CARE MANAGEMENT
(Utitlization, Case Management, and Disease [Condition] Management)
PROGRAM DESCRIPTION
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.
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, 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 Utilization Management Program annually. Updates occur as required.

For product lines on an HMO platform, the Primary Care Physician is 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.

The following provides an overview of the various functions of the Utilization Management 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 are prior authorized. 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 or Pharmacy and Therapeutics Working Group as appropriate. Additionally, potentially cosmetic surgery and other procedures may be reviewed prospectively, at the request of providers and members, to issue coverage determinations.

• **Inpatient Hospital Certification**

  • **Prospective Review** - Using InterQual® Level of Care Criteria, elective inpatient hospitalizations are reviewed to assure that the services are provided in the appropriate setting.

  • **Concurrent review** - InterQual® Level of Care Criteria are utilized to evaluate the quality and appropriateness of care and to assess the medical necessity of continued stay.

  • **Retrospective review** - Analysis of patient care data for medical necessity, quality of care and appropriateness of setting after the care has been delivered will identify patterns of health care services of institutions, physicians, and members.

  • **Discharge Planning** - Patients who require continuing care after release from the hospital are identified and appropriate services are arranged through participating home care, medical equipment and other providers.

  • **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.

  • **Case Management** - Plan Case Managers facilitate the provision of the medically complex and/or high cost member’s care in collaboration with the Primary Care Physician and interdisciplinary care team to ensure that quality medical care is provided in the appropriate setting. The case management program is integrated with the Plan’s disease management programs, providing member-specific interventions to high-risk participants.

  • **Behavioral Health Services** - Paramount reviews inpatient and outpatient mental health/chemical dependency services for all product lines using all of the utilization management functions and tools/guidelines described above. (Ambulatory care for Medicaid members is generally excluded by the Ohio Department of Job and Family Services.) To the extent possible and permissible by current privacy and confidentiality regulations, behavioral health and general medical management is integrated for optimal member health 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.

DELEGATION OF UTILIZATION & CASE MANAGEMENT

Delegation occurs when Paramount Advantage 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 NCQA accreditation standards and ODM regulations. Paramount Advantage 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 delegate’s utilization management functions for dental prior authorizations to DentaQuest and optical benefits to Eye Quest. Case management and utilization management functions (excluding prescription drugs) for children are delegated to Health Network Cincinnati Children’s (HNCC) for members residing in 8 counties in southwest Ohio, which became effective July 1, 2013. 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 southwest Ohio became 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.
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, hospitals, and other ancillary providers. The goal of utilization management is to assure appropriate utilization, which includes evaluation of both potential overutilization 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.
DEPARTMENTAL ORGANIZATION

The Care Management Department is comprised of registered nurses, licensed practical nurses, mental health/chemical dependency professionals (nurses and social workers), medical assistants, outreach coordinators, and support staff. Staffing ratios for utilization management functions have been maintained as follows:

One (1) Utilization Management coordinator to 8,000 members (regardless of product line)

The ratio for case management functions will be as follows:

One (1) Case Manager to 100 case management cases (regardless of product line) with the exception of Paramount Advantage Intensive and High Risk Case Management, a unique staffing ratio is required (Intensive staffing ratio of 1:25 to 1:50; High Risk staffing ratio of 1:51 to 1:100). This ratio is inclusive of members of the interdisciplinary care team (ICT).

An analysis of the current caseload, the mix of case management cases and the demographics of the enrolled population is performed monthly. Based on this analysis, the anticipated percentage of case management cases by product line membership is as follows:

<table>
<thead>
<tr>
<th>Product Line</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial HMO</td>
<td>0.5%</td>
</tr>
<tr>
<td>Paramount Advantage</td>
<td>9.0%       (inclusive of members enrolled in Paramount’s Disease Management Programs)</td>
</tr>
<tr>
<td>Paramount Elite and Early Retiree</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

These ratios are reassessed at least annually and adjusted as needed. In addition to the Utilization Management (UM), Elite and HMO/Advantage Case Managers (CM), the department consists of an Executive Director, Director of Utilization/Case Management, Southern Region, Clinical Director, Behavioral Health, a Case Management Manager (Advantage, Elite, HMO, & Marketplace), a Behavioral Health Utilization/Case Management Manager, a Community Health Services Specialist, a Referral Management/Acute Care Manager, Utilization Management and Case Management Team Leaders for medical and behavioral health needs, Case Management Outreach Coordinators, Behavioral Health Coordinators, UM Referral Coordinators, Social Services Coordinators, Health Risk Assessment/triage Coordinator, Pharmacy Program Director, Pharmacists, Pharmacy Team Leader, Pharmacy Utilization Nurse Coordinators, Pharmacy Utilization Coordinators, Care Management Project Coordinators, Utilization/Case Management Staff Support and Utilization/Case Management Departmental Support. The Disease Management team consists of a Manager of Disease Management, a Disease Management Coordinator, and Health Educators.

The departmental organizational chart is illustrated on the following page.
CARE MANAGEMENT
ORGANIZATIONAL CHART

Vice President / Medical Director
Health Services

Clinical Director
Behavioral Health

Manager CM
CM Team Leaders

Manager DM

Manager UM

Executive Director
Care Management

UCM Educator

UCM Project Coordinators

DM Coordinator

Health Educators

UM Staff Support & Clerical Support

UM Coord Acute Care

UM Coordinators Referral Mgmt

Elie Social Serv Coord

Director UCM South Region

BH Team Leader

BH Coord

CSP Coord

BH CM Coord

BH UM Coord

Case Managers Elite HMO ADV
CM Regulatory Compliance Coord
Quality Improvement Coord
Health Risk Assessment Triage Coord

UCM Team Leaders

Adv CM/UM Coord

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EXECUTIVE DIRECTOR, CARE MANAGEMENT
The Executive Director, Care management is a registered nurse. The executive director’s accountability objective is to manage the Utilization, Case Management, and Disease 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.

