CARE MANAGEMENT
(Utilization, Case Management and Disease [Condition] Management)
PROGRAM DESCRIPTION

August 2018
# 2018 Care Management Program Description

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Our Mission is to improve your health and well-being.

**ProMedica Values** | Our ProMedica is united by these values.

- **Compassion**
  - We treat our patients and each other with respect, integrity and dignity. Because each of us is a caregiver, our actions, words and tone let others know we truly care about them.

- **Innovation**
  - We continually search to find a better way forward. We seek and embrace changes that enable us to deliver high-quality care and the best possible outcomes.

- **Teamwork**
  - We are an inclusive team of diverse and unique individuals who collaborate to meet the ongoing needs of our patients and communities. We partner with others because we are better together than apart.

- **Excellence**
  - We strive to be the best in all we do; we value lifelong learning, practice continuous improvement and provide exceptional service in living our Mission to improve your health and well-being.
GOALS AND OBJECTIVES

Utilization Management is performed to ensure an effective and efficient medical and behavioral health care delivery system. It is designed to evaluate the cost and quality of medical services provided by participating physicians, facilities, and other ancillary providers. The goal of utilization management is to assure appropriate utilization, which includes evaluation of both potential over and underutilization.

The purpose of the utilization management program is to achieve the following objectives for all members:

- To assure effective and efficient utilization of facilities and services through an ongoing monitoring and educational program. The program is designed to identify patterns of utilization, such as overutilization, underutilization and inefficient scheduling of resources.
- To assure fair and consistent Utilization Management decision-making.
- To focus resources on a timely resolution of identified problems.
- To assist in the promotion and maintenance of optimally achievable quality of care.
- To educate medical providers and other health care professionals on appropriate and cost-effective use of health care resources.

Paramount works cooperatively with its participating providers to assure appropriate management of all aspects of the members’ health care.

The desired goals of the Care Management program are:

- Treatment of the member in the least restrictive setting and manner
- To improve self-management knowledge and skills regarding disease and conditions
- Increase member satisfaction
- Return member to his/her maximum potential
- Support for the Primary Care Physician (PCP)
- Comprehensive Primary Care (CPC) transition with support for both members and providers
- Utilization of participating providers
- Reduction in the cost of care
- Reduction of unplanned hospital admissions/readmissions and inappropriate emergency room usage
- Education of member regarding disease process
CARE MANAGEMENT PROGRAM OVERVIEW

Paramount’s Care Management Program is designed to ensure the delivery of high quality, cost efficient health care for the members. Departments within the Care Management umbrella include Utilization Management, Case Management (Intensive, High-Risk) Disease/Condition Management (Medium, Low, and Monitoring risk stratifications) and Pharmacy. The program is under the administrative and clinical direction of the Vice President Medical Director and the Medical Advisory Council. The Associate Clinical Director of Behavioral Health (doctoral level clinical psychologist) has substantial involvement in the implementation of the behavioral health care aspects of the program. The Medical Advisory Council evaluates and approves the Care Management Program annually. Updates occur as required.

For product lines on an HMO platform, the Primary Care Physician along with collaborative providers are responsible for managing all aspects of the member’s health care needs. To this end, all members select a Primary Care Physician at the time of enrollment and are encouraged to establish a relationship with the physician as soon as possible. The member is instructed to contact his/her Primary Care Physician whenever medical or behavioral health care is needed. Thus, the Primary Care Physician is informed about his/her patient’s needs and can make informed, appropriate decisions regarding treatment.

Members with non HMO platform product lines are encouraged to follow the guidelines as noted above however are not required to do so. In these instances, the care management team can provide assistance with navigating the health care system as requested by individual members.

DELEGATION OF UTILIZATION & CASE MANAGEMENT

Delegation occurs when Paramount gives to another organization the decision making authority to perform a function that we would otherwise do ourselves. It is a formal process, contractual, and consistent with National Committee Quality Assurance (NCQA) accreditation standards and Ohio Department of Medicaid (ODM) regulations. Paramount does not delegate management of complaints, grievances and appeals. Paramount conducts pre-delegation reviews to ensure compliance and monitors delegated operations through mutually defined reporting and formal goal-based evaluations. An agreement specific to the function(s) delegated is mutually agreed upon and defines the parameters, responsibilities and expectations of Paramount, including consequences of failure and/or inability to carry out these functions. The Medical Advisory Council oversees activities delegated to the pharmacy benefits manager, case management, and utilization management functions.

Effective June 1, 2013, Paramount Advantage delegated utilization management functions for dental prior authorizations to DentaQuest and optical benefits to EyeQuest. Case management of adults and utilization management for adults and children are delegated to Quality Care Partners (QCP) for members residing in 11 counties in central Ohio; effective July 1, 2013. Case management of children is delegated to Partners for Kids (PFK)/Nationwide Children’s for members residing in 34 central/southeast counties of Ohio; effective September 1, 2013.
DEPARTMENTAL ORGANIZATION

The Care Management Department is comprised of registered nurses, licensed practical nurses, mental health/chemical dependency professionals (nurses and licensed social workers), medical assistants, outreach coordinators, and support staff.

Staffing ratios for utilization management functions have been maintained at one (1) Utilization Management coordinator to 8,000 members (regardless of product line) for the past several years.

Due to membership growth and staff attrition the current ratio is one (1) Utilization Management coordinator to 8,587 members (all product lines).

Recent Centers for Medicare and Medicaid Services (CMS) and Health Services Advisory Group (HSAG) audit results demonstrated immediate need for staffing augmentation for successful transition of care UM activities between care settings, as well as, organization determination outreach requirements. Based on the audit findings, optimal staffing ratio of one (1) Utilization Management coordinator to 6,000 members (all product lines) is required.

Care management staffing is comprised of a multi-disciplinary team, as needed, collaborating to deliver a comprehensive, integrated approach with roles and responsibilities of team members delineated to prevent duplication of activities. Care managers are assigned specific members based on geographic location as well as condition and risk stratification. The care manager’s caseloads and case mix are routinely monitored.

The anticipated percentage of case management cases by product line membership is as follows:

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<th>Product Line</th>
<th>Percentage</th>
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<tr>
<td>Commercial HMO</td>
<td>0.5%</td>
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<tr>
<td>Paramount Advantage</td>
<td>12.0%</td>
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<tr>
<td>(Inclusive of Paramount’s Disease/Condition Management Programs)</td>
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<tr>
<td>Paramount Elite and Early Retiree</td>
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These ratios are reassessed at least annually and adjusted as needed.

In addition to the Utilization Management (UM) Coordinators and product specific (Behavioral and Medical) Case Managers (CM), the department consists of The Vice President/Medical Director, a Director of Utilization, Directors of Case Management (Northwest Ohio and Regional) a Clinical Director of Behavioral Health, a Behavioral Health UM/CM Manager, a Maternal Child/HealthChek Manager, a UM/Operations Manager, Case Management Team Leaders for medical and behavioral health needs, Case Management Outreach Coordinators, Behavioral Health Coordinators, a Case Management Quality Improvement Coordinator, Regulatory Compliance Coordinators for UM, CM, and Behavioral Health, an Acute Care/Readmission Appeals Analyst, a Risk Population Specialist, UM Referral Coordinators, Social Services Coordinators, UCM Project Coordinators, a UCM Operations Team Lead, Utilization/Case Management Assistant Coordinators, a UCM Educator and Staff Development resource, as well as Utilization/Case
Management Departmental Support. The Pharmacy Team collaborates within the structure of the care management department. This team has a Pharmacy Program Director, Pharmacists, a Pharmacy Team Leader, Pharmacy Administrative Coordinators, Senior Pharmacy Administrative Coordinators, Pharmacy Utilization Nurse Coordinators, The Disease/Condition Management team consists of a Manager of Quality Improvement/Disease Management (QI/DM), a QI/DM Clinical Team Lead, a QI/DM Operations Team Lead and Health Educators.

The Directors and Managers collaborate together to provide leadership and oversight to the entire Paramount Care Management Program.

The departmental organizational charts are illustrated on the following pages.
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VICE PRESIDENT/MEDICAL DIRECTOR/CARE MANAGEMENT
The Vice President/Medical Director is a licensed physician whose accountability objective is to provide oversight and manage the Pharmacy, Utilization, Case Management, Quality Improvement and Disease/Condition Management departments; to provide strategic planning, operational oversight, and financial/clinical integration; to support and advance organizational goals and outcomes.

CLINICAL DIRECTOR, BEHAVIORAL HEALTH
The Clinical Director, Behavioral Health is a licensed psychologist. The clinical director's accountability objective is to provide guidance in the development and implementation of Paramount’s behavioral health utilization management (UM), case management (CM), and Quality Improvement (QI), programs. This position provides overall leadership and oversight to the Paramount Behavioral Health Programs.

NORTHWEST OHIO (NWO) DIRECTOR, CASE MANAGEMENT
The NWO Director of Case Management is a registered nurse whose accountability objective is to manage the NWO area of the Case Management Department in partnership with the Regional Director; providing ongoing, effective and efficient assessment of all aspects of patient care to help ensure the delivery of high quality, cost-effective medical care to Paramount Advantage members. In addition, this director will provide oversight for the Commercial/Marketplace and Elite CM products. This position strives to foster and maintain relationships with key community advocacy groups as well as state and federal entities to progress organizational initiatives, strategic business development and bring the voice of the community to internal process and procedure to improve the health and well-being of our members.

REGIONAL DIRECTOR, CASE MANAGEMENT/INFANT MORTALITY SPECIALIST
The Regional Director of Case Management is a registered nurse whose accountability objective is to manage the regional areas of the Case Management Department in partnership with the NWO Director; providing ongoing, effective and efficient assessment of all aspects of patient care to help ensure the delivery of high quality, cost-effective medical care to Paramount Advantage members. This position strives to foster and maintain relationships with key community advocacy groups as well as state and federal entities to progress organizational initiatives, strategic business development and bring the voice of the community to internal process and procedure to improve the health and well-being of our members. The Regional Director serves as Paramount’s primary point of contact for ODM-sanctioned improvement efforts involving community-based organizations, requiring community outreach and active involvement in priority communities.

