SummaCare

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Policy Number: HSCM0007
Manual Name: SMSO Policy Manual
Policy Name: Complex Case Management Program
Approved By: Charles Zonfa
Last Revised: 7/8/25

SMSO Policy Manual
COMPLEX CASE MANAGEMENT PROGRAM DOCUMENTATION AND OUTREACH

Executive Sponsor:	Chief Medical Officer
Issuing Department:	Clinical Management
Gate Keeper:	Director, HSM Clinical Management

COMPLIANCE STATEMENT:

Enforcement:	All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.
Review Schedule:	This policy will be reviewed and updated as necessary and no less than every two years.
Monitoring and Auditing:	The Issuing/Collaborating Department(s) is responsible for monitoring compliance with this policy.
Documentation:	Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

- ☒ SummaCare
- ☐ Summa Management Service Organization (SMSO)
- ☐ Apex
- ☒ Summa Insurance Company

Line of Business:

- ☒ Commercial Groups
- ☐ Medicare Supplemental
- ☒ Off-Exchange
- ☒ Medicare
- ☒ On-Exchange
- ☒ Self-Funded

1.0 Purpose:

1.1 To ensure quality/practice standards are met in the provision of care and services to members.

1.2 To monitor utilization of resources to ensure appropriate deployment of health care dollars.

1.3 To identify specific members who would benefit from complex case management.

1.4 To identify the specific members who would benefit from care coordination.

2.0 Policy:

2.1 The Clinical Management Area will use criteria to proactively identify members who could benefit from case management and from care coordination and provide the level of intervention tailored to their needs in compliance with local, state, and federal regulations and accrediting bodies.

2.2 The Clinical Management plan of care is available, upon request, to all other providers involved in the member's care.

3.0 Procedure:

3.1 **Identification Date for Complex Cases (NCQA anchor date to begin the 30 day clock for beginning the assessment) – see Definitions**

3.2 **Case Management Process and Documentation:**

3.2.1 **New Case Process**

- Discharge Cases: Receive discharge list of possible case management cases daily, limited to case management (CM) criteria. Review accompanying information (e.g. utilization history, comorbidities, past case list, risk information). Review Inpatient UM concurrent review information.
- Proactive Queries: Receive proactive case finding reports (e.g. Case finding spreadsheet) every two weeks.
- ED Treat and Release Reports: Receive reports from select facilities daily for members in the ER as treat and release in the last seven days.
- Observation Reports: Receive reports from select facilities daily for members in observation status.
- Priorities: Each week should include work on new non-ACO High Cost Cases and End-of-Life Cases. The routine Case finding monthly list should be worked next. Referrals will be worked once notified. The admission and readmission lists are looked at daily for case finding.

- Review the known information about the member in *CareManager* by reviewing:

  3.2.1..1 Prior cases, case notes and care plans;

  3.2.1..2 Existing CM Programs (designated by business flags/cases) the member may be enrolled in; and

  3.2.1..3 Authorizations, authorization notes, clinical information

  3.2.1..4 Claims data: Review claims in *PlanCentral* to get an idea of the member's health care utilization patterns and conditions

  3.2.1..5 Eligibility data: Review eligibility in *PlanCentral* to identify plan type and benefits; may also use *Sharepoint* Benefits Site for details as needed.

- Where access to the physician EMR is available, review the Physician plan of care for the member and note items pertinent to case management (CM) or other self-management plans for inclusion in the Plan.

- If research is complete and criteria is not met for case management services:

  3.2.1..6 Enter a note on the case with pertinent information related to the research and reason no call is being made to the member

  3.2.1..7 Close the case with the following nomenclature:
  - Source: Same as above
  - Type: Same as above
  - Priority: Research in Progress
  - Severity: Undetermined
  - Routing: Same as original
  - Closure Reason: Screened Negative
  - Outcome: Criteria Not Met

- If research is complete and criteria is met for case management services:

  3.2.1..1 Contact member to screen/assess all pertinent aspects of the non-complex case management note template

  3.2.1..2 Case nomenclature in *CareManager* is updated as follows:
  - Source: Same as above
  - Type: Same as above
  - Priority: Outreach in Progress
  - Severity: Undetermined
  - Routing: Same as above

- Unable to Contact:

3.2.1..1 If unable to reach member, (i.e., member phone number is not working) contact the Primary Care Physician (PCP) to find out if there is a better phone number for the member or if there is record of an emergency contact person that may be able to help you locate the member.

3.2.1..2 (Note: When identifying a corrected phone number for a member, send the information to be updated in *Amisys*. Use the "Eligibility" Outlook email distribution list for the notification.