DIRECTOR, UTILIZATION/CASE MANAGEMENT, SOUTH REGION
The Director, Utilization/Case Management, South Region is a registered nurse whose accountability objective is to manage the Southern region of the Utilization/Case Management Department to provide 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.

UTILIZATION MANAGEMENT MANAGER
The Referral Management Manager is a registered nurse whose accountability objective is to serve as the departmental resource for outpatient prior authorizations, preadmission, concurrent and retrospective review for inpatient admissions and home health care, PPO utilization and to conduct departmental quality improvement monitoring. This position also coordinates provider appeal determinations and acts as an interdepartmental liaison to ensure prompt resolution of UM issues and questions.

CASE MANAGEMENT MANAGER
The Commercial/Advantage/Elite Case Management Manager is a registered nurse and Certified Case Manager whose accountability objective is to serve as a clinical resource and to provide supervision for staff and the day-to-day operations of the case management functions 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.

CONDITION/DISEASE MANAGEMENT MANAGER
The Disease Management Manager is a registered nurse whose accountability objective is to develop, implement, administer, and report on all disease management programs. The disease management manager is responsible for staff training, reporting, and evaluations.

BEHAVIORAL HEALTH UTILIZATION/CASE MANAGEMENT MANAGER
The Behavioral Health Utilization/Case Management Manager 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 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.
COMMUNITY HEALTH SERVICES SPECIALIST
The Community Health Service Specialist's primary role is building and sustaining stakeholder relationships, communication strategies, and supporting relationship management with a strong emphasis on advocacy and business development opportunities to meet organizational initiatives. This position strives to foster and maintain relationships with key community advocacy groups, political action committees, and 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.

CARE MANAGEMENT DEPARTMENT EDUCATOR
The Utilization/Case 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 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.

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 utilization management. The working team leader acts as an interdepartmental liaison to ensure prompt resolution of utilization management issues, questions, and concerns.

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.

**DISEASE MANAGEMENT COORDINATOR**
The Disease Management Coordinator is a registered nurse or bachelor in healthcare related field whose accountability objective is coordination of disease management activities including employee training. This position assists with development of disease management programs, member identification, stratification, and interventions as well as data collection and provision of documentation related to program specific evaluations and National Committee Quality Assurance (NCQA) compliance.

**HEALTH EDUCATOR**
The Health Educator is a bachelor of public health, nursing, or certification in healthcare related field whose accountability objective is to perform comprehensive assessments, identifies and promotes individualized strategies for behavior modification to members enrolled in one or more disease management programs. Develops individualized health education plans based on member assessment and identification of condition related self-management goals.

**UTILIZATION MANAGEMENT COORDINATOR**
The Utilization Management Coordinators are registered nurses and licensed practical nurses. Their accountability objective is to coordinate medical and pharmacy 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 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 nurses 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.

**HMO CASE MANAGER**
The Case Manager is a registered nurses whose accountability objective is to facilitate, coordinate and evaluate the ongoing care of a specific caseload of Commercial HMO 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.

**PARAMOUNT ELITE CASE MANAGER**
The Paramount Elite 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.

**“ELITE” HEALTH RISK ASSESSMENT/TRIAGE COORDINATOR**
The “Elite” 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 and completion of the comprehensive general assessment to facilitate referrals to case management and social services 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.

**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 object is to provide support to case managers (Accountable Point of Contact). The Case Management 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 providing education, community resource planning, and support.

**UTILIZATION/CASE MANAGEMENT PROJECT COORDINATOR**
The Utilization/Case Management Project Coordinator is a registered nurse whose accountability objective is oversight and coordination of the design of long and short-term U/CM departmental projects as related to Plan goals and objectives.

**UTILIZATION/CASE MANAGEMENT STAFF SUPPORT**
The Utilization/Case Management Staff Support’s accountability objective is to provide administrative, clerical support for the U/CM Department.

**UTILIZATION/CASE MANAGEMENT DEPARTMENTAL SUPPORT**
The Utilization/Case Management Departmental Support’s accountability objective is to support the U/CM Department by coordinating the distribution of the incoming daily UM/CM requests.

**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 MANAGEMENT PROCESS**

Paramount’s Utilization/Case Management Department maintains departmental policies and procedures. These policies are reviewed on an annual basis. In addition, procedures are reviewed annually and updated on an as needed basis. The policies and procedures provide documentation of the framework of authority in which the Utilization/Case Management Program operates. The Utilization Management Coordinator and Case Manager is 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 only upon appropriateness of care and service and 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.
OUTPATIENT CERTIFICATION

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 potentially 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**

Preestablished 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 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.

**INPATIENT CERTIFICATION**

To assure that all hospital admissions are medically appropriate 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 hospital. Urgent and emergency admissions are reviewed the first business day after the admission occurs. This review process is performed by telephone or by telefax with the Utilization Review Department at each hospital.

Preestablished medical necessity/appropriateness criteria are utilized to assure consistency in the certification process. Upon determination that an admission meets
criteria, the UM/CM Coordinator assigns a length of stay in anticipation of the concurrent review process. The admission continues to be reviewed at appropriate intervals until discharge planning results in the patient's discharge. 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:

Prospective Review

Elective inpatient care may be reviewed prior to the admission to assure that the services are provided in the most appropriate setting. Preestablished medical necessity/appropriateness criteria are applied. The admission is then either approved or the provider is encouraged to reschedule the services in a more appropriate setting.

Concurrent Review

Ongoing, inpatient care is reviewed to evaluate the quality and appropriateness of care and to assess the medical necessity of the continued stay. Again, preestablished criteria are utilized. At this time, discharge planning may also be initiated to plan for continuing care after discharge.

Retrospective Review

Retrospective chart review is performed after the patient is discharged from the facility. It is usually implemented at those times when the hospital Utilization Review Department has been unable to provide enough information to demonstrate that the care meets the criteria for inpatient stay. This method of review is also performed when members have been admitted and discharged from a facility during a time period when Plan staff was not available (i.e., weekends, holidays).