DIRECTOR OF UTILIZATION MANAGEMENT
The Director of Utilization Management is a registered nurse whose accountability objective is to lead utilization and referral management to ensure coordinated delivery of high quality, safe, medically necessary, cost-effective and integrated health care to all Paramount members; facilitating oversight of delegated clinical utilization functions; and assures member and provider satisfaction with health care.
MANAGER OF QUALITY IMPROVEMENT/DISEASE MANAGEMENT (QI/DM)
The Manager of Quality Improvement/Disease Management provides ongoing and documented assessment of all aspects of quality improvement and disease management processes and outcomes; manages clinical improvement interventions; manages accreditation process to ensure compliance with NCQA standards; responsible for HEDIS® reporting, CAHPS® and other surveys; facilitates quality of care investigations; publishes newsletters, practice guidelines and educational materials; and contributes to corrective action planning for regulators upon request. This Manager provides oversight for administration of current disease management programs and development and implementation of new programs, including a population health platform.

PHARMACY DIRECTOR
The Pharmacy Director is responsible for coordinating and monitoring all aspects of the pharmacy program for Paramount members. Responsibilities include oversight of the daily pharmacy program operations, contracted Pharmacy Benefits Manager (PBM), utilization management of prescription drugs, oversight of any groups delegated to provide a pharmacy program and providing clinical support to the care management team and other departments.

BEHAVIORAL HEALTH UTILIZATION/CASE MANAGEMENT MANAGER
The Behavioral Health Utilization/Case Management Manager is a registered nurse or social worker; Certified Case Manager, whose accountability objective is to serve as a clinical resource, provide staff supervision, and support the day-to-day operations of utilization and case management services and social service functions. In addition, this position acts as an interdepartmental liaison to ensure prompt resolution of case management issues and questions and adherence with the Ohio Department of Medicaid and the Center for Medicare & Medicaid Services regulatory requirements relative to care/case management.

UTILIZATION MANAGEMENT/OPERATIONS MANAGER
The Utilization Management/Operations Manager has the primary accountability objective to serve as the departmental resource for outpatient prior authorizations, preadmission, concurrent, and retrospective review for inpatient admissions and home health care; along with conducting departmental quality improvement monitoring. This position also coordinates provider appeal determinations and acts as an interdepartmental liaison to ensure prompt resolution of UM issues with the goal of appropriate medical and utilization management oversight to optimize medical expense and member outcome.

HEALTHCHEK MATERNAL/CHILD PROGRAM MANAGER
The HealthChek/Maternal Child Program Manager is a registered nurse whose primary role is the oversight of the HealthChek program and EPSDT compliance. This manager also focuses on promoting family planning services, preventive health strategies, identifying and coordinating assistance for identified member needs specific to maternal/child health and EPSDT, interfacing with community partners to address issues such as social determinants, health equity and infant mortality.

PHARMACIST
The Pharmacists are registered pharmacists (typically a Doctor of Pharmacy) whose
accountability objectives are to promote the clinically appropriate use of pharmaceuticals and to assure the optimal performance of the Pharmacy Benefit Management (PBM) utilized by Paramount. He/she also provides systematic and relevant feedback to Paramount administration regarding pharmacy spends and trend patterns. Review of drug utilization reports, Formulary compliance reporting, and production of member and/or physician communication pieces are additional responsibilities.

**CARE MANAGEMENT DEPARTMENT EDUCATOR**
The Care Management Educator is a registered nurse whose accountability includes development of assessment, planning, implementation, and evaluation of orientation/training and annual competency training/testing for the U/CM department including leadership. The Educator prepares and updates training manuals and other educational materials on an ongoing basis or as critical changes occur. This role provides outstanding customer service and accepts responsibility in maintaining relationships that are equally respectful to all.

**CARE MANAGEMENT STAFF DEVELOPMENT**
The Care Management Staff Development position is held by a registered nurse whose accountability includes assisting with development of assessment, planning, implementation, and evaluation of orientation/training and educational presentations and in-services. The Staff Development Coordinator assists with the preparation of and updating of training manuals and other educational materials on an ongoing basis or as critical changes occur. Provides outstanding customer service and accepts responsibility in maintaining relationships that are equally respectful to all.

**CASE MANAGEMENT TEAM LEADER**
The Case Management Team Leader is a registered nurse or social worker whose accountability objective is to serve as a clinical resource, provide staff supervision, and support the day-to-day operations of case management. The working team leader acts as an interdepartmental liaison to ensure prompt resolution of case management issues, questions, and concerns.

**BEHAVIORAL HEALTH UTILIZATION/CASE MANAGEMENT TEAM LEADER**
The Behavioral Health Utilization/Case Management Team Leader is a registered nurse or social worker whose accountability objective is to serve as a clinical resource, provide staff supervision, and support the day-to-day operations of utilization and case management services. The working team leader acts as an interdepartmental liaison to ensure prompt resolution of utilization/case management issues, questions, and concerns.

**ACUTE CARE/UTILIZATION MANAGEMENT TEAM LEADER**
The Utilization Management Team Leader is a registered nurse whose accountability objective is to serve as a clinical resource, provide staff supervision, and support the day-to-day operations of the (acute/sub-acute utilization management team.) The working team leader acts as an interdepartmental liaison to ensure prompt resolution of utilization management issues, questions, and concerns.
**REFERRAL MANAGEMENT TEAM LEADER**  
The Utilization Management Team Leader is a registered nurse whose accountability objective is to serve as a clinical resource, provide staff supervision, and support the day-to-day operations of (the referral management utilization team). The working team leader acts as an interdepartmental liaison to ensure prompt resolution of utilization management issues, questions, and concerns.

**TRANSITION OF CARE/UTILIZATION MANAGEMENT TEAM LEADER**  
The Utilization Management Team Leader is a registered nurse whose accountability objective is to serve as a clinical resource, provide staff supervision, and support the day-to-day operations of (the transition of care utilization team). The working team leader acts as an interdepartmental liaison to ensure prompt resolution of utilization management issues, questions, and concerns.

**OPERATIONS TEAM LEADER**  
A working Team leader who assumes responsibility and oversight for the implementation, coordination and design of long and short-term Care Management departmental projects, implementation of new software applications, and process improvement initiatives as related to Plan goals and objectives. Review and implement departmental and inter-departmental efficiencies related to all care management work flows and operations.

**QUALITY IMPROVEMENT/DISEASE MANAGEMENT CLINICAL TEAM LEADER**  
A working Team leader whose primary role is to serve as an operations resource and to be primarily responsible for staff orientation and coordination of clinical data gathering to support the Accreditation and Quality Improvement functions of the organization. The team leader acts as an interdepartmental liaison to ensure prompt resolution of QI/DM clinical issues, questions, and concerns.

**QUALITY IMPROVEMENT/DISEASE MANAGEMENT OPERATIONS TEAM LEADER**  
A working team leader who serves as an operations resource and is primarily responsible for staff orientation and coordination of Operational data gathering to support the Accreditation functions and Quality Improvement functions of the organization. The team leader acts as an interdepartmental liaison to ensure prompt resolution of QI/DM operational issues, questions, and concerns.

**PHARMACY PA TEAM LEADER**  
The Pharmacy PA Team Leader is responsible for staff supervision and the day-to-day operations of medication reviews and authorizations. The team leader acts as an interdepartmental liaison to ensure prompt resolution of utilization management issues, questions, and concerns. This position does regular monitoring to assess the work of the group for compliance with regulations set forth by various governing bodies such as Centers for Medicare and Medicaid Services (CMS) or Ohio Department of Medicaid (ODM).

**CASE MANAGEMENT QUALITY IMPROVEMENT COORDINATOR**  
The Case Management Quality Improvement Coordinator is a registered nurse whose accountability objective is assessing, implementing, and auditing of the ongoing training needs of case management coordinators. The utilization/case management quality improvement
coordinator works closely with case management leadership and the Case Management Regulatory Compliance Coordinator to meet the evolving training needs of case management while ensuring integration of all state, federal and accreditation requirements.

**CASE MANAGEMENT REGULATORY COMPLIANCE COORDINATOR**
The Case Management Regulatory Compliance Coordinator is a registered nurse whose accountability objective is monitoring, analyzing and assisting with incorporation of regulatory requirements into case management practice to meet state, federal, and accreditation compliance.

**UTILIZATION MANAGEMENT REGULATORY COMPLIANCE COORDINATOR**
The Utilization Management Regulatory Compliance Coordinator is a registered nurse whose accountability objective is analyzing, reporting, monitoring, and assisting with incorporation of standards, guidelines, and regulatory requirements into utilization management practice to meet state, federal, and accreditation compliance.

**BEHAVIORAL HEALTH REGULATORY COMPLIANCE COORDINATOR (UM/CM)**
The Behavioral Health Care Management Regulatory Compliance Coordinator is a registered nurse whose accountability objective is analyzing, reporting, monitoring, and assisting with incorporation of standards, guidelines, and regulatory requirements into both case management and utilization management practice, to meet state, federal, and accreditation compliance.

**UTILIZATION MANAGEMENT COORDINATOR**
The Utilization Management Coordinators are registered nurses and licensed practical nurses. Their accountability objective is to coordinate medical prior authorization requests, to perform preadmission, concurrent and retrospective review for inpatient admissions and outpatient services, to identify cases for case management and to ensure the delivery of high quality, cost-effective medical care to all Paramount members.

**UTILIZATION MANAGEMENT REFERRAL COORDINATOR**
The Utilization Management Referral Coordinators are certified medical assistants whose accountability objective is to conduct intake/data entry of prior authorization requests and coordinate the review process for Pharmaceuticals. This position acts as a referral source of potential cases for case management.

