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

Title

Care Management Care Plans and Assessment

Review Procedure

No less than annually and as needed as determined by ongoing monitoring and evaluation of the Care 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	**REVIEWED BY**	**REVIEW DATE**	**APPROVED BY**	**APPROVAL DATE**	**DESCRIPTION OF CHANGE**
1	**Quality Committee**	**3/28/2023**	**Quality Committee**	**3/28/2023**	**Original**
2	**Quality Committee**	**1/16/2024**	**Quality Committee**	**1/16/2024**	**Updates integrated from NCQA CM Requirements**
4	**Quality Committee**	**4/3/2024**	**Quality Committee**	**4/3/2024**	**Updates integrated from NCQA PHP Requirements**

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 patients 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 care management services for SOMOS managed patients 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 patients. The Chief Medical Officer (CMO) and the Director of Care Management provide oversight of the CM Department's process. This policy applies to all patients that are enrolled in the SOMOS Care Management Programs.

Glossary/Definitions

Care 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]

Care 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 Care Management: Care 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]

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

Individualized Care Plan (ICP)/Individualized care management plan: Plan of care developed by a patient and/or a patient'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 care 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 patient'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

Patients may be referred for evaluation of Care Management Program through discharge planning and care transitions, utilization management, MCO referral(s), physicians, patients' 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 the proprietary algorithms of the Care Management Platform. The data is analyzed to determine service options that would best contribute to the desired outcomes of the population.

Care management functions and services are determined by the patient's circumstances and therefore will be determined specifically in each care and with the patient's agreement and involvement.

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

(i) The initial contact with the patient.
(ii) Provide information concerning care management.
(iii) Explore the patient's interest in the care management process.
(iv) Identify potential duplication of care management services with other agencies/programs (e.g., medical assistance program, Federal home, and community-based waiver)
(v) Initiate a program specific assessment screening.

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

(i) Assess patient'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
(iii) Mental health status to include substance use disorders, patient'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 patient'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 patient.
(viii) Needs for facilitation of timely access to primary care, specialty care, durable medical equipment (DME), medications and other health services needed by the patient.
(ix) Needs for communication among patient'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 patient 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 care manager will document whether the patient 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 care 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 patient with written material regarding advance care planning via e-mail or postal mail.

(3) Care management plan, implementation, and coordination.
A written individualized care management plan for each patient is completed and implemented within 30 days of the date of referral. The written care plan incorporates summarized findings from the assessment and feedback from the patient, caregiver, patient's providers, social worker, and/or any other professional involved. The Care Plan is shared with the patient's PCP or other involved practitioner. The care management activities required to establish a comprehensive individualized written care management plan and to affect the coordination of services include:

(i) Identify the nature, amount, frequency, and duration of the care management services required by the patient.
(ii) Select the nature, amount, type, frequency, and duration of services to be provided to the patient, with the participation of the patient, the patient's informal support network, and providers of services.
(iii) Specify realistic and comprehensive long-term and short-term goals to be achieved through the care management process.
(iv) Identify participants in the patient'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 care management process.
(b) The continuity of service.
(c) The avoidance of duplication of service (including care management services); and
(d) The establishment of a comprehensive care management plan that addresses the medical, social, psychosocial, educational, and financial needs of the patient.

(v) Secure services determined in the care management plan to be appropriate for the patient through referral to those agencies or persons who are qualified to provide the identified services.
(vi) Assist the patient with referral and/or application forms required for the acquisition of services.
(vii) Being an advocate and mediate for the patient 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 care management plan, the care management staff may visit the patient at home or in other community settings 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 patient's circumstances (e.g., physical abuse, attempted suicide, sexual abuse or exploited)
(ii) Determine the patient's emergency service needs.
(iii) Revise the care 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 care management services.

A reassessment of the patient's need for continued care management and other services must be completed by the care manager every six months, or sooner if required by changes in the patient's condition or circumstances to include:

(i) Verifying that quality services, as identified in the care management plan, are being received by the patient, and are being delivered by providers in a cost-conscious manner.
(ii) Assuring that the patient is adhering to the care management plan.
(iii) Ascertaining the patient's satisfaction with the services provided and advising the preparer of the care management plan of the findings if the plan has been formulated by a practitioner.
(iv) Collecting data and documenting in the case records the patient's progress.
(v) Ascertaining whether the services to which the patient has been referred are and continue to be appropriate to the patient's needs and making necessary revisions to the care management plan.
(vi) Assisting patients in making alternate arrangements if services have been denied by the Health Plan or are unavailable to the patient.
(vii) Assisting the patient and/or provider of services to resolve disagreements, questions, or problems with implementation of the care management plan.

(5) Continuity of service.

(i) Care management services are ongoing from the time the patient is accepted by the care management agent for services to the time when:

(a) The coordination of services provided through care management is not required or is no longer required by the patient.
(b) The patient moves from the social services district.
(c) The long-term goal has been reached.
(d) The patient refuses to accept care management services.

(e) The patient requests that his/her case be closed.
(f) The patient is no longer eligible for services.

(ii) Contact with the patient or with a collateral source on the patient's behalf is maintained by the care manager at least monthly, or more frequently.

(6) Evaluation

The individualized care plan is monitored and evaluated on a continuous basis and progress towards goals is evaluated and measured. As such, the patient's practitioners are informed of any care opportunities that need to be addressed in a timely manner. The risk stratification process and corresponding care plans are modified accordingly, to provide the patient with the skills and strategies for self-care and to help the patient 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.

Monitoring and Oversight

Care management 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 care management services received are reviewed and discussed in the QM Committee on a quarterly basis. Program quality is monitored through quarterly 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 are used as training and guidance for the CM staff.

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