CARE MANAGEMENT PROGRAM DESCRIPTION

Policy 101.1

Version 1.0

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Contents

Program Purpose

The Care Management (CM) Program provides the clinical and administrative identification, coordination, and evaluation of the services delivered to a member who requires close management of their care. The CM Program ensures continuity and coordination of care to improve the health status of members who are at risk for additional health care problems and complications.

The CM Program is designed to objectively and systematically evaluate and review, on an annual basis CM policies, procedures, and programs that are implemented to attain goals set forth by SOMOS to further the well-being of the members, meet organizational goals and applicable Federal, State and Accrediting agency requirements. SOMOS will provide available services to members managed by SOMOS and is not required to provide coverage for benefits not otherwise covered.

SOMOS Background

SOMOS IPA partners, with its affiliate SOMOS Your Health, LLC, provide the administrative and management services necessary for the daily operations of its patients' applicable benefit plans. Collectively, the two (2) entities are known as "SOMOS" and work together to accomplish its goal by collaborating with its participating providers to oversee and deliver health services to SOMOS patients.

SOMOS patients are members attributed to SOMOS Primary Care Providers (PCPs) and enrolled with SOMOS's initial Managed Care Organization (MCO) partners, Empire BlueCross BlueShield HealthPlus ("HealthPlus") and EmblemHealth ("Emblem") for the following lines of business: Medicaid (excluding dual-eligible Medicare members), Child Health Plus (CHP), HARP, and Essential Plans (EP). SOMOS performs the administrative functions in partnership with Evolent Health, which is sub-delegated for claims processing, utilization management, care management, transitional case management and population health as well as certain specialist/hospital/ancillary provider credentialing.

Mission Statement

SOMOS delivers transformative health care innovations that empower independent community physicians to excel in value-based care. SOMOS collaborates across stakeholders to improve health equity in underserved communities leading to better, healthier lives for vulnerable populations.

Department Objectives & Goals

The CM process is directed at coordinating resources and creating improved quality and patient experiences via appropriate cost-effective alternatives for catastrophically, chronically ill, or injured members, and for those members with complex illnesses, on a case-by-case basis, in order to facilitate the achievement of realistic treatment goals.

The objectives and goals of SOMOS's CM Program are to:

- Address the member as a total individual, including medical, psychosocial, and behavioral needs.
- Educate members about the resources available to them and how to use these resources to optimize their wellness.
- To work collaboratively with CM staff across multidisciplinary health agencies.
- Assist members in understanding their health condition and to support members in becoming proficient in maintaining their health.
- Facilitate timely access to care and efficient delivery of health care services.
- Minimize gaps by coordinating transitions across the healthcare continuum.
- Evaluate activities that may include, but are not limited to the areas of:
    - Access and availability of appropriate Provider(s);
    - Continuity and coordination of care;
    - Identification of areas of risk and/or concern for the member including adverse outcomes.

Definitions

Advance Care Planning: Involves discussing and preparing for future decisions about medical care should one become seriously ill or unable to communicate their wishes.[1]

Behavioral Health Care: Prevention, diagnosis and treatment for mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms.[2]

Care Management: Collaborative process designed to manage medical/social/mental health conditions more effectively.[3]

Care Coordination: Organizing care based on the member's needs and preferences and shared amongst their care team to achieve safe and effective care.

Care Transitions: Safe and effective movement of members from one care setting to another taking into consideration the changing condition and needs of the member.

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.[4]

[1] National Institute on Aging - Advance Care Planning
[2] American Medical Association
[3] Microsoft Word - Care Management Matrix_101707.doc (chcs.org)
[4] NCQA 2020 CM Standards and Guidelines, Appendix 4 Glossary

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.[5]

Complex Case Management: CM 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[6].

Continuity of Care: Seamless continuation of healthcare related services by the plan to its eligible members.

Health Home: A person-centered system of care that achieves improved outcomes for beneficiaries by providing linkages to long-term community care services and supports, social services, and family services.[7]

Health Risk Assessment (HRA): Screening tool to help identify and evaluate health risks and provide individual health promotion interventions.