**SOCIAL SERVICE COORDINATOR**
The Social Services Coordinator is a licensed social worker whose accountability objective is to provide service coordination for Medicare beneficiaries with a Skilled Nursing Facility/Extended Care Facility stay and those members with specialized non-medical needs identified from completed health risk appraisal survey responses and/or nursing/behavioral case management, as well as to act as a resource person for community programs and services.

**BEHAVIORAL HEALTH UTILIZATION MANAGEMENT COORDINATOR**
The Behavioral Health Coordinator is a registered nurse, licensed social worker, licensed independent social worker or professional counselor whose accountability objective is to perform
preadmission, concurrent and retrospective review for inpatient and outpatient services and identify high risk members who have complex case management needs due to mental health and chemical dependency issues. In addition, this position acts as a liaison between the Plan and the community mental health board and board-funded alcohol and other drug addiction service providers.

**ADVANTAGE CASE MANAGER**
The Case Manager is a registered nurse whose accountability objective is to serve as the accountable point of contact to facilitate, coordinate and evaluate the ongoing care of a specific caseload of Paramount Advantage patients throughout the Continuum of Care, to collaborate with members of the health team, the patient and the family to assure cost-effective, high quality, appropriate care for the patient during the entire episode of illness and for post discharge services and to monitor and evaluate patient outcomes, including self-management.

**COMMERCIAL/MARKETPLACE CASE MANAGER**
The Case Manager is a registered nurse whose accountability objective is to facilitate, coordinate and evaluate the ongoing care of a specific caseload of Commercial HMO/Marketplace patients throughout the Continuum of Care, to collaborate with members of the health team, the patient and the family to assure cost-effective, high quality, appropriate care for the patient during the entire episode of illness and for post discharge services and to monitor and evaluate patient outcomes, including self-management.

**BEHAVIORAL HEALTH CASE MANAGER**
The Behavioral Health Case Manager is a registered nurse, licensed social worker, or professional counselor whose accountability objective is to facilitate, coordinate and evaluate the ongoing care of a specific caseloads of patients throughout the Continuum of Care, to collaborate with members of the health care team, the patient, and the family to assure cost-effective, high quality, appropriate care for the patient with mental health/chemical dependency during the entire episode of illness and for post discharge services and to monitor and evaluate patient outcomes, including self-management.

**ELITE CASE MANAGER**
The Case Manager is a registered nurse or licensed social worker whose accountability objective is to facilitate, coordinate and evaluate the ongoing care of a specific caseload of Paramount Elite members throughout the Continuum of Care, to collaborate with the health care team, the members and their families to assure cost-effective, high quality, appropriate care during the episode of illness and to monitor utilization and evaluate outcomes, including self-management.

**RISK POPULATION SPECIALIST**
The risk population specialist is a registered nurse whose primary accountability objective is to review incoming documentation from various providers with the primary focus on early identification of pregnant women; triaging to the appropriate care management staff as apparent needs are noted or for further assessment to identify potential needs and/or barriers to care.
HEALTH RISK ASSESSMENT/TRIAGE COORDINATOR
The Health Risk Assessment/Triage Coordinator is a registered nurse whose accountability objective is to coordinate identification of Elite members for Health Risk Assessment (HRA) screening; conduct intake and address HEDIS and Star Rating criteria during the HRA intake process to facilitate referrals to case management and resources as indicated.

MEDICAID HEALTH HOME BEHAVIORAL HEALTH COORDINATOR
The Medicaid Health Home Behavioral Health Coordinator is a RN, LSW, LISW, LBSW or LMSW whose accountability objective is to coordinate with Medicaid Health Homes (Community Mental Health Center-CMHC) to ensure that Advantage members with serious and persistent mental illnesses (SPMI), serious mental illnesses (SMI), and severe emotional disturbances (SED) with/without co-morbidities are receiving behavioral health and medical care to treat the whole person. This position is responsible for coordination of services, integration of care plan, and data sharing with the Health Home to prevent duplication of services and prevent fragmentation of care. The Health Home program will be phased out during 2018 and these coordinators will be absorbed into other Advantage Case Management programs.

COORDINATED SERVICE PROGRAM COORDINATOR
The Coordinated Service Program (CSP) Coordinator is a RN, LSW, LISW, LMSW, or Professional Counselor whose accountability objective is to maintain quality of care and improve the safety of Paramount Advantage members by monitoring the use of health care services and prescription medication dispensing patterns and taking the necessary action to coordinate medical and pharmacy services in accordance with regulatory requirements.

CASE MANAGEMENT OUTREACH COORDINATOR
The Case Management Outreach Coordinator is a SW, LPN, RN, or Certified Health Education Specialist whose accountability objective is to provide support to case managers (Accountable Point of Contact). The Case Management Outreach Coordinator works within their scope of practice as an integral part of the interdisciplinary team under the direction of the case manager to interact with members; conducting assessments, providing education, community resource planning, and support.

HEALTH EDUCATOR
The Health Educator has a bachelor degree in public health, a nursing degree, or a certification in a health related field. The health educator’s accountability objective include performing comprehensive assessments to identify needs and promotes individualized strategies for optimal condition control and well-being to members enrolled in one or more disease management program. The health educator also develops individualized health education plans in conjunction with the member, based on identified medical, behavioral, and/or psychosocial needs and condition related self-management goals.

CASE MANAGEMENT ASSISTANT COORDINATOR
The Case Management Assistant Coordinator assists the case managers and outreach coordinators in scheduling and coordinating in person member/provider visits, completing data
entry of incoming documents and information into appropriate system applications, and working under the guidance of CM staff to obtain member information/documentation from outside medical records/providers/facilities. Other duties include providing administrative support to the care management department.

**UTILIZATION MANAGEMENT ASSISTANT COORDINATOR**
The Utilization Management Assistant Coordinator reviews, evaluates, and authorizes specific acute hospital, home health care admissions or specified prior authorization requests, including authorization data entry and related record-keeping/documentation and ensures department compliance for the ODM Provider Agreement and CMS. Other duties include providing telephone queue line coverage with triage of calls to the appropriate UM team member and/or appropriate Paramount department; identifies members for potential care management.

**PHARMACY ADMINISTRATIVE COORDINATORS and SENIOR PHARMACY ADMINISTRATIVE COORDINATOR**
The Pharmacy Administrative Coordinators and Senior Pharmacy Administrative Coordinator assist with pharmacy-related data collection, review, and quality improvement processes within the pharmacy area. Other duties include web-page maintenance and issue resolution assistance to other departments.

**PHARMACY REGULATORY COMPLIANCE COORDINATOR**
The Pharmacy Regulatory Compliance Coordinator supports the Pharmacy Director in efforts to oversee and maintain departmental compliance, with primary responsibilities in delegation oversight, audit documentation and preparation, and vendor management.

**PHARMACY NURSE SPECIALISTS**
The Pharmacy Nurse Specialists are registered nurses or licensed practical nurses whose accountability objective is to conduct the review process for Pharmacy prior authorization of specialty medications and craft denial letters for these requests as appropriate. This position acts as a referral source of potential cases for case management.

**PHARMACY COORDINATORS**
The Pharmacy Coordinators are certified medical assistants and/or pharmacy technicians whose accountability objective is to conduct the review process for Pharmacy prior authorization, including non-formulary, quantity limit, clinical prior authorizations, and step therapy requests. This position acts as a referral source of potential cases for case management.

**PROJECT COORDINATOR**
The Project Coordinators’ accountability objective is to work independently to provide analytic support on projects and proposals. This position is responsible for task leadership and sub-task management on small to mid-size projects.
**ACUTE CARE/READMISSION APPEALS ANALYST**
The acute care/readmission appeals analyst is a registered nurse whose accountability objective is to identify members for potential related readmission payment exclusion based on medical policy, analyzing data and creating recommendation for process improvement, transition of care and/or educational opportunities as identified. This position works with all product lines.

**UTILIZATION/CASE MANAGEMENT DEPARTMENTAL SUPPORT**
The Utilization/Case Management Departmental Support Staff’s accountability objective is to provide administrative, clerical support for the UM/CM Department by coordinating the distribution of the incoming daily UM/CM requests, printing daily inpatient reports and sorting, filing, faxing, organizing/mailing material to providers and members of all Paramount product lines.

**MEDICAL DIRECTOR, ASSOCIATE MEDICAL DIRECTOR, ASSOCIATE CLINICAL DIRECTOR**
The Medical Director and Associate Medical Directors are physicians who are board certified in his or her designated area of practice whose principle accountability is to provide guidance in the development and administration of the Plan’s Utilization Management and Quality Improvement Programs. The Medical Director/Associate Medical Directors review and make recommendations regarding policies and procedures. The Associate Clinical Director of Behavioral Health is a doctoral level clinical psychologist whose principle accountability is to provide guidance in the development and administration of the Plan’s Behavioral Health Program. The Medical Director, Associate Medical/Clinical Director also provides medical determinations for cases that do not appear to meet the Plan’s guidelines and criteria to assure that the member receives the most appropriate medical/behavioral care in the most cost-effective setting.

**SUBSPECIALIST CONSULTANTS**
The Plan maintains additional consulting arrangements for the purpose of case-specific review when the Medical Director or Associate Medical/Clinical Directors need a subspecialist's expertise. Formal arrangements have been made with a variety of subspecialist consultants in specialty areas including, but not limited to, allergy, dermatology, gastroenterology, OB/GYN, orthopedics, otolaryngology, pathology, podiatry, radiology, plastic surgery, dentistry, pediatric pulmonology, endocrinology, general surgery, neurology, neurosurgery, ophthalmology, retinology, urology, vascular surgery, behavioral health, cardiovascular surgery and cardiology. In addition, all members of the Medical Advisory Council are available for consultation with the Medical Director or Associate Medical/Clinical Director as needed.

