



Title

Disease Management Program

Review Procedure

No less than annually and as needed as determined by ongoing monitoring and evaluation of the Disease Management Program, 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 organizations (“MCOs”) to provide certain services on 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 disease management program services 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 CM 101.10 is intended to provide guidance on disease management program services 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.

Members diagnosed with one or more of the conditions listed below are eligible for the disease management program services:

- I. Asthma
- II. Diabetes
- III. Congestive heart failure (CHF)
- IV. Chronic obstructive pulmonary disease (COPD)
- V. Coronary artery disease (CAD)

- VI. Hypertension
- VII. HIV/AIDs
- VIII. Major depressive disorder for children, adolescents, and adults
- IX. Substance use disorder
- X. Bipolar disorder
- XI. Schizophrenia

Glossary/Definitions

Disease Management: A multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions while supporting the practitioner-patient relationship and plan of care, and emphasizing prevention of complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management.¹

Disease Management Program: An organization’s disease-specific or condition-specific package of ongoing services and assistance that includes education and interventions.²

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

Individualized Care Plan (ICP)/Individualized case management plan: Plan of care developed by a member and/or a member’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 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.³

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

Case 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.⁴

Procedures

To ensure that disease management program 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.

¹ NCQA 2020 CM Standards and Guidelines, Appendix 4 Glossary

² NCQA 2020 CM Standards and Guidelines, Appendix 4 Glossary

³ NCQA CM 3, Element A

⁴ N.Y. Comp, Codes R. & Regs. Tit. 18 § 505.16

Enrollment of the member into the disease management program requires the member’s agreement and involvement. Disease management program services should not be duplicated with other agencies and should not be implemented for the purpose of creating a demand for unnecessary services or programs.

Disease management program goals include:

- Supporting the physician or practitioner/patient relationship and plan of care.
- Emphasizing prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies.
- Evaluating clinical, humanistic, and economic outcomes on an on-going basis with the goal of improving overall health.

Members may be referred for disease management program services through discharge planning and care transitions, MCO referral(s), physicians, completion of the initial health risk assessment conducted by SOMOS’s general case management program, and from data sources such as claims or encounter data, pharmacy data, lab data or hospital discharge data.

Disease management program components include at a minimum:

- 1) Population identification processes: identify members with chronic diseases and high healthcare use and expenditures.
- 2) Evidence-based practice guidelines: ensuring consistency in treatment based on clinical evidence across targeted population.
- 3) Collaborative practice models: involvement of a multidisciplinary team of providers, including physicians, nurses, pharmacists, family members/caregivers.
- 4) Patient self-management education: may include primary prevention, behavior modification programs, support groups.
- 5) Process and outcomes measurement, evaluation, and management: a method for measuring outcomes and member satisfaction.
- 6) Routine reporting/feedback loop: may include communication with patient, physician, health plan and ancillary providers.

Members referred to the disease management program would require completion of an initial health risk assessment tool and care plans (refer to Policy Number CM 101.2 Care Management Care Plans and Assessment).

The developed care plans are specific to the needs identified and ranked by priority during the assessment and include goals and level of involvement discussed with the member and/or families or caregivers. Each of the ranked issues will indicate a target completion date and will identify any known barriers to achieving the goal within the targeted completion timeframe. The care plan will outline the actions the member and/or families or caregivers have agreed to take in managing the condition(s) and issues. A reassessment of the member’s need for continued complex case management and other services must be completed every six (6) months, or sooner if required by changes in the member’s

condition or circumstances (refer to Policy Number CM 101.2 Care Management Care Plans and Assessment).

Remediation

The Disease Management Program is monitored and evaluated on a continuous basis to ensure compliance with all applicable state and federal laws and regulations. Progress and outcomes of the disease management program 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 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 CMO and shared with the QM Committee. Audit findings are used to share with the individual and is used as 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

N.Y. Comp, Codes R. & Regs. Tit. 18 § 505.16

42 CFR §438.208

NCQA 2020 CM Standards: CM 2, Element D

NCQA 2020 CM Standards: CM 3, Element A

Whom Do I Contact with Further Questions?

Chief Executive Officer

Chief Compliance Officer

General Counsel