Healthcare Effectiveness Data and Information Set (HEDIS): Performance improvement tool developed and maintained by the National Committee for Quality Assurance (NCQA) to measure performance on dimensions of care and service in order to maintain and/or improve quality.

Individualized Care Plan (ICP)/Individualized Case Management Plan: Plan of Care (POC) developed by a member and/or a member's Interdisciplinary Care Team (ICT) or health plan that includes prioritized goals that considers the member'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.[8]

Interdisciplinary Care Team (ICT): Participation of the Primary Care Provider (PCP) and support staff along with the member's family in maintaining the member's ICP.

Long Term Services and Supports (LTSS): Provided to members/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]

Primary Care Provider (PCP): Responsible for delivering primary care services, providing health counseling and advice, conducting baseline and periodic health examinations, diagnosing and

[5] N.Y. Comp. Codes R. & Regs. Tit. 18 § 505.16
[6] NCQA 2020 CM Standards and Guidelines, Appendix 4 Glossary
[7] State Medicaid Director's Letter 10-024
[8] NCQA CM 3, Element A
[9] 42 CFR § 438.2

treating conditions, consultations with specialists and other healthcare providers when medically necessary.

Provider Network: Group of health care professionals and facilities that provide health care services to individuals.

Scope of Services

CM is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and social determinants of health (SDOH) needs of patients and their families, while promoting quality and cost-effective outcomes.

SOMOS' CM Program includes, but is not limited to:

- Complex Case Management (CCM) Programs 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.
- Transitional Case Management (TCM) Programs focused on evaluating and coordinating post-hospitalization needs for patients who may be at risk of rehospitalization.
- Chronic Care Improvement Programs aimed at patients with multiple or sufficiently severe chronic conditions (e.g., Diabetes, Hypertension etc.)[10] to effectively manage the chronic disease and improve care and health outcomes.
- High-risk and high-utilization programs aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, patients at high risk (e.g., patients with high-risk pregnancies).
- Discharge Planning Programs designed to coordinate care for patients during an inpatient admission and transition to a lower level of care or back to a home/community setting.
- Advance Care Planning Programs focusing on facilitating discussions with patients to discuss their health care wishes should they become unable to make decisions about their care.[11]
- Behavioral Health (BH) Case Management Programs focusing on the needs of patients seeking treatment for mental illness and substance use disorders, as applicable.
- Health Home Program to ensure all of a member's caregivers communicate with one another so that all needs are addressed in a comprehensive manner.

Evidence & Criteria

SOMOS uses up-to-date evidence-based clinical guidelines and/or algorithms to administer its CM Program, and regularly updates the program with relevant findings and information as they become available, no less than every two (2) years and as needed.

[10] 42 CFR § 422.152 (a)(2) and (c)
[11] CMS Advance Care Planning

Clinical guidelines, standards, and criteria set by the Centers for Disease Control and Prevention (CDC) and the Agency for Healthcare and Research Quality (AHRQ), Milliman Care Guidelines (MCG), regulatory, and any accrediting agencies are adhered to as appropriate for the IPA. CM decisions are based upon evidence-based guidelines and/or algorithms within the CM technology platform and consistent with professionally recognized standards of care. All patient and staff training materials are reviewed against the CM Program content and evidence-based guidelines to ensure materials are consistent with current evidence. In the event guidelines have been modified, the appropriate steps to update all patient and/or staff training material will ensue.

SOMOS ensures all CM Programs meet cultural and linguistic appropriateness by reviewing feedback from staff trained in cultural competency and those fluent in the SOMOS threshold languages for their members and eliciting feedback from community organizations representative of the member's cultural and linguistic diversity and from SOMOS members.

Changes to existing evidence-based clinical guidelines will require the review of at least two (2) appropriate practitioners (e.g., nurses, physicians, social workers) who are certified or have received specialized training related to the program's subject matter.