In addition, the plan utilizes a delegated medical review organization to provide medical determinations for a variety of subspecialty requests based on a formal workflow process.

**UTILIZATION CARE MANAGEMENT PROCESS**
Paramount’s Utilization/Care Management Department maintains departmental policies and procedures. These policies and procedures are reviewed on an annual basis and updated on an as needed basis. The policies and procedures provide documentation of the framework of authority on which the Utilization/Case Management Program operates. The Utilization Management Coordinator and Case Manager are authorized to make decisions providing that he/she is operating within the framework described within these policies and procedures. The
Utilization Management Coordinator and Case Manager are authorized to approve services. Paramount’s utilization management decisions are based upon appropriateness of care and service criteria as well as existence of coverage. Utilization Management staff and Associate Medical/Clinical Directors are not financially or otherwise compensated to encourage underutilization and/or denials.

The Medical Director/Associate Medical Directors or Pharmacists, as appropriate, are the only Plan representatives with the authority to deny payment for a service based on medical necessity/appropriateness. In addition, the Clinical Director of Behavioral Health Services (doctoral level clinical psychologist, psychiatrist or certified addiction medicine specialist) has the authority to deny payment for behavioral health care services based on medical necessity/appropriateness.

To eliminate the fragmentation that often occurs within an unmanaged health care delivery system, the Primary Care Physician is responsible for coordinating all aspects of the member's health care. Conversely, the member is responsible for coordinating his/her medical and behavioral health care through the Primary Care Physician. Although in-Plan specialist referrals are not required by Paramount for claim payment, members are encouraged to seek their PCP’s advice before seeking specialist consultation and treatment.

The following provides an overview of the various functions of the Utilization Management (UM) Program.

REFERRAL SYSTEM

- **Specialist Referrals** - The Primary Care Physician (PCP) may request a consultation from a participating specialist physician at any time. No referral is required from Paramount prior to consultation with any participating specialist.

- **Emergency Room Services** - No referrals are required for treatment of an emergency medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

  a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman, or her unborn child, in serious jeopardy;
  b. Serious impairment to bodily functions;
  c. Serious dysfunction of any bodily organ or part.

Emergency Room services are also covered if referred by an authorized Plan representative, PCP or Plan specialist. Plan notification (referral) is not required for payment of Emergency Room services for an emergency medical condition.
• **Out-of-Plan Referrals** - These requests are reviewed individually and determinations are made based on the patient's medical needs and the availability of services within the Provider Network to meet these needs.

• **Tertiary Care Services** - All referrals to Plan tertiary care centers are reviewed on an individual basis. The member's medical needs and the availability of the requested services within the non-tertiary care network are taken into consideration.

• **Predetermination of Benefits/Outpatient Certification** – Certain procedures, durable medical equipment and injectable medications require prior authorization. Paramount uses InterQual® criteria for Imaging, Procedures and Molecular Diagnostics. When InterQual® criteria does not exist within Paramount’s purchased products, criteria are developed internally by the Technology Assessment Working Group, Medical Policy Committee, or Pharmacy and Therapeutics Working Group as appropriate. Also, utilized are CMS & ODM criteria. Additionally, potentially cosmetic surgery and other procedures may be reviewed prospectively, at the request of providers and/or members, to issue coverage determinations.

**INPATIENT CERTIFICATION (applicable to both Medical and Behavioral Health)**

To assure that all admissions are appropriate, based on medical necessity, and that the health care services are being provided in the most appropriate setting, the Plan reviews all hospital, long term acute care facility (LTAC), skilled nursing facility and inpatient rehabilitation admissions. Elective admissions may be reviewed before the member enters the facility. Urgent and emergency admissions are reviewed the first business day after the admission occurs. This review is received by telefax or portal from the Utilization Review Department at each facility.

Pre-established medical necessity/appropriateness criteria are utilized to assure consistency in the certification process. Upon determination that an admission meets criteria, the UM Coordinator assigns a length of stay in anticipation of the concurrent review process. The admission continues to be reviewed at appropriate intervals until the member is medically appropriate for discharge to the next level of care or discharged to home without additional service required. The facility will be requested to provide updates to the discharge plan to allow care management involvement in the transition of care. Authorization of the admission includes all physician and ancillary services rendered during the inpatient stay. Excluded are those services that are not a covered benefit, such as convenience items.

The following methods of review are utilized:

• **Post-Service Initial (Inpatient) Review** - Using InterQual® Level of Care Criteria and Clinical judgment; inpatient hospitalizations are reviewed to assure that the services are provided in the appropriate setting.

• **Concurrent review** - InterQual® Level of Care Criteria and clinical judgment are utilized to evaluate the quality and appropriateness of care and to assess the medical-necessity of continued stay.
**Retrospective Review** – InterQual® Level of Care Criteria and Clinical judgment are utilized to evaluate the quality and appropriateness of care and to assess medical necessity. Timely notification is important to assess and meet our member’s needs. It is expected that clinical notification be submitted by the end of the next business day on a Monday through Thursday In-Patient admission and by the end of business, Tuesday for a Friday through Sunday admission. Paramount will not consider retrospective reviews that fall outside of these parameters, unless there is a holiday, in which a special consideration will be made. There are some contractual and non-contractual exceptions to the retrospective policy that will also be considered upon submission.

**Discharge Planning** - During the course of precertification and/or concurrent review, the Utilization/Case Management Coordinators will identify ongoing, continuing care needs that will be required after discharge. Collaboration occurs with facility staff and arrangements are made for these needs to be met through participating providers, e.g., skilled nursing and/or rehabilitation facilities, home health care, medical equipment and/or supplies.

**Transition of Care** - The Utilization/Case Management Coordinators will effectively and comprehensively assess and assist high risk members with transitions of care between settings in order to prevent unplanned or unnecessary readmissions, emergency department visits, and/or adverse outcomes. The goal of this program is to assure compliance with the discharge plan/required follow up care and to assist in the coordination of needed care/services to prevent adverse outcomes. Telephonic, in-person or written follow-up communication is conducted with identified at-risk members and/or their providers to ensure post discharge services have been provided.

**Outpatient Certification** - Specified outpatient services are reviewed utilizing criteria developed by the Technology Assessment Working Group and/or the Pharmacy and Therapeutics Working Group and approved by the Medical Advisory Council.

**Behavioral Health Services** - Paramount reviews inpatient mental health detox services for all product lines using the utilization management functions and tools/guidelines described above. In addition to InterQual®, the American Society of Addiction Medicine (ASAM) criteria are used to determine the level of care for Substance Use Disorder (SUD). To the extent possible and permissible by current privacy and confidentiality regulations, behavioral health and general medical management is integrated for optimal member outcomes.

**Utilization Management Reporting System** - Relevant cost and utilization data is reported for review and analysis. Action is taken to correct any patterns of potential or actual inappropriate under- or overutilization.

 Appropriately licensed, professional staff performs all of the above functions.
Providers may review criteria upon request by contacting the Director of Utilization Management. Internally developed criteria are also available on Paramount’s Internet site. www.paramounthealthcare.com.

OUTPATIENT CERTIFICATION  (applicable to both Medical and Behavioral Health)

Prior authorization is conducted for select outpatient procedures and durable medical equipment to ensure appropriateness of the service and availability of coverage. A list of services that require prior authorization can be found on Paramount’s Internet site, www.paramounthealthcare.com.

Coverage for specific self-injectable drugs is provided under either the medical or prescription drug benefit to decrease disease progression and avoid future costly medical care. Prior authorization is conducted to assure that the pharmaceutical is the most appropriate, cost-effective intervention.

The Utilization/Case Management Department reviews all home health care services prospectively and concurrently to assure that the services provided are medically necessary and being provided in the most appropriate setting.

- Behavioral Health
  Historically, for the Paramount Advantage product, Paramount has only been responsible for managing the behavioral health inpatient benefit. The outpatient behavioral health benefits were “carved out” and directly billed to Medicaid Fee-for-Service. In an attempt to align with Medicaid’s medical benefit and allow for more efficient and effective care coordination between settings, the outpatient behavioral health benefit is in the process of being redesigned and “carved in” to Medicaid Managed Care. This process will be complete and take effect as of July 1, 2018. To the extent possible and permissible by current privacy and confidentiality regulations, behavioral health and general medical management is integrated for optimal member outcomes. Outpatient behavioral health services are intended by the state to be provided by the community mental health and ODADAS agencies. However, in the event that services are not available on a timely basis, or the member chooses to use a provider outside of the community system, the Plan must make arrangements for services outside the community network. The Plan maintains an adequate provider panel from which the member may choose in these instances.

Utilization management functions for behavioral health services follow the same processes as medical utilization management. This includes Out-of-Plan specialist (psychiatrist/psychologist) referrals, tertiary care and inpatient certification. A listing of product specific Prior Auth requirements can be found on the Paramount internet site. www.paramounthealthcare.com. Paramount does not operate a centralized behavioral health triage service.
• **Specialist Referrals**

Although Paramount does not require In-Plan specialist referrals for claim payment, members are strongly encouraged to coordinate their specialist care with their Primary Care Physician.

In turn, Plan specialists are always responsible for communicating a treatment plan to the Primary Care Physician to assure that the Primary Care Physician is aware of all aspects of the patient's care.

• **Emergency Room Services**

Paramount maintains an Emergency Health Services policy that defines the process for the provision of emergency care. Emergency Services are defined as treatment of a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman, or her unborn child, in serious jeopardy;

b. Serious impairment to bodily functions;

c. Serious dysfunction of any bodily organ or part.