3.2.1..3 If unable to reach the member because there is no answer, or a voicemail message is left, add task to attempt contact again within 7 calendar days at a different time of day. If no response from the member within 10 calendar days of the initial outreach, send a CM Unable to Contact letter within 14 calendar days of the initial contact attempt and task to close the case in the next week. If no response in that time period, close case with the following nomenclature:

- Source: Same as above
- Type: Same as above
- Priority: Outreach in Progress
- Severity: Undetermined
- Routing: Same as above
- Closure Reason: Non-Participating
- Outcome: Unable to Contact

3.2.1..4 If the member responds to the letter, continued the CM activity.

- If the member is reachable, meaningful conversation occurs and complex needs are identified, complete the complex case management assessment. The following are required elements to be assessed and may not be skipped:

3.2.1..1 Perform the medical history assessment;

3.2.1..2 Perform the medication reconciliation assessment;

3.2.1..3 Complete disease specific assessment(s) (i.e., Heart Failure, Diabetes, Depression, Asthma/COPD, CKD);

3.2.1..4 Evaluation of available benefits;

3.2.1..5 Evaluation of cultural, linguistic, visual and hearing needs, preferences and limitations;

3.2.1..6 Initial assessment of activities of daily living;

3.2.1..7 Initial assessment of behavioral health status, including cognitive function;

3.2.1..8 Assessment of substance abuse disorder (asking about ETOH, Drug Abuse);

3.2.1..9 Initial assessment of psychosocial issues;

3.2.1..10 Initial assessment of social determinants of health;

3.2.1..11 Evaluation of caregiver resources;

3.2.1..12 Evaluation of community resources;

3.2.1..13 Assessment of life planning activities; and

3.2.1..14 Identification of barriers to meeting goals or complying with the plans.

- Consider candidacy for any of these programs:

3.2.1..1 Summa House Calls or other House Calls programs

3.2.1..2 SummaCare Enhanced Support Program (Palliative Program)

3.2.1..3 Healthy at Home Monitoring Program (Medtronic Home Telemonitoring)

3.2.1..4 Employer programs, including affinity programs (add-on Employer benefits)

3.2.1..5 Supplemental Benefits – Papa Pals, Transportation, Home Safety Devices, Acupuncture, Therapeutic Massage, Over the Counter Benefit and others

3.2.1..6 Other Community Programs

- Establish CM level according to Continuum of Care Guide (see Appendix A). Include other Care Managers (i.e. ACO or value based group care managers) in collaboration, as appropriate.

3.3 **Ongoing Case Management**

3.3.1 <u>When keeping a case open:</u>

- Finalize the care plan and agree with member on next steps. Care plan should include development and communication of a member self-management plan;
- Send CM Enrollment letter, summarizing discussion and next steps;
- Create Initial Complex Case Note to capture NCQA required info regarding how and why this member is being enrolled in case management - Note Type: Care Coordination, Subtype 1: Initial Complex Case Note, Subtype 2: Member. A Data Collection Record will drop in to the bottom of the note; complete all fields and add all other pertinent information in the note body.
- Notify PCP of Enrollment and CM Recommendations via the Physician Electronic Medical Record. Send a letter using the CM/Physician letter template by postal mail when electronic access is not available.
- Call the PCP, appropriate Specialist or designee with anything urgently actionable or to consult for input on a complex case. Be aggressive in integrating case management with the Physician's Plan of Care. Give regular updates to the PCP on the member's progress in case management.
- Set Case Nomenclature as follows:
  - Source: Same as above
  - Type: Same as above
  - Priority: Engaged
  - Severity: Complex Level 1, 2, or 3
  - Routing: Same as above
- Ongoing Contacts Guidelines

3.3.1..1 **Complex Level 3**: Every 1 to 7 days, until member achieves 3 months without an unplanned ER Visit or Inpatient stay, and is keeping follow-up appointments. Then progress to Level 2.

3.3.1..2 **Complex Level 2**: Every 1 to 2 weeks, until member achieves 3 months without an unplanned ER Visit or Inpatient stay, and is keeping follow-up appointments. Then progress to Level 1.

3.3.1..3 **Complex Level 1**: Every 2 weeks to monthly,

- When stepping down from level 2: until member achieves 3 months without an unplanned ER Visit or Inpatient stay, and is keeping follow-up appointments.
- When entering CM at Level 1: Until no further needs.

3.3.1..4 **Non-Complex (Level 0)**: Frequency and duration as appropriate to member needs.

*****Schedule Tasks for follow up contacts*****

- Ongoing Documentation

3.3.1..1 Regularly review care plan with each contact. Address care plan, and discuss and document the member self-management plan during member contacts.

3.3.1..2 Create Ongoing Complex Case Note to capture NCQA required info regarding self-management and goal progress; Note Type: Care Coordination, Subtype 1: Ongoing Complex Case Note, Subtype 2: Member. A Data Collection Record will drop in to the bottom of the note; complete all fields and add all other pertinent information in the note body.