The CM Program criteria are evaluated, updated as appropriate and approved no less than every two (2) years[12]and as needed by the Quality Management (QM) Committee, further described in the QM Committee charter. Documentation of activities and approval by the QM Committee can be found in the QM Committee meeting minutes. CM activities are reported to the Utilization Management Sub-Committee as needed, further described in UM Sub-Committee charter. All criteria, policies, and procedures of SOMOS are made available upon request.

Identification & Referral

SOMOS systematically identifies members who can benefit from CM services and support. At least annually, SOMOS uses demographic information derived from available data sources to assess the characteristics and needs of its member population and relevant subpopulations to identify members who can benefit from the assistance of case management. CM processes and resources are reviewed and updated as necessary to address patient needs.

Data sources used to identify members for CM include, but are not limited to:

- Claim or encounter data.
- Hospital discharge data.
- Pharmacy data.
- Lab data, as applicable.
- Health appraisals or risk appraisals/scoring tool.
- Data collected through the UM process.
- Data supplied by clients or purchasers, as applicable.

[12] NCQA 2020 CM Standards and Guidelines, Standard CM 1, Element B, Factor 1

- Data supplied by patient or caregiver.
- Data supplied by practitioners.
- Predictive modeling software.

Characteristics considered for CM include, but are not limited to:

- Mobility, vision, or other physical disability.
- Physical health.
- Intellectual and developmental disabilities.
- Serious and persistent mental illness.
- Nature and extent of carved out benefits.
- Race/ethnicity and language preference.
- Age.
- Languages spoken and language preference.
- Housing status.
- Food security.
- Employment status.
- Subpopulations with common comorbidities.
- Subpopulations of a certain age group.
- Dual eligibility for Medicaid and Medicare.
- Type of Special Needs Plan (SNP) (e.g., Dual, Institutional, Chronic).
- Transition of care.

Additionally, referrals for CM services may include, but are not limited to interdepartmental referral, PCP and provider referral, hospital referral, member and/or member family/caregiver referral or sent directly to the CM Department via phone.

The Case Manager obtains eligibility and benefit coverage information on the member and notifies the referral source of the member's eligibility status for involvement in the CM Program. If the member is eligible and has benefit coverage, the Case Manager continues to work with the referral source to obtain necessary information for implementing the case management process. Members are given the option to opt-in or opt-out of some aspects or the overall CM Program.

Program Structure

SOMOS' organizational chart reflects the CM personnel and committee reporting structures. Staff positions and committee descriptions explain associated responsibilities, duties, and reporting relationships. The staff ratios are consistent with the organization's needs and are accommodated by the departmental budget. Performance objectives are included in the staff evaluations. Interdepartmental coordination of care and services is clearly delineated in the description of each department.

Through the QM Committee review process and directly, the standing committee oversees the CM Program activities, and reports to the QM Committee quarterly. Documented summaries of CM statistics and focus study results are reviewed. All CM policy, procedures, and program changes are submitted for approval of the QM Committee.

Essential Case Management

SOMOS has multiple programs at no cost to the member that focus on improving quality of care and services provided to members with complex medical needs (e.g., chronic conditions, severe mental illness), Seniors and Persons with Disabilities (SPD), individuals who are receiving or are eligible to receive Long Term Supportive Services (LTSS), and individuals with physical and developmental disabilities. These essential CM services include, but are not limited to, the following:

- Care coordination, including arranging appointments and referrals to community resources.
- Case management plan development, with person-centered goals.
- Self-management plan development and monitoring.
- Self-directed services.
- Personal care assistance.
- Housekeeping and chore service.
- Money management.
- Transportation.
- Housing-related services.

Care Coordination

Continuity and coordination of care are key determinants for overall health outcomes. Comprehensive care coordination improves patient safety, avoids duplicate assessments, procedures or testing, and results in better treatment outcomes. SOMOS evaluates continuity and coordination of care on an annual basis through monthly audits. The purpose of these studies is to assess the effectiveness of the exchange of information between:

- Medical care providers working in different care settings.
- Medical and behavioral health providers.

The results of these studies are presented and discussed at the QM Committee. Based on the findings, the committee members recommend opportunities for improvement that are implemented by the CM Department.