Discharge Planning

During the course of precertification or concurrent review, the Utilization Management Coordinator and/or the Case Manager will often identify ongoing, continuing care needs for a patient that will be required after discharge. In these cases, 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. Within a few days of discharge from an acute care setting, follow up phone calls are made to select members who are at risk for readmission. The goal of this program is to assure compliance with the discharge plan/required follow up care and assist in the coordination of needed care/services to prevent adverse outcomes.

OTHER OUTPATIENT CERTIFICATION

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.

PRESCRIPTION DRUG UTILIZATION MANAGEMENT

Paramount utilizes 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 dispensing pharmacist, ordering physician or member when the member accesses these drugs. The pharmacy 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 Pharmacist. All UM processes, including verbal and written notification of the decision to the provider and member, are followed in making the determination.

CASE MANAGEMENT

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. A full description of this program is provided beginning on page 24 of this document.

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 enrollment 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 eighteen (18) months. Exceptions are made for emergency situations. All members enrolled in CSP are followed closely by Behavioral Health Case Management.

BEHAVIORAL HEALTH SERVICES

Paramount conducts utilization and case management for mental health/chemical dependency services provided to all commercial and Medicare members.
Paramount Advantage mental health/chemical dependency services are managed by Paramount’s Behavioral Health Coordinators in cooperation with community mental health and Ohio Department of Alcohol and Drug Addiction Services (ODADAS) certified agencies. The state of Ohio does not capitate the Plan for the provision of outpatient/ambulatory mental health/chemical dependency services. These 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, the Plan must make arrangements for services outside this network. When this occurs, the Plan is financially liable for the services and follows them closely to assure that quality care is being provided in the most appropriate setting. In addition, the Plan is responsible for the provision of inpatient mental health/chemical dependency services.

Utilization and case management functions for behavioral health services follow the same processes as general medical. This includes out-of-Plan specialist (psychiatrist/psychologist) referrals, tertiary care and inpatient certification. Outpatient prior authorization is conducted for partial hospitalization and intensive outpatient treatment. Paramount does not operate a centralized behavioral health triage service

**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>
<thead>
<tr>
<th>Request Type</th>
<th>Decision standard</th>
<th>Verbal/e-notification</th>
<th>Written notification to practitioner &amp; member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent Pre-Service</td>
<td>Within 7 working days from receipt of request</td>
<td>Within 3 working days of making the decision</td>
<td>Within 3 working days of making the decision.</td>
</tr>
<tr>
<td>Urgent Pre-Service</td>
<td>Within 2 calendar days</td>
<td>Within 2 calendar days of receipt of request</td>
<td>Within 2 calendar days of receipt of request</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>Within 24 hrs. of receipt of request</td>
<td>Within 24 hrs. of receipt of request</td>
<td>Within 72 hrs. of receipt of request</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>Within 30 calendar days of receipt of request</td>
<td>None required</td>
<td>Within 30 calendar days of receipt of request</td>
</tr>
<tr>
<td><strong>Advantage</strong> Drug requests covered under medical or pharmacy benefit. Elite expedited requests</td>
<td>Within 24 hrs. of receipt of request</td>
<td>Within 24 hrs. of receipt of request</td>
<td>Within 24 hrs. of receipt of request (denials only)</td>
</tr>
</tbody>
</table>

**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 Manager monitors the consistency of the UM/CM staff in handling approval, denial and inpatient decisions. 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 service, as related to the percentage of calls that go into the hold queue, abandonment rate and average speed of answer is tracked. Additional monitoring of the Utilization Management Program is performed through comments from the Member Satisfaction Survey, the Physician and Office Manager Satisfaction Survey, Case Management Member Satisfaction Survey, the quarterly appeals reports and the monthly Member Service survey cards.

**ACCESS TO UM STAFF**

Utilization and Case 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. 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 UM and Case 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 annually 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 web site. InterQual® criteria are available to providers through Paramount Direct. 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 2015 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. In addition, the InterQual® criteria are 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 and for home health care services. It is the practice of local participating hospitals to utilize the InterQual® criteria during their internal Utilization Review process. Physicians may review the InterQual® criteria at any participating hospital or by contacting the Director of Utilization/Case Management.

Outpatient/Other Certification

Where it exists, 2015 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 Technology Assessment or the Pharmacy and Therapeutics Working Groups. 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 2015 edition of McKesson InterQual® Imaging Criteria is used as the basis for authorization of the following elective, outpatient imaging studies:

- CT Scans
Genetic Testing

The 2013 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 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 and the members are directed to the most appropriate Center of Excellence transplant facility for evaluation based on benefits.

The Case Manager works 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 cornea 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 that are 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.

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 Group, 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.

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 Physician
- Specialist physician
- Hospital Utilization Review Department
- Patient chart
- Home health care agency
- Skilled nursing facility
- Physical, occupational or speech therapist
- 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 good nursing 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 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.

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

The purpose of the Case Management (CM) Program at Paramount Health Care is to identify and manage members at high risk for complex, costly, or long-term health care needs. Through a logical process of utilizing contracted provider network, the Case Manager will coordinate medically appropriate services in a supportive, cost-effective environment.

ELITE AND COMMERCIAL CASE MANAGEMENT

The Elite and Commercial Case Management Program has three components: Complex Case Management, Routine Case Management, and Disease Management. All Case Management activity will maintain member’s privacy, confidentiality and safety. The case manager will advocate for the member, and adhere to ethical, legal, and accreditation/regulatory standards.

Disease management evaluations are performed annually based on rolling calendar years, while case management program metrics are measured annually on the actual calendar year.

