SOMOS Your Health, LLC ("MSO")
Department Care Management
Policy Number 101.10

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.

VERSION 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	4/3/2024	Quality Committee	4/3/2024	Updates integrated from NCQA CM and PHP Requirements

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.

The organization systematically collects and integrates relevant data to produce actionable information. Patients may identified or referred for disease management program services utilizing the following:

1. Medical and behavioral claims or encounters
2. Pharmacy claims/data, where available
3. Laboratory results
4. Health appraisal results
5. Data collected through the utilization management, case management or care management process
6. Electronic health records
7. Information collected from individuals, practitioners and client organizations
8. 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 a program specific assessment 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).

At regular intervals of every two years, our organization will conduct a comprehensive systematic review of the evidence utilized in the development of the program. This review will be undertaken by a team comprising a minimum of two experienced practitioners. Additionally, this process will encompass the evaluation of emerging evidence to ensure that our program remains aligned with current best practices and standards within the field.

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.

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