The Plan also covers Emergency Room Services if referred by an authorized Plan representative, PCP or Plan Specialist. Plan notification (referral) is not required for payment of Emergency Room services for an emergency medical condition. The member is instructed to contact his/her Primary Care Physician after receiving urgent care services in any setting. The intent of this procedure is to allow the Primary Care Physician to coordinate any needed follow up care. Referrals are not required for payment of urgent care services received in an urgent care facility. Emergency room utilization is monitored quarterly and members with a pattern of overuse/abuse are referred to Case Management for investigation and follow-up.

• **Tertiary Care Services**

All referrals to Plan tertiary care centers are reviewed on an individual basis. The member's medical needs and the availability of the requested services within the non-tertiary care network are taken into consideration. Formal or informal consultation with a participating specialist, if available, is required prior to considering a referral for tertiary care services. The participating specialist's recommendations for referral to a tertiary care center are taken into consideration by the Plan Medical Director or Associate Medical/Clinical Directors when he/she makes the determination. It is important to note that the member's Primary Care Physician must also agree with the referral.
• Out-of-Plan Referrals

All requests for services outside the provider network are reviewed on an individual basis. Determinations are made based on the member's medical needs and the availability of the services within the network. Services that are available within the network are not approved outside the network except in cases where the patient's health care status could be negatively impacted by not approving the Out-of-Plan services. Decisions of this nature are made by the Plan Medical Director or Associate Medical/Clinical Directors. Specific guidelines are in place for UM/CM Coordinators to approve certain out-of-Plan requests.

• Predetermination of Benefits

Prior to services being rendered, members and/or providers may request a determination as to whether a specific procedure is covered. Requests for potential cosmetic surgeries are common predetermination of benefit requests. The Medical Director or Associate Medical Directors make the determination as to whether a procedure is considered cosmetic. The UM/CM Coordinators can deny a procedure only if it is specifically referenced as a benefit exclusion.

Additionally, several procedures, durable medical equipment and injectable medications require prior authorization. The UM/CM Coordinators can approve these services if specific medical necessity criteria are met. All others decisions, including denials, are made by the Plan Medical Director/Associate Medical/Clinical Directors or Prescription Drug Coordinators (Pharmacists) as appropriate.

• Diagnostic Imaging

Pre-established medical necessity/appropriateness criteria are utilized in the certification of elective outpatient CT scans, CTA of the coronary arteries, MRIs, MRAs and Nuclear Cardiology studies. Prior authorization is not required when the diagnostic imaging studies are done as part of an emergency room visit for an emergency medical condition, an observation stay or an authorized inpatient stay.

Physician groups are reviewed annually for Imaging “Gold Card” status. This designation allows the ordering physician to bypass imaging medical necessity reviews when the study is done at a network facility.

• Genetic Testing

Pre-established medical necessity/appropriateness criteria are utilized in the certification of elective genetic testing. Prior authorization is not required for those genetic tests needed for potential organ transplant recipients.
**UTILIZATION MANAGEMENT DECISION/NOTIFICATION TIMEFRAMES**

Paramount follows federal, state and NCQA decision and notification timeframes for all utilization management determinations. Where regulatory and accreditation bodies differ, Paramount will use the strictest/shortest timeframe to assure compliance with all requirements. The following is a summary of Paramount’s decision and notification timeframes:

<table>
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<th>Decision</th>
<th>Standard</th>
<th>Initial Notification</th>
<th>Written Notification</th>
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| Precertification of non-urgent care | Decisions for precertification of non-urgent care will be made within 7 calendar days of receipt of request. | Telephonic or electronic confirmation of the decision to the provider is made within three (3) calendar days after making the decision. | Written or electronic notification of the decision is given to the provider and member three (3) calendar days after initial notification.  
-For Paramount Advantage, written notification of a denial decision and the Notice of Action is sent to the practitioner and the member on the same day as the coverage determination except in those cases when the coverage determination occurs after the close of regular business hours. Written denial notification for coverage determinations made after regular business hours occur the next business day. |
| Precertification of urgent care | Decisions for precertification of urgent care will be made within 48 hours of receipt of request. | Telephone or electronic confirmation of the decision is given to the provider within 48 hours of the receipt of the request. In cases of a denial; members also need to be notified of the decision. (Reference U/CM Procedure Denial of Services, Section E, No. 3) **NOTE:** For Paramount Advantage members, if the member signed a liability statement specific to that service, the member would have financial responsibility. If the member did not sign the liability statement, the member will not have financial responsibility. | Written or electronic notification of the decision is given to the provider and member within 48 hours of the receipt of the request. For Paramount Advantage, written notification of a denial decision and the Notice of Action is sent to the practitioner on the same day as the coverage determination except in those cases when the coverage determination occurs after the close of regular business hours. Written denial notification for coverage determinations made after regular business hours occur next business day. **NOTE:** For Paramount Advantage members, if the member signed a liability statement specific to that service, the member would have financial responsibility. If the member did not sign the liability statement, the member will not have financial responsibility. In addition, a letter would go out to the member along with a notice of action (NOA). Exception: Out of Plans do not require a NOA to be sent. |
| Concurrent Review | Within 24 hours/ 1 calendar day of receipt of the request. | Telephone or electronic confirmation of the decision is given to the provider within 24 hours of the request | Written or electronic notification of the decision is given to the provider within 3 calendar days after initial notification. |
| Retrospective Review | Retrospective review decisions are made within 30 calendar days of receipt of the request. | Telephone or electronic confirmation of the decision is given to the provider within 30 calendar days of receipt of the request. | Written or electronic confirmation of the decision is given to the provider and member within 30 calendar days of the request. Members will receive a copy of the denial letter only if the member will be financially liable for the services (Example: Out-of-Plan admissions). 

**NOTE:** For Paramount Advantage members, if the services were retrospectively denied as not medically necessary, an NOA would not be issued. |
| PA requests for drugs given in a provider setting – Paramount Advantage | Decisions for Paramount Advantage for drugs that require PA in a provider setting must be made within 24 hours of receipt of request. | Decision results must be communicated by telephone or electronically to the practitioner/provider the same day the decision is made. | Written notification of a denial decision is sent to the practitioner and member the same day the decision is made. |
| Elite expedited request | Decisions for Elite expedited requests will be made within 72 hours of receipt of request. | Decision results must be communicated by telephone or electronically to the practitioner/provider and member within 72 hours of receipt of request. | Written notification of an approval or denial decision is sent to the practitioner and member the same day the decision is made via UPS. 

**Note:** Per CMS, The enrollee must receive the notice in the mail within 72 hours of receipt of request. |
UTILIZATION MANAGEMENT REPORTING SYSTEM

Product-line specific, high level, summary cost and utilization data is reviewed and analyzed monthly for the following areas:

- Discharges/1,000
- Percentage of members receiving any mental health service
- Hospital outpatient services/1,000
- ED visits/1,000 (not resulting in admission)
- Primary Care visits/1,000
- Specialty Care visits/1,000
- Prescription Drug services

Actual unit cost and utilization rates by treatment type category are compared to budgeted and benchmark figures. If any significant over or underutilization trend is noted, additional, more detailed reports are reviewed. Reports are structured so that they are available on a patient specific, provider or group specific, service specific, or diagnosis specific basis. Data can be reported in summary or at an individual claim level of detail. The utilization reporting system allows for focused problem identification and resolution.

Paramount’s Pharmacy Benefit Coordinator routinely monitors and analyzes pharmacy use in each product line to detect potential underutilization and overutilization. Pharmacy utilization is also monitored by individual physicians and across practice and provider sites. Appropriate clinical interventions and/or other strategies are implemented when required and monitored for effectiveness.

UTILIZATION MANAGEMENT PERFORMANCE MONITORING

The Utilization Management Regulatory Compliance Coordinator monitors the consistency of the UM/CM staff in handling approval, denial and inpatient decisions and reports the results to the UCM Management Team. Turnaround time of UM decisions, including verbal and written notification is also monitored. Medical Director and Associate Medical/Clinical Director decisions are periodically reviewed by a physician for consistency of medical appropriateness determinations. Telephone queue line statistics are tracked and reported to UCM Management, specific to number of calls received, abandonment rate and average speed of answer. Additional monitoring of the Utilization Care Management Program is performed through comments from the Member Satisfaction Survey, the Physician and Office Manager Satisfaction Survey, Case Management Member Satisfaction Survey, and the quarterly appeals reports.

ACCESS TO UTILIZATION MANAGEMENT STAFF

Utilization Management staff is available Monday through Friday (excluding holidays) from 8:00 a.m. to 6:00 p.m. to answer questions regarding UM decisions, authorization of care and the UM program. The Department has both local and toll-free telephone and telefax numbers and offers TDD/TTY services for deaf, hard of hearing or speech impaired members. Language assistance/interpretation is also available for members to discuss UM issues. Telephone lines are
staffed with professionals who have access to most information/resources needed to provide a timely response. Staff is identified by name, title and organization name when initiating or returning calls regarding UM issues. Callers have the option of leaving a voice mail message either during or after business hours. These calls are returned promptly the same or next business day. Staff is also a resource for other Plan Departments for Utilization Management questions.
MEDICAL NECESSITY

According to Plan policy, medical necessity/appropriateness is defined as those services determined by the Health Plan or its designated representative to be (i) preventive, diagnostic, and/or therapeutic in nature, (ii) specifically relates to the condition which is being treated/evaluated, (iii) rendered in the least costly medically appropriate setting (e.g., inpatient, outpatient, office), based on the severity of illness and intensity of service required, (iv) not solely for the Member's convenience or that of his or her physician and (v) is supported by evidence-based medicine.