The desired goals of this program include:
- Treatment of the member in the least restrictive setting and manner
- 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)
Utilization of participating providers
Reduction in the cost of care
Reduction of unplanned hospital admissions and inappropriate emergency room usage.
Education of member regarding disease process

DEFINITIONS: Complex/Routine Case Management, and Disease (Condition) Management

A. Complex Case Management:
Complex case management is the coordination of care and services provided to members who have experienced a critical event or diagnosis requiring the extensive uses of resources. These members often need help navigating the system to facilitate appropriate delivery of care and services, including community resources.

B. Routine Case Management:
Members that do not qualify for complex case management may be eligible for routine case management. Routine case management focuses on chronic disease conditions that require monitoring and education to help members self-manage. This may include: members in an acute care setting, continuity of care, post hospital discharge issues, and members with inappropriate emergency room use, and repeated hospital utilization.

C. Disease 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 to every 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.

STANDARDS OF CARE:
The Case Management process will include:
(Resource: CMSA Standards of Practice for Case Management, 2016)

Case Identification:

Identification of Members for Case Management:
Members may be recommended to CM by telephone, email, letter, and fax, through the electronic care management software reviews from the following sources:
- Member Services
- Administrative data
- Health Care Providers (e.g. hospital discharge planners, physicians, navigators, home care providers, social work, purchasers)
- Utilization Management and Acute Care Coordinators
- Member/Caregiver referral
- Disease Management referrals either through the automatic process or by a disease management coordinator.
- Referrals from the High Dollar Report from Finance
- Inpatient/Discharge Reports
- Referrals from pharmacy UM staff
- Pharmacy Specialty Drug Reports
- Report of one inpatient hospital readmission within 90-day rolling 12 month period-All products
- Report of three or more acute inpatient hospitalizations within 12 months- All products
- 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
- Elite Post Enrollment Health Risk Assessment
- Health Information Line
- Predictive Modeling Report
- Partnership Agreements

Case Evaluation
Cases recommended for case management will be screened within two business days, (see 3g). Place member in pre-agreement/assessment until agreement obtained and comprehensive general assessment completed.

Note: Coverage when case manager 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.

- Member will be contacted for the appropriate general assessment within 30 (thirty) business days of the referral except members that cannot be reached (see 3.f.). Document variance in CCMS notes. Referred cases are opened or rejected within 10 (ten) business days of referral. Document variance in CCMS notes.

- An Adult or Pediatric GA will be completed within 30 business days of placing case in pre-assess/agreement. Completion of the Adult or Pediatric GA depends on the special circumstances of the member (e.g. NICU, member unresponsive). The case manager will document the special circumstances as a variance in the GA- Overview Tab. The case manager will initiate the assessment and complete as appropriate.

- Case Managers are to document within the electronic medical record all attempts complete the General Assessment. If the assessment is not completed, the assessment is pended automatically triggering a reminder to the case manager. Reminders will appear daily on the case manager’s
reminder log until the assessment is completed. A monthly report is generated to identify members with missing reminders. This report is to prevent members from inadvertently being missed. The date of the completion of the assessments will automatically populate into the electronic health record notes upon completion.

- Member’s verbal or written case management agreement is documented in the General Assessment. Written agreements will be scanned into the electronic care management system and attached within member notes. Members may refuse to participate in Case Management.

- Members that cannot be reached after a minimum of 3 telephone calls in 10 business days will be mailed a case management “Unable to Reach” letter and a health questionnaire. No member response to the letter and questionnaire in 10 business days will result in rejection for case management. The questionnaire may be sent prior to completing all 3 attempts.

- Reviews generated from Disease Management have 15 days to evaluate for case management. If member does not meet criteria for case management, refuses CM or is unable to be reached, review is sent back to the Health Educator in Disease Management for follow up. Reviews that are identified via monthly reports i.e.: Health Risk Assessments have 30 days to be completed.

Identification of Case Type: Members are to be assessed for Complex or Routine Case Management.

- Complex Case Management:
  - Hospital admissions WITH 3 or more in 6 months, same or related diagnosis.
  - Major or multiple system failure.
  - Multiple traumas.
  - Medical/surgical inpatient cases with extenuating complications.
  - Head or spine injuries with potential residual deficits including cerebral vascular accident (CVA).
  - Severe burns covering over 20% of body surface.
  - Complicated coordination of care of discharge planning (any disease/condition).
  - Cancer with critical event or treatment requiring the extensive use of resources.
  - Chronic disease condition with co-morbidities or complications leading to high dollar claims or high utilization.
  - High risk pregnancy

- Transplant – solid organ (excluding corneal transplants) or bone marrow transplants

- Major mental health disorders such as depression, substance abuse/chemical dependency, or a suicide ideation characterized by suicidal or homicidal ideation or behaviors limiting member’s ability to carry out activities of daily living independently due to mental health needs, or persistent issues impacting the treatment plan.
Extensive use of health care and/or community resources.

Newborn/Pediatric with critical event or diagnoses requiring the extensive use of resources.

Routine Case Management: Member does not meet complex case management, but may benefit from the case management process to assist with health care education, improve self-management skills, coordination of care, and improved benefit utilization.

Examples:
- Chronic diseases
- Co-morbidities
- Short term medical condition with coordination of care needs
- Hospice cases
- Controlled Substances and Member Management (CSMM) Program
- ER Diversion
- LTAC admissions

**Problem Identification**

**Assessment**
The initial comprehensive assessment (Adult GA or Pediatric GA) includes documentation of member specific health care needs. Documentation includes clinical history, Activity of Daily Living, medications, mental health status, functional and cognitive level, educational level, life planning, cultural and linguistic needs preferences or limitations, visual and hearing needs preferences or limitations, available plan benefits and community resources, and caregiver support systems resources and involvement. This information is used for develop the member’s individualized plan of care.

After completion of the Adult GA/Pediatric GA, the appropriate CCMS Case Type Specific Assessments (CTSA or SGSA) is completed. If the CTSA or SGSA assessment is available, it is completed within 10 business days of opening case. Members and their Primary Care Provider/Specialist will be notified in writing via an introduction letter, that the member has been identified as meeting the criteria for case management, including their enrollment into case management and instructions on how to opt out. The case manager includes their business card and email address.