Transition of Care (TOC)

Transitioning care without assistance for members with complex needs (e.g., SPD members that very often have three (3) or more chronic conditions) can be complicated by several other health and social risk factors. SOMOS' TOC program has been designed to provide solutions to these challenges. Through the TOC program, SOMOS makes concerted efforts to coordinate care when

members move from one setting to another. This coordination ensures quality of care and minimizes risk to patient safety.

Complex Case Management (CCM)

The CCM Program was established for members with poorly controlled chronic diseases and/or complex conditions. The goal of the CCM Program is to optimize member wellness, improve clinical outcomes, and promote self-efficacy and appropriate resource management across the care continuum, through efficient care coordination, education, referrals to health care resource, and advocacy.

SOMOS assesses the performance of the CCM Program annually using a number of established measures and quantifiable standards. These reports are presented to the QM Committee for discussion and next steps. Based on the committee recommendations, the CM Department collaborates with other departments within the organization to implement improvement activities.

Discharge Planning

SOMOS has developed a system to coordinate the delivery of care across all healthcare settings, providers, and services to ensure all hospitalized members are evaluated for discharge needs to provide continuity of care and coordination of care. SOMOS also works with the member or their caregiver to ensure they have the necessary medications/supplies to prevent readmissions or complications. The goals of the hospital CM Program include but are not limited to the following:

- Avoiding of hospital readmissions post discharge.
- Improvements in health outcomes post discharge from inpatient facilities.
- Improving member and caregiver experience with care received.

Advanced Care Planning

Advanced care planning services are incorporated into each member's individualized care plan. Care Managers will discuss with the members their health care wishes should they become unable to make decisions about their care. As part of the member's care plan, Care Managers will discuss advance directives (AD) with or without completing legal forms. Examples of Ads include:

- Living wills
- Instruction directives
- Health care proxy
- Health care power of attorney

Behavioral Health Care Program

As applicable, the SOMOS Behavioral Health Care Program manages the needs of patients seeking treatment for mental illness and substance use disorders. Providers can refer patients who may benefit from case management to SOMOS. Patients who have multiple admissions for a BH condition, including substance use disorders and mental health conditions, homelessness,

are restricted, have had their first break (FEP), are transitioning from foster care or aging out of the children's system (TAY) are some of the members who are eligible for case management services. Additionally, consenting members meeting eligibility criteria will be referred to a Health Home for additional care coordination.

Health Home Program

The SOMOS Health Home Program is a care management service whereby all of a patient's caregivers communicate with one another so that all needs are addressed in a comprehensive manner. A dedicated SOMOS Care Manager will oversee and provide access to all of the services the member needs. The Health Home services are provided through a network of organizations – providers, health plans and community-based organizations – when all services are considered collectively, they become a virtual "Health Home".

Chronic Care Improvement Program (CCIP)

SOMOS has implemented a Chronic Care Improvement Program (CCIP) to engage members diagnosed with chronic conditions, such as asthma or diabetes, and their managing providers. As part of the CCIP members receive relevant education materials that give them a better understanding of the disease condition and ways to better manage their health. The CCIP also helps to facilitate member access to disease management services, health education programs, case management, and other healthcare services. Members in CCIP can access health education programs to prevent co-morbidities or mitigate their effects. The CCIP is a component of SOMOS' member-centric care. SOMOS evaluates the effectiveness of the CCIP using available data on an annual basis. The annual evaluation is reported and discussed at the QM Committee.

Diabetes Care Management Program

An evidence-based educational and support program designed to assist members who are at-risk and those with a primary diagnosis of diabetes. The Diabetes CM Program will include attributed and risk stratified patient populations tuned to align with SOMOS caseload objectives. Quality monitoring will be conducted via the CM analytic tool to allow for review of population trends before, during and after CM interventions with outcome metrics. Goals of the Diabetes Care Management Program include improvement in patient diabetic preventative care, adherence and reduction in ED visits and inpatient admissions after a successful discharge from the Diabetes Care Management Program (with a six (6) month lookback period) and members successfully discharged from the care program will meet goals relating to understanding of medication management and recognizing sign and symptoms of hypoglycemia/hyperglycemia.

