
- Claims data from New York State feeds to SOMOS
- Data exchange with Medicaid Managed Care Organizations (MCO's)

Member's agreement and involvement is required for participation in the SOMOS Health Home project. Policies and procedures for the case management plan for the project include developing individualized person-centered care plans with involvement from family members and other supports identifying medical, behavioral health, and social service needs and network supports. 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.

SOMOS has a system in place with hospitals and residential/rehabilitation facilities in their network for prompt notification of a member's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting. SOMOS has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers, and community-based services to help ensure coordinated, safe transitions in care for members who require transfers in the site of care. SOMOS utilizes HIT (Health Information Technology), as feasible, to facilitate interdisciplinary collaboration among all providers, the member, family, care givers, and local supports. SOMOS has a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes, at a minimum, receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, care manager verification with outpatient provider that the member attended the appointment, and a plan to outreach and re-engage the member in care if the appointment was missed.

Members may additionally be referred to home and community-based services (HCBS). For adults, on completion of the state-mandated assessment, the Health Home is expected to give patients a choice of at least three (3) providers for the HCBS service. Once linked to the service, the HCBS provider contacts SOMOS for authorization. Additionally, for Health and Recovery Plan (HARP) members, the Health Home completes the Community Mental Health Assessment (InterRai) and offers the member choices of in-network HCBS providers if the assessment indicates a need for HCBS. Assessments must be conducted by a Health Home or other state designated entity in compliance with conflict free case management

requirements. For children who may be referred to HCBS, the assessment is used to determine whether the patient is eligible for HCBS services and for which type of HCBS. SOMOS has a dedicated team of care managers that are properly trained to review assessments, HCBS eligibility determinations, and plans of care for children. SOMOS will review the assessment and care plan with the Health Home, ensure it is comprehensive, authorize HCBS services, and inform the HCBS provider, the member, and the Health Home. The HCBS provider will work with SOMOS and Health Home to ensure that the member's plan of care for HCBS is person-centered. Health Homes are expected to incorporate the HCBS plan of care within the member's overall plan of care. The plan of care is expected to be strength-based and recovery-focused and is expected to take member's wishes and choices into consideration. HCBS and Health Home plans of care will be reviewed to ensure that the plan is person-centered and that the member is progressing with identified goals, and if not, that barriers are being addressed and goals are modified as needed.

(**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. Provide applicable resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources.
(vii) If applicable, referral to home and community-based services (HCBS) upon completion of state-mandated assessment.

(2) Assessment.
A health risk assessment screening must be completed by a dedicated case manager within 15 days of the date of the referral. This dedicated case manager has overall responsibility and accountability for coordination all aspects of the member's care. The case manager, with the member's permission be able to obtain additional information from various sources:

(i) Assess member's service needs including medications.
(ii) Activities of daily living.
(iii) Mental health status to include substance use disorders.
(iv) Cultural, linguistic, and socioeconomic needs.
(v) Visual and hearing needs.
(vi) Need to assess adequacy of appropriate involvement of caregivers (paid or unpaid).
(vii) Needs for referrals to appropriate community resources and other agencies for services outside the scope of responsibility of SOMOS.
(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.

Commented [PW1]: N.Y. Comp. Codes R. & Regs. Tit. 18 § 505.16 (d)(1)(iii)
42 CFR § 438.208 (b)(3)

(ix) Needs for communication among member's health care providers by describing communication methods and frequency between case manager and treating providers.
(x) Identify and address coordination of care with other providers/services when conflicting treatment is being provided.
(xi) Ensure Health Home provider(s) are available 24 hours/seven (7) days a week to provide information and emergency consultation services to the member.
(xii) Ensure Health Home provider ensures availability of priority appoints for Health Home members to medical and behavioral health care services within their Health Home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.
(xii) Needs for providing other activities or services, such as LTSS services to assist the member in optimizing their health status.
(xiii) Life-planning activities such a will, living wills or advance directives, healthcare powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment forms.

(**3) <u>Case management plan, implementation, and coordination</u>.**
A written individualized case management plan for each member must be completed and implemented within 30 days of the date of referral. 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 active 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 and timeframes for improvement 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 (e.g., behavioral health care provider), 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.
  (e) Availability of self-help recovery, peer supports, support groups and self-care programs.
(v) Establish regular case review meetings, to include all members of the interdisciplinary team. Technology conferencing tools such as audio, video and/or web deployed solutions with security protocols and precautions to protect PHI will be utilized.
(vi) 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.

(vii) Assist the member with referral and/or application forms required for the acquisition of services.
(viii) Being an advocate and mediate for the member with all providers of services and taking into appropriate consideration for language, literacy and cultural preferences.
(ix) Develop alternative services to ensure continuity in the event of service disruption.
(x) 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.
(xi) 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 (6) 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) Identifying the member's progress in adhering and meeting goals and changes 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 are 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 goal(s) 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. The Health Home provider has a system to track and share information and care needs across providers and to monitor outcomes and initiate changes in care, as necessary, to address the individual's needs.