MEDICAL NECESSITY CRITERIA

The Utilization Management Program is conducted under the administrative and clinical direction of the Vice President Medical Director and the Medical Advisory Council. Therefore, it is Paramount's policy that all medical appropriateness/necessity criteria are developed, reviewed and approved by the physician entities prior to implementation. Part of this review process may also include input from appropriate participating subspecialists. As part of the review of the Utilization Management Program, all criteria are reviewed and updated as needed, but no less than annually. Providers are advised that criteria are available upon request. Internally developed criteria and a general list of services that require prior authorization are also available on Paramount's internet site, www.paramounthealthcare.com. Physicians may review the InterQual® criteria at any participating hospital or by contacting the Director of Utilization. InterQual® criteria are also available to providers through the MyParamount Provider portal. The individual needs of the member and the resources available within the local delivery system are considered when applying Utilization Management criteria.

Inpatient Certification

The Utilization Management Program uses the current edition of the McKesson InterQual® Level of Care Criteria (Acute Pediatric; Acute Adult; Behavioral Health Chemical Dependency & Dual Diagnosis (Adult & Adolescent); Behavioral Health Psychiatry (Adult, Child, Adolescent, Geriatric); Residential and Community-Based Treatment (Adult, Adolescent & Child) as the basis of the inpatient certification process. The InterQual® criteria are also applied in reviewing the appropriateness of admissions for inpatient rehabilitation services, admissions to skilled nursing facilities, mental health and chemical dependency partial hospitalization, intensive outpatient and ambulatory services as well as for home health care services. In addition, for the Behavioral Health UM program, the American Society of Addiction Medicine (ASAM) criteria are used to determine the level of care for Substance Use Disorder (SUD) inpatient admissions. It is the practice of participating hospitals to utilize the InterQual® criteria during their internal Utilization Review process.

Outpatient/Other Certification

Where it exists, current InterQual® Procedures and Molecular Diagnostics (MdX) criteria are used to determine medical necessity for outpatient services. When absent from the InterQual® criteria sets, internal criteria for certification are based on current evidence-based medical literature and
are developed by the Medical Policy Committee, the Technology Assessment or the Pharmacy and Therapeutics Working Groups and/or CMS/ODM criteria. At least annually, the criteria are reviewed by the Working Groups and applicable participating subspecialists. The Medical Advisory Council takes the Working Group's recommendations for modifications into consideration during the approval process. The criteria are used by the Utilization and Case Management Coordinators during the prior authorization process. The internally developed criteria are available on Paramount’s internet site, www.paramounthealthcare.com.

Diagnostic Imaging

The current edition of McKesson InterQual® Imaging Criteria is used as the basis for authorization of the following elective, outpatient imaging studies:

- CT Scans
- MRI
- MRAs
- Nuclear Cardiology
- CTA Coronary Arteries

Genetic Testing

The current edition of McKesson InterQual® Molecular Diagnostics (MdX) Criteria is used as the basis of authorization for genetic testing.

Durable Medical Equipment

Medicare guidelines are used in the prior authorization of select durable medical equipment for the Commercial/Marketplace and Medicare product lines. Medicaid guidelines are used for Paramount Advantage members. A list of durable medical equipment that requires prior authorization can be found on Paramount’s internet site, www.paramounthealthcare.com.

Transplants

It is Paramount’s policy that all requests for organ transplants be reviewed by the Medical Director or Associate Medical Director and Case Manager. The members are directed to the most appropriate Center of Excellence transplant facility for evaluation based on benefits.

For Paramount Advantage members, based on the ODM provider agreement, providers may submit prior information for the purposes of the UCM Coordinator assisting the member with identifying available providers, initiating case management services and addressing any compensation issues, however, when identifying available providers that could ultimately impact where the transplant is performed, Paramount does not solely consider the provider’s panel status but also considers the proximity to a member’s residence, support system and the network of providers who have coordinated the member’s care.

The Case Manager coordinates with the facility transplant coordinator to send the transplant recommendation to either the Ohio Solid Organ Transplant Consortium or the Ohio Hematopoietic
Stem Cell Transplant Consortium, as appropriate, prior to approval by the Plan. Renal and corneal transplants are excluded from Consortium review. The Plan's determination of medical necessity will be based on the Transplant Consortium’s determination, thus providing an outside, impartial, expert evaluation. Once the patient has been approved, the patient is enrolled in the United Network for Organ Sharing (UNOS). The patient's acceptance into UNOS serves as the Plan's medical necessity determination.

All members approved for transplant are followed closely by Case Management as well as Paramount’s interdepartmental transplant team, consisting of Medical Directors, Case Managers and Financial, Claims and Actuarial representatives. The purpose of the team is to ensure ongoing medical necessity for transplant, employer group high dollar alert (if self-insured), and reinsurance notification and to ensure appropriate claims payment.

MEDICAL NECESSITY DETERMINATIONS

Medical necessity determinations are made based on information gathered from many sources. Each case is different; however, these sources may include some or all of the following:

- Primary Care Provider
- Specialist physician
- Facility Utilization Review Department
- Patient chart
- Home health care agency
- Physical, occupational or speech therapist
- Social Worker
- Registered Nurse
- Behavioral health/chemical dependency provider
- Patient or responsible family member

The information needed will often include the following:

- Patient name, ID#, age, gender
- Brief medical history
- Diagnosis, co-morbidities, complications
- Signs and symptoms
- Progress of current treatment, including results of pertinent testing
- Providers involved with care
- Proposed services
- Referring physician’s expectations
- Psychosocial factors, home environment

The Utilization/ Management Coordinator and Case Manager will use this information, along with clinical judgment, departmental policies and procedures, needs of the individual member and characteristics of the local delivery system, including the availability of the proposed services
within the network service area, to make a decision. The Utilization Management Coordinator and Case Manager have the authority to approve services based on medical necessity. If the decision is outside the scope of the Utilization Management Coordinator and Case Manager's authority, the case is referred to the Medical Director/Associate Medical Directors for a determination. The Medical Director/Associate Medical Directors or Prescription Drug Coordinators (Pharmacists), as appropriate, are the only Plan representatives with the authority to deny payment for services based on medical necessity/appropriateness. Psychiatrists, doctoral-level clinical psychologists, or certified addiction medicine specialists have the authority to deny payment for behavioral health care services based on medical necessity/appropriateness. Alternatives for denied care/services are given to the requesting provider and member and are based on the criteria set used or individual case circumstances. In making determinations based on contract benefit exclusions/limitations, the Member Handbook and Group Services Agreement are used as references.

PRESCRIPTION DRUG UTILIZATION MANAGEMENT

Paramount utilizes CVS Caremark™ as its Pharmacy Benefit Manager (PBM). Quantity limits, dollar limits, step therapy and prior authorization (criteria established by the Pharmacy and Therapeutics Working Group, a subcommittee of the Medical Advisory Council) are placed on certain drugs. Additionally, for Medicare beneficiaries with drug benefits, Part D vs. Part B determinations are required using specific coverage criteria set by the Centers for Medicare and Medicaid Services (CMS). The utilization management process is activated by the pharmacist, ordering physician or member when the member accesses these drugs. The UM staff collects all pertinent medical information and has the authority to approve coverage if criteria are met. All other determinations are made by the Medical Director, Associate Medical Director or Prescription Drug Program Coordinator (Pharmacist). All UM processes, including verbal and written notification of the decision to the provider and member, are followed in making the determination.

PARAMOUNT ADVANTAGE COORDINATED SERVICES PROGRAM (CSP)

An Advantage member may be enrolled in CSP if a review of his/her utilization demonstrates a pattern of receiving controlled substances at a frequency or in an amount that exceeds medical necessity. Reasons for enrollment may include the use of multiple pharmacies, multiple controlled substances, multiple visits to emergency rooms, a high volume of prescriptions or visits to medical professionals, previous enrollments in CSP or recommendations from medical professionals indicating that the member has demonstrated fraudulent or abusive patterns of medical service utilization. Members are locked in to a designated pharmacy for the purpose of filling their prescriptions for a minimum period of twenty four (24) months. Exceptions are made for emergency situations. All members enrolled in CSP are followed closely by Behavioral Health Case Management. This program will transition to other Managed Care Plans if members change plans during the CSP enrollment. There is current consideration for exploring the opportunity of a similar program for other Paramount product lines.
NEW TECHNOLOGY ASSESSMENT

The Plan investigates all requests for new technology or a new application of existing technology using the HAYES Medical Technology Directory® as a guideline to determine whether the new technology is investigational in nature. If further information is needed, the Plan utilizes additional sources, including Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This includes medical and behavioral health procedures and devices. Pharmaceuticals are investigated by the Pharmacy and Therapeutics Working Group.

If the new technology/pharmaceutical or new application of an existing technology/pharmaceutical is addressed in the above documents, the information is taken into consideration by the Medical Director or Associate Medical/Clinical Directors at the time of benefit determination. If the new technology/pharmaceutical or new application of an established technology/pharmaceutical is not addressed in the above documents, the Medical Director or Associate Medical/Clinical Directors may confer with an appropriate specialist consultant for additional information. This information will be presented to the Technology Assessment or Pharmacy and Therapeutics Working Groups, subcommittees of the Medical Advisory Council, to provide a recommendation to the physician Council regarding coverage. The decision will be based on safety, efficacy, cost and availability of information in published literature regarding controlled clinical trials. If a decision cannot be made, a committee of specialists may be convened to review the new medical technology/pharmaceutical and make a recommendation to the Medical Advisory Council.

CONFIDENTIALITY

Paramount has written policies and procedures to protect a member’s personal health information (PHI). The Utilization/Case Management Department collects only the information necessary to conduct case management services or certify the admission, procedure or treatment, length of stay, frequency and duration of health care services. We are required by law to protect the privacy of the member’s health information. Before any PHI is disclosed, we must have a member’s written authorization on file. Within the realm of utilization review and case management, access to a member’s health information is restricted to those employees that need to know that information to provide these functions. A full description of Paramount’s Notice of Privacy Practices may be found on our website at: www.paramounthealthcare.com.
CASE MANAGEMENT/DISEASE (CONDITION) MANAGEMENT

Development of new initiatives and program enhancements are based on the most current evidenced-based clinical practice guidelines, established by nationally recognized organizations, such as the American Diabetes Association and the Global Initiative for Chronic Obstructive Lung Disease in conjunction with National Committee for Quality Assurance standards. Expert physician advisors assist in the design of each program and the final program descriptions are approved by the Medical Advisory Council and the Board of Directors.