- Attach notes to care plan goals to document progress.
- Complete care plan goals as they are met.
- Complete care plan opportunities as the goals within them are met

- Referrals:

3.3.1..1 Document referrals using the Note Type "Referral OUT".

3.3.1..2 Create a task to follow-up on the referral. When following up on the referral, use the Note Type "Referral Follow-up/CM Outcomes"

3.3.2 When a member in Case Management is hospitalized:

- Share the current problem list and plan of care with the hospital designee (TCC, Case Manager, UR Nurse, Social Worker, etc.) Document discussion in the CM Notes.
- Assist in discharge planning as needed.
- Upon notification of discharge, review the UM Event details and perform outreach to the member to re-establish the plan of care**. Note: Re-Take the Complex Assessment within 30 days of discharge for members in Complex Case Management (NCQA QI 5) who were inpatient at any level (Acute, LTAC, Rehab, SNF) for 30 consecutive days, and adjust the plan of care, based on findings.**

3.3.3 At close of case:

- Review progress and completed goals with the member;
- Finish addressing care plan goals. Indicate met or not met and reason if not met;
- Arrange to have the Member Experience Survey completed at case closure; and
- Inform member and PCP of case closure, summarizing progress and goals achieved.

3.3.3..1 Inform the PCP by phone **or** enter update note in PCP EMR (if access is established) to notify of case closure and member achievements toward goals.

- Add Case Closure Reason and Outcome when closing the cas**e**

3.4 **Quality Monitoring Process:**

3.4.1 Complex cases will be audited on a regular basis for compliance with NCQA standards. Informatics Team will assist in revisions or software content build needed to support compliance with NCQA standards.

3.4.2 Frequency and Responsibility:

Item	Target Case	Focus	Frequency	Responsibility
Complex Case Checklist review	Case open between 20 and 29 days	• Completion of Required Elements of Assessment • Goal-directed notes • Referrals and follow-up	All complex cases per month, reviewed with the case manager	Manager
QI 5 Standards review	Case open between 50 and 59 days	• All Elements on Complex Case audit checklist (Appendix B)	All complex cases per month, reviewed with each Case Manager	Manager

3.5 HSM Clinical Management Director, has the authority and responsibility for the activities in this policy or procedure.

3.6 The Issuing Dept. is responsible for monitoring/enforcing the compliance with this policy.

3.6.1 Compliance will conduct periodic reviews to monitor and audit compliance with this policy.

4.0 References:

4.1 Source of the policy (regulatory citation, accreditation standard, internal standard)

4.1.1 NCQA PHM 5 Complex Case Management; Medicare Managed Care Manual Chapter 4

4.2 Are there any references to other documents, regulations, or intranet locations?

4.2.1 None

4.3 Are there other policies that work in conjunction with this policy?

4.3.1 None

4.4 Replaces (if applicable):

4.4.1 None

5.0 Definitions:

5.1 Identification date for complex CM (anchor date to start the 30 day clock for starting assessment) is identified as:

5.1.1 Inpatient acute/sub-acute discharge referral: discharge date. Member may be referred to Complex Case Management during the acute or sub-acute stay.
5.1.2 Queries: last report run date
5.1.3 Referral: referral date

6.0 Key Words or Aliases (Optional):

6.1 Complex case management

6.2 Ongoing case management

ORIGINAL *EFFECTIVE DATE*: 01/10/2013
REVIEWED: 04/2014; 05/2015; 12/02/2016; 11/30/2017, 04/25/2023, 7/8/25
REVISED: 04/2014; 05/2015; 04/01/2016; 12/02/2016; 08/02/2019 (format), 04/25/2023; 7/8/25