Health Information Technology for Health Home

Use of Health Information Technology (HIT) to Link Services Health Home providers will make use of available HIT and access data through the regional health information organization/qualified entities to conduct these processes as feasible, to comply with the initial standards for implementation of Health Homes. In order to be approved as a Health Home provider, applicants must provide a plan to achieve the final standards within eighteen (18) months of program initiation.

Initial Standards:

1). Health Home provider has structured information systems, policies, procedures, and practices to create, document, execute, and update a plan of care for every patient.
2). Health Home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.
3). Health Home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.
4). Health Home provider makes use of available HIT and accesses data through the regional health information organization/qualified entity to conduct these processes, as feasible.
5). Health Home provider gives the individual access to plans of care and options for accessing clinical information.

Final Standards:

1). Health Home provider has structured interoperable health information technology systems, policies, procedures, and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.

2). Health Home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.

3). Health Home provider will be required to comply with the current and future version of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange.

4). Health Home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE (Qualified Entities) provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).

5). Health Home provider supports the use of evidence based clinical decision-making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance.

Additional Health Home Standards and Requirements

Health Homes must have policies and procedures in place to satisfy each of the requirements below. Health Homes shall ensure compliance by their subcontracted care management providers with applicable policies and procedures or require such providers to establish additional policies and procedures to ensure compliance with these requirements.

1). Lead Health Homes must identify a single point of contact and establish communication protocols with Managed Care Organizations (MCOs).

a) Health Homes must use information and performance data, including outreach and enrollment data, dashboards and other data made available through Medicaid Analytic Performance Portal(MAPP), and hold periodic meetings with care managers and MCOs to evaluate and improve performance.

b) Health Homes should ensure care managers have access to other pertinent administrative data that may not be available in MAPP to inform real time decision making regarding outreach and engagement efforts.

c) The Health Home should have an identified point of contact and clear processes for community referrals (inclusive of individuals/providers who do not have access to the Children's Health Home Referral Portal) including (but not limited to) from Local Government Units/Single Point of Access (LGUs/SPOA), Local Department of Social Services (LDSS), inpatient settings, forensic releases, pediatricians, and community providers to coordinate timely linkage to a care manager, with special consideration for individuals receiving Assisted Outpatient Treatment(AOT), and other specific populations as described in this document.

2). Health Homes must have policies and procedures in place for responding when critical events occur, including when a member 1) has presented at a hospital ER/ED and was not admitted 2) is admitted to inpatient hospital or 3) when the member is in crisis and presents at a location that provides additional opportunities to outreach, connect to services, and engage the member. Such policies and procedures must incorporate information that will become available through MAPP referral portal and MAPP alerts.
3). Health Home care management providers must contact enrollees within 48 hours of discharge from an inpatient unit, ER, hospital, residential, detention, etc.(when they are notified or become aware of the admission), or sooner if clinically indicated, to facilitate the care transition. Health Home care managers shall engage in the discharge planning process, including the review of upcoming appointment dates and times, medication reconciliation, and potential obstacles to attending follow-up visits and adhering to recommended treatment plan.
4). When Health Home care management providers are notified or become aware of an enrollee's admission to a detox facility, they must attempt to make a face-to-face contact 1) during the stay of an enrollee that has been admitted to a detox facility and 2) within 24 hours of discharge from a detox facility to ensure that the enrollee is aware of follow-up appointments and to provide supports for getting to appointments.
5). As a best practice, *Health Homes Serving Adults* should communicate with care management providers to assess their capacity to accept new referrals prior to sending them assignments. Such communication will help ensure that the care management providers will be able to act promptly in their efforts to locate and enroll prospective members. As a best practice, after receipt of a referral from a Health Home, Health Home care management providers should begin outreach immediately.

> For Health Homes Serving Adults, if the Health Home sends an assignment list during the 1st to the 15th of the month, outreach should begin immediately. If Health Home sends an assignment list on the 16th of the month or later outreach can begin immediately but may be initiated the following month to take advantage of the full month of outreach, but no later than the 5th business day of the following month. Health Homes shall require documentation from Health Home care management providers regarding any failure of the care management provider to commence outreach activities within these timeframes. Such documentation shall state the reasons for not meeting such timeframes and shall propose a corrective action plan. Health Homes shall thereafter report such deficiencies and corrective action plans to the MCO and the State.

6). Health Home care management providers must assign care managers to enrollees based upon care manager experience and defined member characteristics including, but not limited to, acuity, presence of co-occurring or co-morbid Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED),Substance Use Disorder (SUD) or co-occurring medical co-morbid conditions, and patterns of acute service use.

Remediation

Behavioral health case management and health home services are monitored and evaluated on a continuous basis to ensure compliance with all applicable state and federal laws and regulations.

Progress and outcomes of the behavioral health and health homes 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 to 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 a 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
21.27 Health Home of Section 21 in the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract
New York State Department of Health, Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations, updated May 1, 2022
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