CARE MANAGEMENT PROGRAM DESCRIPTION

Policy 101.1

April 2024

Contents

Program Purpose

The Care Management (CM) Program provides the clinical and administrative identification, coordination, and evaluation of the services delivered to a patient who requires close management of their care. The CM Program ensures continuity and coordination of care to improve the health status of patients 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 patients, meet organizational goals and applicable Federal, State and Accrediting agency requirements. SOMOS will provide available services to patients 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 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, and certain specialist/hospital/ancillary provider credentialing.

SOMOS patients are also members enrolled with SOMOS's MCO partners HealthFirst and Fidelis Care for the Medicaid line of business. SOMOS is delegated for care management and transitional care management programs.

SOMOS conducts oversight of all sub-delegated functions and maintains accountability for these functions.

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 patients, and for those patients 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 patient as a total individual, including medical, psychosocial, and behavioral needs.
- Educate patients 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 patients in understanding their health condition and to support patients 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 patient 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 patient's needs and preferences and shared amongst their care team to achieve safe and effective care.

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

Case Management: Collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet comprehensive medical,

[1] National Institute on Aging - Advance Care Planning
[2] American Medical Association
[3] Microsoft Word - Care Management Matrix_101707.doc (chcs.org)

behavioral, and social needs of patients and their families while promoting quality, cost-effective outcomes.[4]

Care 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 Care 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 patients.

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]

Program Assessment: 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 Care Management Plan: Plan of Care (POC) developed by a patient and/or a patient's Interdisciplinary Care Team (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 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 patient's family in maintaining the patient's ICP.

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

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[4] NCQA 2020 CM Standards and Guidelines, Appendix 4 Glossary
[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

Practitioner: Also known as a healthcare provider or healthcare professional, is an individual who is trained and licensed to diagnose, treat, and prevent illnesses, injuries, and various medical conditions. These professionals play a critical role in maintaining and improving the health and well-being of individuals and communities. Medical practitioners encompass a wide range of specialties, including physicians, surgeons, general practitioners, specialists, nurses, physician assistants, and other allied health professionals.

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

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

- Behavioral Health (BH) Case Management Programs focusing on the needs of patients seeking treatment for mental illness and substance use disorders, as applicable.

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.

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 patients and eliciting feedback from community organizations representative of the patient's cultural and linguistic diversity and from SOMOS patients.

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 patients 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 patient population and relevant subpopulations to identify patients 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 patients for CM include, but are not limited to:

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

- 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.
- 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, patient and/or patient family/caregiver referral or sent directly to the CM Department via phone.

The Care Manager obtains eligibility and benefit coverage information on the patient and notifies the referral source of the patient's eligibility status for involvement in the CM Program. If the patient is eligible and has benefit coverage, the Care Manager continues to work with the referral source to obtain necessary information for implementing the care management process. Patients 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 Care Management

SOMOS has multiple programs at no cost to the patient that focus on improving quality of care and services provided to patients 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.
- Care 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 patients with complex needs (e.g., SPD patients 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 patients move from an in-patient facility to a residential setting. This coordination ensures quality of care and minimizes risk to patient safety.

Complex Care Management (CCM)

The CCM Program was established for patients with poorly controlled chronic diseases and/or complex conditions. The goal of the CCM Program is to optimize patient 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

The SOMOS discharge planning program is developed as a system to coordinate the delivery of care across all healthcare settings, providers, and services to ensure all hospitalized patients are evaluated for discharge needs to provide continuity of care and coordination of care. SOMOS also works with the patient 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 patient and caregiver experience with care received.

Advanced Care Planning

Advanced care planning services are incorporated into each patient's individualized care plan. Care Managers will discuss with the patients their health care wishes should they become unable to make decisions about their care. As part of the patient'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 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 patients who are eligible for case management services.

Disease Management

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

Unplanned Transitions

SOMOS' aim of monitoring unplanned transitions to effectively prevent or manage these transitions, including emergency room (ER) visits, unplanned hospitalizations, and preventable hospital admissions/readmissions. Monthly, SOMOS works to identify patients at high risk of unplanned transition and the Care Management team works to take action to mitigate the risk of these transitions. By implementing proactive measures, SOMOS aims to reduce these occurrences, enhance patient outcomes, and optimize resource utilization.

Care Management Program

SOMOS has implemented a care Management Program as a comprehensive healthcare initiative designed to optimize the well-being of individuals with complex or chronic medical conditions. It employs a multidisciplinary approach, involving healthcare professionals, care coordinators, and often, the patient's family. The program begins with a thorough assessment of the individual's health needs, considering physical, mental, and social aspects. A personalized care plan is then developed, incorporating preventive measures, treatment strategies, and lifestyle modifications. Care Managers play a pivotal role in coordinating services, monitoring progress, and providing

ongoing support, ultimately aiming to enhance the individuals overall health outcomes and quality of life.

Team Roles and Responsibilities

The SOMOS CM Department consists of appropriate professionals (e.g., nurses, social workers, social service providers) who are certified, licensed, 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 patient 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 patients, health care providers and SOMOS' CMO or physician designee. Care Managers coordinate individual services for patients whose needs include ongoing medical care, home health and hospice care, rehabilitation services and preventive services while promoting quality and cost-effective outcomes. The Care Manager monitors the progress of the implemented plan of care. The Care Manager serves as a resource throughout the implementation of the plan and makes revisions as appropriate. The Care Manager also coordinates appropriate educational sessions and encourages the patient's role in self-help.

Community Health Worker/Health Care Guide: Works in collaboration with the CM team members, provides support and guidance to patients 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 care management with patients, health care providers and SOMOS' CMO or physician designee. Manages patient's SDOH and psychosocial aspects of the patient's health care and coordinates care with the medical team members.

All staff members are available during usual business hours only. For inquiries made outside of our regular business hours, callers have the option to leave a detailed message. A CM Team member will promptly return all calls on the next business day.

Care Management Program Quality Monitoring and Oversight

SOMOS obtains and analyzes patient 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.

Member complaints, grievances, and appeals (including providers appealing on behalf of a member), are handled directly by the member's respective MCO. At least annually, the MCO shares, with SOMOS, complaints related data pertaining to SOMOS patients.

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
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

Vaishali Patel, Director of Care Management *Signature on file*	4/3/2024
Director of Care Management	*Date Approved*

Richard Petrucci, MD – CMO & QMC Chair *Signature on file*	4/3/2024
Chief Medical Officer & QMC Chair	*Date Approved*