Member's Rights and Responsibilities are noted in the Member Handbook and received upon enrollment. In addition, they are reinforced throughout case management interventions. All assessment questions are to be addressed with the appropriate actions taken. It is at the discretion of the case manager to accept the radio buttons which trigger the system to create problems, interventions, and goals that are appropriate for the members’ care.

Comprehensive GA to be repeated at a minimum annually.

Case Next Review Assessment to be completed at least quarterly or any time there has been a transition of care. Clinical notes, physician notes and member/care giver responses are utilized in the assessment process.
Planning
The case manager will develop a formal plan of care within 10 business days of the member being opened in active case management. The goal of planning is to develop an appropriate and fiscally responsible plan of care that enhances quality, access, and cost effective outcomes. The formal plan of care will be developed in collaboration with the member. 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 of the care plan. The case manager is to attempt to involve the PCP in developing and revising the clinical portion of the care treatment plan. The case manager is to document in CCMS all attempts to involve the PCP.

Plan of Care
- Problems, prioritized goals and interventions will be reviewed with the member in order to develop an individualized plan of care. The individualized plan of care will also include evidence based criteria.
- The plan of care will include system generated long term and short term goals and will be time-specific.
- The plan of care will include interventions (i.e. education, referrals, etc) and will be time-specific.
- Identify situations that are or may become barriers to goal attainment. The care treatment plan will include goals and actions taken to address access to care barriers.
- Self-Management will be part of the plan, i.e.; COPD, Asthma Action Plan.
- Continue to involve the member in modifications of plan of care.
- At the time the case is closed, unmet goals will be addressed by entering a reason for closing the case (i.e.; Member Expired, Member Declined etc.).
- A team meeting with the Care Plan Team (PCP, member, family, CMC, discharge planner, Plan Medical Director, and other appropriate providers) may be of benefit for development and implementation of the plan of care.
- Printed copies of the CCMS Plan of Care may be provided to the member and physicians as appropriate.
- Life Care Planning (life care planning forms will be scanned into the MACESS EXP member folder.)
- Problems and goals are identified and dated. Electronic care management system reminders are generated to notify the case manager of the case next review (CNR).
- Cases will be monitored for compliance with the completion of the assessments and development of the care treatment plans.
- Prioritized goals “Prioritized goals” refer to what must be done in order of importance related to the member’s situation or condition as determined by the case management team. It takes into consideration members’ and caregivers’ specific needs and preferences. Prioritized goals are to be documented in notes within the electronic care management software with notation that it is a “PRIORITIZED GOAL”.

Facilitation/Coordination of the Plan of Care
Facilitation of the Plan of Care Is accomplish through specific case management interventions that address the problems identified in the plan of care leading to goal achievement. The case 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 follow up process to determine whether members acts on referrals.
- Utilize Health care providers to provide interventions as identified by 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 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
  - 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.

**Communication**
The case manager will facilitate coordination of communication between service providers, member/family, including an accountable point of contact to help obtain medically necessary care, assist with health related services and coordinate care needs. Coordination will include (not all inclusive):

- Communication and coordination of care between PCP and specialists.
- Continuity of care communication as the member moves between multiple levels of care.
- Access to interpretive/translator services.
- Develop mutually agreed upon communication plan based on member preference
  - Member Summary Report Content and frequency: Complex cases report to be sent after 3 months of the Complex status, and at appropriate intervals (relevant to the case), or when there are significant changes in the members' status or treatment plan. Content to include Demographics, PCP, Cases, Admissions, Diagnoses, problems, interventions, and goals, and notes if requested. Report must be attached as PDF in CCMS, (refer to grid).

**Monitoring**
Monitoring is the process of ongoing assessment and documentation of the plan of care for determination of the plan’s effectiveness.

- Member contact may be daily if necessary but minimum of twice a year. Frequency of member contact will be documented within the electronic health record, which will automatically document the staff member’s name, date and time of interaction.
- Prompts for case follow up will be generated by electronic medical record
• Facilitate communication with member and the health care team to update member’s health status and progress toward goals.
• Reinforce benefits of the case management program with the member while recognizing that member has the choice to decline case management at any time.
• Collaborate with the health care team to address continuity of care, barriers to care and plan of care revisions.
• Monitor and assess health care provider delivery of service, quality and utilization as per the appropriateness of the plan of care.
• Team meeting with the Care Plan Team (PCP, member, family, case manager, discharge planner, Plan Medical Director, and other appropriate providers) for modification of the care plan may be appropriate.
• Education review for member adherence and understanding
• Progress toward Self-Management goals
• Medication Reconciliation and adherence. Utilize Member Summary View, if medication not available in software, document in CCMS notes
• Monitor disease specific diagnostic tests, etc.
• Monitor that routine health care screenings are obtained.
• Monitor that appointments are kept with the PCP and specialist. If the member fails to keep scheduled appointments, a call may be placed to the member and the reason for the missed appointment is determined.
• Utilize the Member Utilization Report to evaluate for Under and Over Utilization

Evaluation
The process to measure the member’s response to the plan of care:

• Evaluation at appropriate intervals to determine the care plan’s effectiveness in meeting outcomes, e.g. gaps in care, barriers, lack of participation.
• The plan of care may be modified or changed as determined by the case management process.
• The case intensity will be reviewed for appropriate level: Complex vs. Routine and changed as per evaluation.

Discharge from case management occurs when:

• The member and the case manager are satisfied that the member’s goals have been met, the member will be notified by phone and/or in writing that case management is no longer needed.
• The member no longer wishes to participate, or opts out of CM.
• A member is no longer working toward his/her goals.
• A member is no longer covered by the Plan.
• Elite member elects Hospice benefit.
• Member needs are being met by other services.
• The member’s problems and goals are at the level of Disease Management.