Collectively, the mission of ProMedica and Paramount, the Institute for Healthcare Improvement Triple Aim (IHI), and the Standards of Practice for Case Management (CMSA 2016), are keystones for Paramount's care management philosophy, culture, and practice. These foundational concepts have been adopted to improve the health and well-being of the membership (ProMedica, 2016), to standardize case management adherence guidelines and practice tools, to improve the member experience of care, to improve the health status of populations, and reduce health care expenses (IHI, 2016).

The care management team at Paramount is comprised of health care professionals dedicated to these efforts. The team uses a holistic health approach, assessing physical, psychosocial, behavioral health, nutritional, environmental, and life style issues. The broad continuum of interventions and services are determined in collaboration with internal and external provider/partners, using risk level severity and whether the member has acute or chronic needs. Social determinants, including assessment of living arrangements and/or caregiver capabilities are assessed during the initial outreach and with ongoing reassessments.

Paramount evaluates encounter/utilization, medical and pharmacy costs, and social/clinical data to determine most prevalent member needs and opportunities for improvement. Care management initiatives and programs are adjusted to meet member and population needs, as well as regulatory requirements.

Approximately 1% of a Plan's members will utilize approximately 25% of the Plan's resources. The Case Management Program was established to more effectively manage this segment of the population. Members are reviewed for potential case management when specific criteria are triggered. The Case Manager will review the case to determine if a positive impact can be made in the quality and cost-efficiency of the care.

The purpose of the Paramount Care Management Program is to identify and manage members at high risk for complex, costly, or long-term health care needs. Through a logical process and utilizing the contracted provider network, the case manager or health educator will coordinate medically appropriate services in a supportive, cost-effective environment. The Care Management program is in collaboration with Disease/Condition Management. All Care Management activity will maintain member's privacy, confidentiality and safety. The care managers will advocate for the member, and adhere to ethical, legal, HIPAA, and accreditation/regulatory standards. The Care Management team consists of: Health Coaches, Health Educators, Case Managers, and Outreach Coordinators.
The goal is to promote wellness that encompasses the entire person, not just acute and chronic condition(s). Core objectives of Paramount’s care management include consistent long-term self-management, reductions in acute care utilization, lower unnecessary health care costs, prevention and/or delay of disease complications, care coordination, improved functional status, and connection with community resource support.

Paramount care managers assess, identify, and develop a care plan with members with risk and/or safety factors addressing gaps in care that may impact the member’s health, safety and welfare. When risk factors or gaps in care are identified, services and supports are put in place for the member in order to mitigate and address the identified issues as expeditiously as the situation warrants to the best of their ability.

Case managers work with provider offices and coordinate member care management with the Navigators within the offices when available. Paramount Advantage (Medicaid) Case Managers provide social/safety wrap around services for members attributed to CPC (Comprehensive Primary Care) offices.

Case managers have established strong collaborative relationships with staff at many provider/partners including Community Mental Health Centers (CMHCs), Federally Qualified Health Centers, skilled nursing facilities, acute and long term care hospitals. The interdisciplinary health care team works together to ensure appropriate follow up, engagement in services, and safe, successful care transitions.

**Member Identification**

In compliance with National Committee for Quality Assurance (NCQA) guidelines members are identified via the following methods but not limited to:

- Claims/encounter data
- Hospital discharge data
- Pharmacy data
- Data collected through UM process
- Data supplied by purchasers
- Data supplied by members or caregivers, practitioners

In addition Paramount has multiple avenues for members to have access to case management services including:

- Health information line
- Disease/condition Management program referral
- Discharge planner referral
- Utilization Management/Acute Care Coordinators
- Member/caregiver
- Health Care Providers (e.g. Hospital discharge planners, physicians, navigators, home care providers, social work, purchasers)
- Member Services
- Administrative Data
- Referrals from High Dollar Report from Finance
- Inpatient/Discharge Reports
- Referrals from Pharmacy UM staff
- Post Enrollment Health Risk Assessment
- Predictive Modeling Report
- Partnership Agreements
- Report of two or more ED visits within 180 days with primary diagnosis of asthma, CAD, CHF, DM, BP, COPD, BH, Substance Abuse. All products

Members are initially identified with a specific population stream and risk stratification based on output data from the Paramount developed proprietary Population Health web-based application. After the initial stratification, risk levels can be adjusted for members assessed through the care management team and/or data outputs.

**Streams**
Streams are listed in order of hierarchy which was set by Ohio Department of Medicaid (ODM) per the Provider Agreement and used for all product lines

- Women’s Health
- Behavioral Health
- Chronic Conditions
- Healthy Children
- Health Adults

**Stratification**
Risk stratification framework is comprised of five levels set by ODM per the Provider Agreement and used for all product lines

**Disease/Condition Management**
Member identification occurs at least monthly for Paramount’s *Steps2HealthSM condition management* programs. The purpose of condition management is to provide timely, appropriate intervention for Paramount member accurately identified with one or more of the targeted chronic diseases or conditions. The programs are designed to function as an adjunct to care provided in medical offices and to support the medical home concept. Common program objectives include consistent long-term self-management, reducing emergency services and inpatient admissions, lowering unnecessary health care costs, and prevention and/or delay of disease complications. A holistic health approach is used to promote wellness that encompasses the entire person, not just the chronic conditions. As with all aspects of care management, telephonic outreach and comprehensive assessments are integral components of the Steps2HealthSM programs. Paramount’s condition management programs are considered opt-out programs.
• **Monitoring (Medicaid Only)**
  o Members not meeting any of the Disease/Condition management program identification/stratification or preventive gaps in care criteria are assigned to the Monitoring risk level and receive routine educational newsletters and health information. New members without claims default to this stratification.

• **Low (All Products)**
  o Members identified for Disease/Condition Management programs without identification for a higher risk program or at risk acuity rule and/or have preventive gaps in care are stratified as Low. Low Risk members are referred to the Disease/Condition Management team for written condition-specific correspondence. Members with gaps in care are referred to outreach coordinators in the Quality Improvement Department and/or to the Disease/Condition Management team for additional written/telephonic correspondence to encourage the missing recommended service(s).

• **Medium**
  o Medicaid members identified for the higher risk programs without triggering an exception rule are initially classified as medium risk and receive telephonic outreach for evaluation and comprehensive assessments; Advantage Asthma, Advantage Diabetes, Chronic Heart Failure, Chronic Kidney Disease, Co-morbid Depression, Enhanced Maternal Care, and Post Cardiac Event. Additionally, medium acuity rules also include medication adherence, acute care utilization, and program specific gaps in care and uncontrolled clinical metrics, such as member not being on an asthma controller medication or with elevated A1C levels. Additionally, members referred from bariatric programs receive outreach preoperatively to encourage post-operative tele-health monitoring and post-operative re-assessments are attempted after tele-health services are completed to educate and identify any additional needs.

  o For Commercial and Medicare, members identified for any of the following programs are considered at higher risk, classified as medium risk, and receive telephonic outreach for evaluation and comprehensive assessment even if they do not trigger an exception rule: Chronic Heart Failure, Chronic Kidney Disease, Co-morbid Depression, and Post Cardiac. Additionally, members referred from bariatric programs receive outreach preoperatively to encourage post-operative tele-health monitoring and post-operative re-assessments are attempted after tele-health services are completed to educate and identify any additional needs.

  o For Medicare only, same as above for the Osteoporosis Fracture Management Program (anyone identified, exception or not, is considered medium risk, and receives outreach)
Case Management

- **High**
  - Members that are at risk for increased utilization and increased costs are considered high risk. Members stratified as high risk will have case manager outreach for assessment with the intent of reaching Paramount’s goal to decrease overall cost, hospital admissions and readmissions as well as avoidable Emergency Room utilization.
  - Pregnant members identified by claims and additional analysis using the ODM provided Vital Statistic report and the geographically targeted birth outcome efforts in areas of the state with the highest infant mortality rates (priority communities) to assess and assign risk as defined in the Enhanced Maternal Care Services document.

- **Intensive / NCQA Complex**
  - Members identified with highest risk per claims and diagnoses including but not limited to: Schizophrenia, psychosis, substance dependence, major depression, suicide attempts, eating disorder, bipolar and autism with inpatient admission, oncology, transplants, uncontrolled and/or multiple chronic conditions, premature infants, high risk pregnancy, serious trauma, as well as members with readmissions and avoidable emergency room overutilization.

**Status**

Defines the level of member engagement with the care management team

- **Inactive-** A member is regarded as inactive if the care manager is not attempting or able to make contact with the member and is not engaged with the provider for care coordination.

- **Outreach/Coordination-** This indicator is used when a care manager performs one or more of the following activities for a member:
  - Care manager conducts outreach, educates the member; makes referrals for physical, behavioral, or social services; provides a transition of care and/or service coordination (defined as a planned, active interaction between the MCP and any provider involved with the member).

- **Engaged-** A member is classified as engaged after the care manager completes an assessment, and documents at least one goal in the care plan. Ongoing, the engaged status is maintained as the care manager is able to meet the frequency requirements for the member’s contact schedule.

Care managers will continue to evaluate the risk stratification and status while the case remains open within population health. Any changes to Population Health are made in MARS Population Health application. The Population Health Structured note is completed in order to document the rationale of these changes.
Assessment

Members identified for potential case management will have a Member Utilization Report (MUR) and/or a Fee for Service (FFS) claims report generated and analyzed for under/over utilization and gaps in care. A structured note is created to document these findings.

