SOMOS Your Health, LLC ("MSO")
Department Care Management
Policy Number 101.3

Title

Continuity of Care and Transition of Care

Review Procedure

No less than annually and as needed as determined by ongoing monitoring and evaluation of the Care Management (CM) process that include continuity and transition of care, 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 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 101.3 is intended to provide guidance on continuity of care and transition of care 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 for continuity of care and transition of care.

This policy applies to the following populations:

I. Members newly enrolled to be managed by SOMOS.
II. Members whose healthcare provider leaves the SOMOS network.
III. Members who have been disenrolled from Medicaid and are no longer managed by SOMOS.

IV. Members who were previously enrolled in a Medicaid managed care plan and receiving Long Term Support Services (LTSS).
V. Members with chronic illnesses and physical or developmental disabilities.
VI. Transition of care between care settings including appropriate discharge planning for short term and long-term hospital and institutional stays.
VII. Members who are identified as persons who need LTSS or persons with special health care needs.

Glossary/Definitions

Care Transitions: Movement of patients between care settings (e.g., from home to hospital, hospital to rehabilitation facility) as condition and care needs change during the course of a chronic or acute illness.

Case Manager: An individual with two (2) years' experience in a substantial number of activities including the performance of assessments and development of case management plans.[1]

Continuity of care: Permits an eligible Medicaid member receiving an ongoing course of treatment to continue the treatment for a specific amount of time when a provider leaves the issuer's network during a transitional period.

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.[2]

Personal Care Services: Services ordered by a physician or nurse practitioner that include the provision of some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support (meal preparation and housekeeping).

Planned Transition: Include elective surgery or a decision to enter a long-term care facility.

Unplanned Transition: Include sudden hospitalizations resulting from emergencies.

Procedures

To ensure that continuity of care 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.

Continuity of care, also known as "service continuation", shall be considered for new enrollees, enrollees whose health care provider leaves the network, and enrollees who have been disenrolled. Transition of care services are ensured for members that transition between settings of care and include appropriate

[1] N.Y. Comp, Codes R. & Regs. Tit. 18 § 505.16
[2] 42 CFR § 438.2

discharge planning for short-term and long-term hospital and institutional stays and to members requesting continuity of care.

The following procedure outlines the criteria and process for continuity of care and transition of care to eligible SOMOS managed members.

I. Continuity of Care Criteria
   a. New Enrollees
      i. For newly enrolled SOMOS managed members with an existing relationship with a health care provider who is not currently part of the SOMOS provider network, SOMOS shall permit the member to continue an ongoing course of treatment by the out of network provider during a transitional period of up to sixty (60) days from the effective date of enrollment if the member has a life-threatening disease or condition or a degenerative and disabling disease or condition.
      ii. If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall continue for the remainder of the pregnancy, including delivery and the provision of post-partum care directly related to the delivery up to sixty (60) days after the delivery.
      iii. If a member elects to continue to receive care from the out of network provider, care shall be authorized by SOMOS for the transitional period only if the out of network provider agrees to:
         1. Accept reimbursement from SOMOS at rates established by SOMOS as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the SOMOS provider network for such services; and
         2. Adhere to SOMOS quality assurance requirements and agrees to provide SOMOS the necessary medical information related to such care; and
         3. Otherwise adhere to SOMOS policies and procedures including but not limited to procedures regarding referrals and obtaining prior authorization in a treatment plan approved by SOMOS.
      iv. SOMOS shall request service utilization information from the Local Departments of Social Services (LDSS) or member's previous Medicaid Managed Care Organization (MCO), if such member is in receipt of LTSS or is an individual included in a State Department of Health identified special population, as necessary to ensure the member's continued access to necessary services.
   b. Members Whose Health Care Provider Leaves the Network
      i. SOMOS shall permit a member, whose health care provider has left the SOMOS contract provider network, for reasons other than imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, to continue an ongoing course of treatment with the member's current health care provider during a transitional period, consistent with PHL § 4403(6)(e).

ii. The transitional period shall continue up to ninety (90) days from the date the provider's contractual obligation to provide services to the SOMOS member terminates, or if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of post-partum care directly related to the delivery through sixty (60) days post-partum. If the member elects to continue to receive care from the out of network provider, SOMOS shall authorize for the transitional period only if the out of network provider agrees to the terms outlined in Section I.iii.1-3, of this policy.

iii. In accordance with Section 21.10 of the Medicaid Managed Care Model Contract, SOMOS shall notify impacted members whose health care provider has left the SOMOS provider network.

c. Members Who Have Been Disenrolled
   i. If a member has been disenrolled from SOMOS, SOMOS shall promptly provide the member's service utilization information to the member's new Medicaid MCO, SDOH and/or LDSS, upon request by the new Medicaid MCO/SDOH/LDSS.

d. Out-Of-Network Providers
   i. If a member requires healthcare services from a provider that is outside of the SOMOS and MCO network, for reasons of medical necessity or because a particular service or specialty is not available within the network, providers should submit a request for prior authorization review to Evolent Health. SOMOS will render a determination on whether out-of-network care can be supplied by an in-network provider and whether the requested service(s) are medically necessary.