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 that 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)

**Case Management Programs**
- Aggregate of All Case Types
- Enhanced Maternal Program (including High Risk Obstetrics and NICU)
  - HEDIS® Measures for HPV Vaccine for Female Adolescent
  - HEDIS® Measure for Prenatal and Postpartum Care

(Phase I (2015) includes Case Type Aggregate and Enhanced Maternal Program. Phase II (2016) expand Case Type reporting to includes Asthma/COPD, Depression, and Diabetes (based on claims stratification of prevalence, risk, and denominator size).

**Case Management Program Effectiveness Measures**
- Member satisfaction
- Quality of Life Stability/Improvement
- Reduction in ambulatory emergency room utilization
- Reduction in preventable inpatient admissions
- Reduction in all-cause 30 day readmissions
- Reduction in overall medical cost

**Program Enrollment Statistics / Stratification**
- Percentage of members receiving care management services compared to overall Medicaid population
- Risk stratification of members receiving care management
- Comparative analysis of annual performance indicators according to overall population aggregate and risk stratification level sampling (Complex/Routine, medium, and low):
o Commercial and Elite Medical and Prescription Costs
o Commercial and Elite Emergency Room Utilization (including emergency room visits resulting in admission and ambulatory emergency room visits [ambulatory])
o Commercial and Elite Inpatient Admissions
o Commercial and Elite 30 day All-Cause Readmissions

• Stratification Breakdowns

o Complex/Routine
  • Percentage of membership
  • Population Statistics
  • Total number of members in sample
  • Quality of Life Stability/Improvement
  • Case Studies of Outliers
  • Program Summary
    o Barriers/Limitations
    o Opportunities for Improvement

ADVANTAGE CASE MANAGEMENT MODEL OF CARE

RISK STRATIFICATION LEVELS

Paramount Advantage is committed to improving the health and well-being of our members and has developed several initiatives and programs to positively impact health outcomes. 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 Advantage, the Institute for Healthcare Improvement Triple Aim (IHI), and the Standards of Practice for Case Management (2010), 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 complex needs. Social determinants, including assessment of living arrangements and/or
caregiver arrangements are assessed during the initial outreach with ongoing reassessments.

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 program 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 community resource support.

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

The purpose of the Paramount Advantage 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 collaboration with Disease Management.

All Care Management activity will maintain member's privacy, confidentiality and safety. The case manager and the health educator will advocate for the member, and adhere to ethical, legal, HIPAA, and accreditation/regulatory standards. Treatment of the member shall be in the least restrictive setting and manner:

- Improve self-management of disease and conditions
- Increase member satisfaction
- Return member to his/her maximum potential
- Support for the Primary Care Physician (PCP) and other providers
- Utilization of participating providers
- Reduce medical expenses
- Reduce unplanned hospital admissions and inappropriate emergency room usage.
- Educate members regarding their disease process
- Encourage member/provider relationship for coordination and continuity of care

**STANDARDS OF CARE:**
The Care Management process will include:
(Resource: CMSA Standards of Practice for Case Management, 2010)

**DEFINITION:** Care Management mechanism and criteria thresholds for identification strategy and risk stratification.

**Risk Stratification Levels**

The risk level for each member is assigned initially through a multi-layered comprehensive data-driven claims analysis. Data sources for the initial risk identification currently include: Paramount disease-management program identifications and stratification processes, member claims algorithms, ODM-provided new member reports (Chronic Care, CSP, and Health Home), maternal vital statistics, infant mortality hot spot zip codes, and Paramount delegated entity
reports. Future data streams are either in process of being implemented or will be implemented to supplement this process and include: Paramount health risk assessments, fee-for-service reporting, food desert data, poverty data and homelessness identification. Paramount will continue to expand partnerships with providers, to assist with members that have been identified with social determinants to health. Ongoing data extracts will continue to identify homeless Paramount members residing in shelters and missions statewide.

After the initial risk assignment, members at higher risk are assessed individually by the Paramount Care Management team and the risk level is verified or adjusted, as appropriate, based on personal interaction and clinical expertise. Ongoing evaluation of member risk occurs and includes monthly runs of the data-driven processes for assessment of new members and reassessment of members with new data that could change their current risk level.

**Population Stream**

Each member will be assigned to one of five populations streams: Maternal health, behavioral health, chronic conditions, and healthy adults and healthy children.

**Chronic Condition Population Stream**

Paramount’s Disease Management program proprietary algorithms are built into a software application that systematically analyzes laboratory results and medical and pharmacy claims to identify and stratify members for the following conditions; Asthma, Chronic Heart Failure, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, High-risk/Co-Morbid Depression, Diabetes, Migraine, and Post Cardiovascular Event. Through this stratification process, members are assigned into one the following risk categories; Intensive, High, Medium, or Low based on exception rule hierarchies and programs considered at higher risk.

- Highest acuity rules have been developed and are automatically referred to case management with a risk level of Intensive or High.
- Medium acuity rules are automatically referred to disease management and have an associated risk level of Medium.
- Members identified for the higher risk programs without triggering an exception rule are initially classified as medium risk and receive telephonic outreach to evaluate; Advantage Asthma, Advantage Diabetes, Chronic Heart Failure, Chronic Kidney Disease, Co-morbid Depression, and Post Cardiac Event.
- Members identified for Disease 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 disease management members are referred to the Disease Management team for written condition-specific correspondence. Members with gaps in care are referred to outreach coordinators in the Quality Improvement Department for telephonic outreach
and/or to the disease management team for additional written correspondence.

☐ Members not meeting any of the disease management identification/stratification or preventive gaps in care criteria are assigned to the Monitoring risk level and receive routine educational newsletters and health information.

☐ For members not identified for Disease Management, Paramount uses another claims based analysis application from a third-party claims warehouse; Truven Health Analytics. The Truven database has a variety of analytical tools to assess risk and categorize members. These tools include:

☐ Clinical Condition Tool; used to identify clinical conditions using primary diagnosis coding on claims.