Intensive Risk:

- Initial needs assessment for a member with intensive risk stratification is to be completed within 30 calendar days after notification of eligibility for case management services, unless there is a delay which is beyond Paramount control, including (NCQA Standards, 2018);
  - Member is hospitalized during the initial assessment period
  - Member cannot be reached through telephone, letter, e-mail or fax
  - Natural disaster
  - The member is deceased

- All members classified in the Intensive Risk stratification are considered Complex according to NCQA standards. Evidenced Based comprehensive general assessment; Start of Care Assessment (SOC) to be completed within 30 calendar days of identification of intensive risk stratification. The assessment will address the following format:
  - Initial assessment of members’ health status, including condition-specific issues
  - Documentation of clinical history, including medications and medication reconciliation
  - Initial assessment of activities of daily living, functional capability
  - Initial assessment of behavioral health status, including cognitive functions
  - Initial assessment of psychosocial issues
  - Initial assessment of life-planning activities
  - Initial assessment of social determinants of health
  - Evaluation of cultural and linguistic needs, preferences or limitations
  - Evaluation of visual and hearing needs, preferences or limitations
  - Evaluation of caregiver resources and involvement
  - Evaluation of available plan benefits and limits
  - Evaluation of community resources
  - Development of an individualized case management plan, including prioritized goals, that considers the member’s and caregivers’ goals, preferences and desired level of involvement in the case management plan
  - Identification of barriers to a member meeting goals or complying with the plan
  - Facilitation of member referrals to resources and follow up process to determine whether members act on referrals. Development of a schedule for follow up and communication with members
  - Development and communication of member self-management plans
• Evidenced Based disease/condition specific assessments should be completed within 120 calendar days from case open date and ongoing as appropriate.
• Clinical assessments completed by provider/partners will be integrated into Paramount assessment and plan of care process
• SOC assessment to be repeated annually
• Case Next Review/Follow-up Assessments (CNR) are completed at least once every 60 days including medication reconciliation. The exception is if the SOC Assessment is done, it is not necessary to do CNR Assessment at the same time. (i.e. annual repeat of the SOC)

High Risk:
• Initial Needs Assessment for a member with high risk stratification to be completed within 30 calendar days after notification of eligibility for case management services
• Evidenced based disease/condition specific assessments to be completed within 120 calendar days from case open date and ongoing as appropriate
• Case Next Review/Follow-up Assessments including medication reconciliation are completed at least once every 90 days

Contact Schedule

Established with the member based on their needs and facilitates ongoing communication with the member. A mutually agreed upon communication plan, follow up schedule is communicated with the member.

Initial outreach to a member requires at least 3 attempts within 10 business days at varying times.

An Unable to Reach (UTR) letter is sent to the member:
• Immediately when there is not a working number identified
• At any time during the 10 day outreach, the care manager may send the UTR letter as appropriate while continuing to make a total of at least 3 phone calls if there is a working number

The UTR letter explains that the case manager has been attempting to contact the member for case management and requests the member contact the case manager. If there is no response from member or caregiver 14 days after the letter is sent, further attempts to reach the member may occur. If unsuccessful, the case is reviewed and status is changed to Inactive.

Intensive contact: Engaged members in the intensive risk level, at a minimum:
• Interaction with member of care management team every 30 days

High Risk contact: Engaged members in the high risk level, at a minimum:
• Interaction with member of care management team every 90 days
Coverage When the Case Owner is not Available (vacation, ill, etc.)

- The CM covering will review the case and facilitate hospital reviews and immediate needs
- The case review timeline will start when the case manager returns to work and follow the established time guidelines for non-urgent reviews
- It is the responsibility of the case manager covering to identify outstanding reviews
- If the case manager is not available for more than 2 weeks, the Manager will determine case transition

Care Plan Development Implementation and Coordination

The case manager will develop a member-centric case management plan of care. The plan of care will be developed in collaboration with the member, family, and/or caregiver input. The case manager assists the member in making informed decisions when developing the plan of care and communication plan schedule and follow up. The PCP and other health care providers will be given the opportunity to participate in the development and ongoing revisions to the care plan.

- Member can be engaged in case management if one problem is identified. Self-management plans are identified and communicated with the member
- Goals are prioritized based on member/caregiver preference, need, desired level of involvement and readiness to change
- Internal and external utilization management transitional care plans are included in the overall care plan process for continuity of care
- Assessments contain embedded problems, interventions, and goals
- Problems, interventions, and goals may be accepted, rejected, or modified with specific target dates and timeframes for re-evaluation based on the required minimum contact schedule and member preference. More frequent interaction may be mutually scheduled, as appropriate
- Psychosocial/cultural/medical barriers that may impede the member’s ability to meet goals and comply with care plan are identified and communicated to provider as appropriate
- Provider/partner input, assessment results, and clinical data are incorporated into the care plan, as appropriate.
- Initial and ongoing care plans are shared with members and providers/partners of the interdisciplinary health care team
- Based on the assessment results, the case manager may identify needed resources such as home care, transportation, and durable medical equipment to ensure the appropriate level of care is being delivered. Need for community resource referrals with follow up and support are also identified in the care plan initially and ongoing
- Care plan conferences including family/caregiver and other provider/community partners are conducted, as appropriate. Needs identified through this collaborative approach are included in the care plan
- Modifications are made based on changing priorities
- Focus is on member/caregiver preference and progress
- Ongoing assessments and new data including over/under utilizations, and gaps in care are utilized to identify new problems, interventions, and goals
- Providers are notified of member’s inability to adhere to the treatment plan
- Copies of signed care plans by member and or providers are saved in member notes

**Facilitation/Coordination of the Plan of Care**

Facilitation of the Plan of Care is accomplished through specific care management interventions that address the problems/opportunities identified in the plan of care leading to goal achievement. The care manager and health care team will work with the member to provide access to services:

- Co-management of case management cases with Behavioral Health when indicated
- Identify gaps in care: Ensure that referrals are in place when required and a follow up process is completed to determine whether members act upon referrals/receives recommended services
- Utilize health care providers to provide interventions as identified in the plan of care
- Facilitate member education and understanding to improve health outcomes and improve self-management
- Education may be provided by:
  - Home Health Care Agencies
  - Formal classes available at provider hospitals to assist the members in management of acute and/or chronic illness/injuries
  - Paramount Health Care Disease Management Programs and Case Management provides educational material that supports clinical guidelines and are endorsed by leading national organizations i.e., ADA, CDC, AHA, etc.
- Identify and encourage use of government programs and community resources as appropriate
- Facilitate transportation either as a covered service or through community resources
- Vendor management and fee negotiation

**Monitoring/Evaluation of the Plan of Care**

Paramount care management team will work with community partners and providers to facilitate access to needed services and resources by:

- Identifying available community services and resources
- Identifying individual member needs
- Linking the member with the appropriate community services and/or resources
- In-person warm transfers
- Telephone call for the member or conference call including both the member and the community partner
- Referral made on the member’s behalf
- Requesting an order from the provider for needed services, i.e. home care,
durable medical equipment

- Verification is required to ensure that linkage has occurred
- Evaluation and updates occur as member makes progress towards goals, is no longer interested in working towards goal, or goal is completed
- Updated care plans which show the progress against case management plans and goals are shared with members and providers/partners of the interdisciplinary health care team, which includes members' self-management plans
- Percent completion of the goal should be updated with every contact

**Discharge/Closure from Care Management**

The care manager is an advocate for the member and the payer to facilitate positive outcomes. Discharge from care management may occur when the member:

- Mutually agrees to no longer participate and opts out of care management
- Needs are being met by other services
- Maximum benefit from case management services has been reached
- Goals/target outcomes have been achieved
- Is no longer working toward his/her goals
- Is no longer covered by the Plan

**Evaluation**

**Member Satisfaction**

As participation in Case Management varies in duration, the Case Management satisfaction survey is conducted when the member is enrolled in case management for at least 100 days and annually thereafter for members continuing with CM. As part of an effort to improve standardization, validity, and performance measurements, the case management satisfaction survey is administered by a third party vendor. The five survey questions are based on the NCQA Standards. They explore several aspects of the member’s CM experience and the survey is sent to both high and intensive members. Quarterly report cards are received from the vendor with several reporting aspects available for comparison including product line, risk level, teams (including delegates) and individual case manager results. Members enrolled in DM programs are assessed at each telephonic contact for satisfaction with the program.

Evaluation of the efficacy, quality, and cost-effectiveness of care management's interventions in achieving the established goals documented in the Model of Care and care management program descriptions

- Emergency room utilization
- Admissions
- Readmissions within 30 days
- Overall medical and pharmacy costs
Primary care and professional visits
HEDIS® Access to Care and Effectiveness of Care measures, including:
- Minimum Performance standards
- Pay for Performance Measures
- Quality Withhold Indices  (Advantage)
- Utilization of evidence-based guidelines in appropriate client populations
- Linkage to community resources (social determinants of health) to reduce:
  - Homelessness
  - Food insecurity

Outcomes

Outcome measurement is critical to ensuring development of an evidence-based care management practice as well as continuous quality improvement efforts. Through a global view approach, the effectiveness and impact of the care management program is evaluated from the member level, risk stratification level, and overall population. Care Management outcome data is collected, analyzed, and reported to demonstrate the benefit of the program and identify areas of improvement.

The condition management programs and care management programs are evaluated at least annually and include enrollment, stratification, acute utilization data, and overall medical cost.

Condition Management Programs
- Asthma
- CHF
- Chronic Kidney Disease
- COPD
- Depression (high risk/co-morbid)
- Diabetes
- Enhanced Maternal
- Migraine
- Post Cardiac
- Osteoporosis (Paramount Elite)
- Reproductive Health
- Behavioral Health

Case Management Program
- Member satisfaction
- Reduction in ambulatory emergency room utilization
- Reduction in preventable inpatient admissions
- Reduction in all-cause 30 day readmissions
- Reduction in overall medical cost
- Linkage to Community Resources