Team Roles and Responsibilities

The SOMOS CM Department consists of appropriate professionals (e.g., nurses, pharmacists, social workers, social service providers) who are certified and/or have received specialized training related to the program's subject matter.

Chief Medical Officer: The governance of the Chief Medical Officer (CMO) is critical to the CM Program's effectiveness. The CMO serves as a resource to determine the medical needs of the member and the clinical appropriateness of treatment based on established evidence-based clinical guidelines and standards.

Director of Care Management: Provides oversight of the CM Program(s) and services. Works with the CMO and Medical Directors to meet organization and department goals and developing and tracking measurable outcomes of department services.

Care Manager: Licensed Registered Nurse who initiates and coordinates a multidisciplinary team approach to case management with members, health care providers and SOMOS' CMO or physician designee. Case Managers coordinate individual services for members whose needs include ongoing medical care, home health and hospice care, rehabilitation services and preventive services while promoting quality and cost-effective outcomes. The Case Manager monitors the progress of the implemented plan of care. The Case Manager serves as a resource throughout the implementation of the plan and makes revisions as appropriate. The Case Manager also coordinates appropriate educational sessions and encourages the member's role in self-help.

Community Health Worker/Health Care Guide: Works in collaboration with the CM team members, provides support and guidance to members referred to the CM Department for CM services and CM program(s) and serves as a team resource for community-based services.

Social Worker: Initiates and coordinates a multidisciplinary team approach to case management with members, health care providers and SOMOS' CMO or physician designee. Manages member's SDOH and psychosocial aspects of the member's health care and coordinates care with the medical team members.

Clinical Care Coordinator: Provides administrative support to the CM Team by answering phones, maintaining department files and calendars, ordering, and managing department inventory and supplies.

Care Management Program Quality Monitoring and Oversight

SOMOS obtains and analyzes member feedback using focus groups and/or satisfaction surveys. Feedback is specific to the CM Program(s) being evaluated and covers, at a minimum:

- Overall experience with the program.
- Experience with program staff.
- Experience with access to the program.
- Patient-reported number of contacts with the program.
- Usefulness of program information disseminated by the organization.
- Access to care manager.
- Satisfaction with care manager.

- Satisfaction with case management plan.
- Timeliness of case management services.

SOMOS monitors complaints to identify opportunities to improve experience with its CM Program. Complaints are analyzed for:

- Themes and significance in complaints about a specific service area or service provider.
- Themes and significance of complaints about a Case Manager.
- Themes and significance of complaints about a CM strategy.
- Volume of complaints provided by an individual or population group.
- Changes in trends of complaints.

Annually, SOMOS conducts qualitative and quantitative analysis of data to identify patterns in member feedback and complaints received and conducts a causal analysis and uses the results of its analysis to prioritize opportunities for improvement. SOMOS continues to remeasure to determine the impact of interventions, using methods consistent with initial measurements.

Documentation/Attachments

CM Department organizational chart
Quality Committee Charter

Governance

N.Y. Comp, Codes R. & Regs. Tit. 18 § 505.16
42 CFR §438.208
42 CFR § 422.152 (a)(2) and (c)
NCQA 2020 CM Standards: CM 1, Elements A, B; CM 2, Element B, C*
NCQA 2022 Health Plan Accreditation Standards

Whom Do I Contact with Further Questions?

Chief Executive Officer
Chief Compliance Officer
General Counsel
Chief Medical Officer
Director of Care Management

* 2020 CM and 2020 CM-LTSS Standards are the most current version. NCQA is proposing updates to the CM-LTSS standards for the 2024 standards year (effective July 1, 2024).

Care Management Program Approval

(Insert name, Title) (Signature)	

Director of Care Management *Date Approved*

(Insert name, Title) (Signature)	

Chief Medical Officer *Date Approved*

(Insert name, Title) (Signature)	

Quality Management Committee Chairperson *Date Approved*