☐ Opportunity Score Tool; algorithms classifying members into a risk-stratified hierarchy based on individual scores from the following weighted components; Compliance, Cost, Lifestyle, Risk and Utilization with definitions as follows:

a. The Compliance sub-score evaluates pre-defined chronic or preventable gaps in care.

b. Cost calculations are based on the net pay per member per month (PMPM) for each member and scored on a comparative scale.

c. The Lifestyle component evaluates member specific socio-demographic health status, including homelessness.

d. Risk is scored by combining member risk levels from both clinical conditions and claims.

e. The Utilization sub score evaluates each member based on avoidable and non-avoidable admissions, chronic acute flare-ups, 30-day readmissions, and ER visits.

☐ Current Health Status Classification Tool, including; Major Acute Conditions; Cancers; Major Cardiac; Chronic Management; Minor Acute/Chronic; Well Care; No Current Episodes.

While the Clinical Conditions are used to classify members into the appropriate Population Stream, it also helps assess risk in conjunction with the other tools described above. Once a member is identified for the Chronic Conditions population stream, their Current Health Status and Opportunity Score are analyzed through a matrix to further define their risk level.

**Chronic Conditions risk workflow¹**

**Maternal and Child Health Population Stream**

The Maternal and Child Health population stream is first identified through claims with additional analysis using the ODM-provided Vital Statistics file and the geographically targeted birth outcome efforts in areas of the state with the highest
infant mortality rates and Appalachia (“priority communities”) to assess and assign risk as defined in the Enhanced Maternal Care Services document.

- **Intensive:**
  a. Currently pregnant with a previous delivery of infant weighing less than 1500 grams and/or
  b. Previous delivery at/before 32 weeks of gestational age and residing in a hot spot zip code.

- **High Risk:**
  a. Currently pregnant with a previous delivery of infant weighing less than 1500 grams.
  b. Currently pregnant with a previous delivery at/before 32 weeks of gestational age.
  c. Currently pregnant classified at medium risk and residing in a hot spot zip code.

- **Medium Risk:**
  a. Currently pregnant with a previous delivery of an infant weighing 1500-2500 grams and/or delivered between 32 1/7 -36 6/7 weeks of gestational age and/or had a prior poor outcome.
  b. Currently not pregnant and reported on the ODM Vital Statistic file.
  c. Currently not pregnant and residing in a hot spot zip code.

- **Low Risk:**
  a. Currently pregnant and not reported on the ODM Vital Statistic file and not residing in a hot spot zip code.

- **Monitoring:**
  a. Currently not pregnant and not reported on the ODM Vital Statistic file and not residing in a hot spot zip code.

**Reference the Maternal and Child Health risk workflow**

**Behavioral Health Population Stream**

Members identified through Disease Management processes with High Risk or Co-morbid Depression is assigned to the Behavioral Health Population Stream with the following risk levels:

- **Intensive**=Recent suicide attempt or emergency care or inpatient admission for depression.
- **Medium**=Co-morbid Depression.

The remaining Behavioral Health Population Stream is assessed for risk using the Truven Condition Code assignment based on professional and institutional claims.
Risk levels for all behavioral health members stratified as Intensive may be adjusted to high risk level post assessment.

- Members identified with the following condition codes they are classified as Intensive risk: Schizophrenia, Psychosis, Substance Dependence, Major Depression, Suicide Attempts, Eating Disorder, Bipolar (Inpatient required) and Autism (Inpatient required).

- The less severe Behavioral Health stream subset includes the following Condition Code assignments and is classified at Medium risk: Bipolar, Autism, Antisocial Behavior, Anxiety, Depression, Obsessive Compulsive Disorder, Substance Abuse, and Neurosis.

- Pharmacy claims are also used to group members into Low risk if they have claims for the following therapeutic class assignments: Anti-depressants, Anti-anxiety, Bipolar, Medication Assisted Treatment, Antipsychotic, and Attention Deficit Hyperactivity Disorder.

**Reference the Behavioral Health risk workflow** ³

**Healthy Adult Population Stream**

Members in the Healthy Adults population stream are initially assigned to the Monitoring risk level until additional claims based data or other clinical information is available to modify their population stream or risk level.

**Additional Data Stream Elements**

Data streams from Paramount’s delegated entities and ODM-provided new member reports are additional sources utilized in the identification process. Member specific information is loaded into the Care Management software and integrates with the final data file.

New member reports indicate member-reported health conditions via a data feed that will adjust the initial risk assignment and will also be integrated in the final data file.

**Risk Assignment Hierarchy**

The overall risk assignment follows a hierarchy that will first utilize the Disease Management program results and supplement the remaining membership with the Truven analytics output. The two analytical methods are compared to each other (for like-members only) and if the risk assignments differ, the higher risk is chosen.

This data-driven process is completed initially to set a risk baseline for each member. Risk assignment can be modified by the Care Manager, as appropriate, based on their evaluation of and interaction with the member. Care Managers will be expected to review the Risk and Status frequently, especially as new data becomes available to insure members are appropriately stratified.

After the identification and risk stratification process is completed, a monthly “refresh” process will occur. The refresh process will follow the same methodology
as the initial process, but will only update if the risk assignment has changed and the Care Manager has not changed the status in the last 90 days. The 90 day modification rule is in place to prevent the data from overwriting the Care Manager’s risk assignment decision, if they are actively managing the member.

Reports are set up to notify team-leads of members with changes in risk stratification via claim analytics.

Reference the risk refresh process

Chronic Conditions risk workflow
Maternal and Child Health risk workflow

Behavioral Health risk workflow
**Risk refresh process**

**Model of Care (Population Stream)**

**Population Stream**

Each member must be assigned to one of four population streams: maternal and child health behavioral health, chronic conditions, and healthy adults.

The population stream is assigned using a data-driven process from the Paramount disease-management program identifications and member-claims algorithms. Fee-for-service data is also used. The data-driven process is re-run monthly to assess new members, and to reassess members with new data that could change their population stream.