II. Continuity of Care Process

a. SOMOS shall provide case management to a member who requests continuity of care.

b. Members, their authorized representative, or their provider may make a request to SOMOS for continuity of care via phone. The continuity of care process begins when SOMOS starts the process to determine if the member has a pre-existing relationship with the provider.
   i. SOMOS will utilize the following criteria to determine if a pre-existing exists:
      1. Utilization data provided by the previous Medicaid MCO, SDOH and/or LDSS, or
      2. Documentation from the member and/or provider that demonstrates a pre-existing relationship, or
      3. SOMOS claims data

   SOMOS will begin to process the request within three (3) business days of receipt of the request. SOMOS will complete the request within 14 calendar days from the date SOMOS receives the request, or within three (3) calendar days if the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. SOMOS will accept and review retroactive continuity of care requests within 30 calendar days from the receipt of the requests, for services that were already provided if the request meets all the continuity of care requirements in I-IV.

c. SOMOS shall develop a transition of care plan upon receipt of a member's request for continuity of care.

III. Transition of Care Criteria
   a. Members requesting continuity of care.
   b. Members transitioning between settings of care and to include appropriate discharge planning for short-term and long-term hospital and institutional stays.
   c. Members experiencing planned or unplanned transitions.

IV. Transition of Care Process
   a. Sources of identification and referral of members for transition of care services may include:
      i. Weekly Hospital Discharge Reports
      ii. Daily Inpatient Census Reports
      iii. Other Care Coordination programs
      iv. Referrals from SOMOS Utilization Management team
      v. Attendance in SOMOS Utilization Management Inpatient Rounds
      vi. Hospital Case Managers/Discharge Planners or Social Workers
   b. A SOMOS Case Manager will be assigned the referral and will reach out to the member or the member's designated representative within 3 business days to inform them of the person responsible for supporting them during their transition.
   c. The SOMOS Case Manager will be assigned the referral and will develop a transition of care plan that will include:
      i. Notifying the member's usual care providers (Primary Care Provider or Specialists) responsible for the member's care.
         1. Within 3 business days
      ii. Notify the member or the member's designated representative within 3 business days to communicate to the member or the member's designated representative, the person responsible for supporting their transition. Members and their designated representatives will be educated about the transition process. Members can determine the level of involvement of their designated representative which will be captured within the care plan. Any changes to the care plan are communicated to the member or the member's designated representative via fax, phone or mail within 1 business day.
      iii. Collaborating and communicating with the appropriate members of the healthcare team (e.g., Utilization Management team, Hospital CM's/Discharge planners, receiving facility/setting) involved with the member's transition to facilitate a continuity of care across settings and to resume or initiate services, including LTSS.
         1. Within 1 business day of notification after notification of transition
      iv. The status of the member's transition. The transition of care plan will include:
         1. The current location of the member
            a. If the member has intensive medical or behavioral health needs, SOMOS will ensure sufficient time is provided to fully implement

the discharge plan including assurance of informal and formal support at the lower level of care.

2. Planned date of discharge/transfer
3. Planned setting for discharge/transfer
    a. SOMOS Case Managers will arrange for covered services as medically necessary for the member's care.
    b. When safe discharge cannot be arranged solely due to a member's lack of housing, SOMOS will work collaboratively with the facility to explore all options and referrals available considering the member's specific circumstances, including coordination with housing providers, homeless services, and Health Home care management agencies, as applicable.
4. Contact information for staff who coordinate care at the current setting (e.g., Hospital CM/Discharge Planner/Social Worker)

v. Medication reconciliation of new and existing medications during a transition between settings and for informing providers about discrepancies between the medication list and documented medications.

Remediation

The overall continuity of care process is monitored and evaluated on a continuous basis to ensure compliance with all applicable state and federal laws and regulations. Progress and outcomes of continuity of care 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

18 CRR-NY 505.16 (c)(3)(iv) and (b)(4)(iv) of the New York Codes, Rules and Regulations
42 CFR §438.208 (b)(1)(2) - Title 42 of the Code of Federal Regulations
10.37 Discharge Planning in the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract
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
PHL § 4403(6)(e) - New York Public Health Law
2020 NCQA CM Standards: CM 5, Element A, Factors 1-7
2022 NCQA HPA Standards: LTSS 3, Element A, Factors 1-7
SOMOS Provider Manual updated April 30, 2021

Whom Do I Contact with Further Questions?

Chief Executive Officer
Chief Compliance Officer
General Counsel