Appendix A

<table>
<tr><th colspan="9">ADVANCED ILLNESS MANAGEMENT</th></tr>
<tr><th colspan="4">LEVEL 0,1
CARE MANAGEMENT</th><th colspan="5">LEVEL 2, 3
INTENSE CARE MANAGEMENT</th></tr>
<tr><td colspan="4" rowspan="2">Level 0 – Medium-term non-complex care management
Level 1 – Complex care management</td><td rowspan="2">Utili-zation</td><td colspan="3">Expected high Utilization</td><td></td></tr>
<tr><td colspan="3">Has High ED Use</td><td></td></tr>
<tr><td rowspan="3">Care Coor Needs</td><td colspan="3">Needs Caregiver Support</td><td></td></tr>
<tr><td colspan="3">Needs help w/Social / $ issues</td><td></td></tr>
<tr><td colspan="3">Needs Community Resources</td><td></td></tr>
<tr><td rowspan="3">Self-Mgmt</td><td colspan="3">Has learning needs</td><td></td></tr>
<tr><td colspan="3">Has cognitive deficits</td><td></td></tr>
<tr><td colspan="3">Has Medication issues</td><td></td></tr>
<tr><th>Initial Score</th><th>Entry Level</th><th>Frequency</th><th>Duration*</th><th>Initial Score</th><th>Entry Level</th><th>Frequency</th><th>Duration</th><th>TOTAL
_____</th></tr>
<tr><td>0-2</td><td>0→</td><td>Ad hoc</td><td>Until no further needs</td><td>5-6</td><td>2→</td><td>Up to Weekly</td><td rowspan="2">3 mo. w/no unplanned utilization; Then step down to next lower level.</td><td rowspan="2"></td></tr>
<tr><td>3-4</td><td>1→</td><td>Bi-weekly</td><td>Varies</td><td>7-8</td><td>3→</td><td>Up to Daily</td></tr>
<tr><td colspan="4"><u>Level 1 Entering CM at Level 1 without Utilization as a driving issue</u>→Until no further needs
<u>Level 1→(stepping down from L2</u>
→<u>Until 3 months w/no unplanned utilization</u></td><td colspan="5"></td></tr>
<tr><td colspan="4">• Complex Assessment & Stratification
• Carry out customized Plan of Care
<u>Level 1 additionally includes</u>:
• Reassessment w/in 30 days of any hospital discharge during open complex case
• PCP Notification Update at new Open, bi-monthly and at close of case</td><td colspan="5">• Complex Assessment & Stratification
• Reassessment w/in 30 days of any hospital discharge during open complex case
• Carry out customized Plan of Care
• PCP Notification at open, monthly, handoff to Level 1, and close of case if transitioning to Hospice.</td></tr>
</table>

Appendix B

SummaCare

NCQA Complex Case Management File Review

2. **Case ID #**:_____

   Regarding Member: _____

REQUIRED ELEMENTS:

3. Case status ☐Active ☐ Closed
4. Program: _____
5. Delegate, if applicable
6. Identification date:_____
7. Date closed_____
8. Enrolled at least 60 days ☐Yes ☐ No
9. Date initial assessment started: _____
10. Initial assessment all completed on a single date ☐Yes ☐ No **look at assessments, check to see if Medication Reconciliation Assessment was done at the same time**
11. If initial assessment was completed on a single date, enter date _____**look at assessments**
12. **PHM 5D Factor 1**: Initial assessment of member's (current) health status **Section 2: 1-2**, including condition-specific issues **Section 1: 11-26**, info on event or dx that led to identification for complex CM **Section 1:1 and notes**, member's self-reported health status **Section 1: 6 and notes**
13. **Factor 2:** Documentation of clinical history (past), including medications and past procedures/surgeries **Section 2: 7-8 past medical hx, 9-10 past behavioral health hx**, **Section 2: 19-21**
14. **Factor 3:** Initial assessment of activities of daily living **Section 3: 17-18**
15. **Factor 4:** Initial assessment of current behavioral health status **Section 2: 3-6**, including cognitive function (include substance abuse disorder) **Section 2: 3-4 Current BH Hx, 5-6 PHQ 9, Section 3: 15-16, Section 5:5**
16. **Factor 5:** Initial assessment of social determinants of health - psychosocial issues **Section 3: 1-2**
17. **Factor 6:** Evaluation of cultural and linguistic needs, preferences or limitations **Section 3: 5-6, 11-12**
18. **Factor 7:** Evaluation of visual and hearing needs, preferences or limitiations **Section 3: 3-4, 7-8**

19. **Factor 8:** Evaluation of caregiver resources and involvement including info on adequacy of resources **Section 1: 5-10**
20. **Factor 9:** Evaluation of available benefits **Section 4: 1**
21. **Factor 10:** Evaluation of eligible and available commmunity resources **Section 4: 2-6**
22. **Factor 11:** Assessment of life planning activities **Section 4: 7**
23. **PHM 5E Factor 1:** Development of case management plans, including prioritzed goals **that consider the members and cargiver's goals, preferences and desired level of involvement** in the case mgmt plan **Section 5:13 and Initial Complex Case Note**
24. **Factor 2:** Identification of barriers to meeting goals or complying with the plans **Section 3: 19-20, notes**
25. **Factor 3:** Development of schedules for follow-up and communication with member **task and notes**
26. **Factor 4:** Development and communication of member self-management plans and that member agrees to expected actions **Section 5: 11-12 Initial template note, summary note and other notes**
27. **Factor 5:** Assessment or progress against complex case management plans and goals and modification as needed **Ongoing Summary Notes, other notes**
28. Summary statement about meaning and implications of assessment to be used for the care plan **Section 5:14 and Initial Complex Case Note**