The Disease Management programs analyze laboratory results and medical and pharmacy claims to identify and risk stratify members for the following conditions; Asthma, Chronic Heart Failure, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Co-Morbid Depression, Diabetes, Migraine, and Post Cardiovascular. If a member has been identified for any of the DM programs with the exception of High Risk/Co-morbid Depression they will be assigned to the Chronic Conditions stream. Disease Management also identifies members for the High Risk/Co-morbid Depression program and those members are placed in the Behavioral Health stream. Additional suicide attempt data from Truven is analyzed and those members are also placed in the Behavioral Health stream. Reference the DM stream flowchart

The Truven Health Analytics tool is also used to identify population streams for those members not identified through Disease Management processes. Population streams have been developed using ODM’s hierarchy which stratifies members into one of nine specific buckets of stream/risk combinations. Reference the ODM Proposed Population Stream Hierarchy

Paramount utilizes a complex report that identifies members for each of the nine buckets, and then the hierarchy is applied to insure that the member is assigned to the highest bucket level category. Each bucket has specific criteria based on claims data, vital statistic data, and condition codes derived from primary diagnosis codes, pharmacy claims, product, gender and age. Reference the Truven stream flowchart
The overall stream assignment hierarchy uses the Disease Management program assignment first and supplements data for the remaining membership with the Truven analytics output. The two analytical methods are compared to each other (for like-members only) and if the stream assignments differ, the higher stream hierarchy is chosen. This data-driven process is done initially to set a stream baseline for each member. In addition to data-driven stream assessments, there will be a monthly “refresh” process. The refresh process will follow the same method as the initial process, but it will only update a member if the stream has changed. This refresh process is designed to assign the appropriate population stream to new members and to reevaluate and reassign members with additional data. Reports are available to show how many members change streams during the monthly refresh. Reference Stream monthly refresh process

### Population Stream Prevalance

As depicted above, maternal and child health comprises the largest segment of the population, followed by behavioral health prevalence, chronic conditions, and healthy adult. Risk level, age, gender, social determinants, and other factors that impact health status are defined previously in the overview and are specific to the population stream.
DM stream flowchart

[Flowchart image]

ODM Proposed Population Stream Hierarchy

[Flowchart image]
Truven stream flowchart

UCM Data Team runs cohort through Truven report to assign Population Streams based on UCM PowerPoint methodology using Condition codes. Hierarchy is as follows:

1. Bucket A: Pregnant and Postpartum
2. Bucket B: Non Pregnant Higher Risk WRA
3. Bucket C: SMR
4. Bucket D: Severe/Obesese/Chronic Condition
5. Bucket E: Less Severe/Medical Controlled Chronic Condition
6. Bucket F: Less Severe/Well Controlled Chronic Condition
7. Bucket G: Healthy Adult
8. Bucket G: Healthy Child

Additional conditions:
- Clinical Conditions
  - Eating Disorders
  - Anxiety
  - Depression
  - Stroke
  - Adult Attention Deficit Hyperactivity Disorder
  - Other Mental
  - Neurological
  - Cancer
  - Other Chronic Condition

UCM Data Team adds members from CCMIS result that were not found in DM/Truven reports. They are added as Healthy Adult/Child or WRA.

UCM Data Team sends Excel output to IT to load into CCMIS.

END

Stream refresh process

UCM Data Team runs query for cohort of Medicaid members who are in the current coverage table (CCMIS Access/Excel).

If member existed in initial load or prior refreshes, then member already has population stream attributes.

CM Changes = YES: Case Managers have the ability to change population stream based on other knowledge, external reports, referrals, IPER sources, etc.

CM Changes = NO: Case Managers have not looked at the member and have not made any changes to population stream.

If the Assignment Date field was not updated in the past 90 days: Place holder for FTS identified member. Not part of Truven/CCMIS.

If member is new and does not have population stream attributes:

UCM Data Team runs cohort through DM/Truven workflow to assign Population Streams.

UCM Data Team adds members from CCMIS result that were not found in DM/Truven report. They are added as Healthy Adult/Child or WRA.

UCM Data Team sends Excel output to IT to load into CCMIS.

The population Assignment Date will be the date the initial load was put into CCMIS. The “modified by” field will read “505” or “ABRM.”

If the Assignment Date field was updated in the past 90 days:

- Qualifies as a UCM dept change and does not get updated through the refresh process
- Member was recently assessed in the population stream process and will remain in its stream for 90 days.

If the Assignment Date field was updated in the past 90 days:

- Member was recently assessed in the population stream process and will remain in its stream for 90 days.

CM Changes = YES: Case Managers have the ability to change population stream based on other knowledge, external reports, referrals, IPER sources, etc.

CM Changes = NO: Case Managers have not looked at the member and have not made any changes to population stream.

These members will not be updated this month.

Members updated and members not updated combine to show our whole population.

END
Specialized Services and Resources:

For each population stream, the MCP must describe the specialized services and resources that the MCP expects to make available to members (e.g., health and wellness programs, 24/7 nurse advice line, transitions of care, care management, home visits, medication therapy management programs, etc). The MCP should articulate if certain add on services and resources will be made available to subsets of the membership based on the MCP’s population stream analyses (e.g., risk level, community, prevalence of co-occurring conditions, etc.). The MCP must also describe how it will work with community partners and providers to facilitate access to needed services and resources. The MCP may structure this section similar to ODM’s Guidance for Managed Care Plans for the Provision of Enhanced Maternal Care Services. ODM also requests that the MCP submit a high level visual depiction of the model of care framework that demonstrates how level of services and resources will connect to risk level within each population stream.

<table>
<thead>
<tr>
<th>POPULATION STREAM</th>
<th>SPECIALIZED SERVICES &amp; RESOURCES (includes Add On Services &amp; Resources)</th>
<th>COMMUNITY PARTNERS</th>
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<tbody>
<tr>
<td>Maternal Child</td>
<td><strong>ALL RISK LEVELS:</strong></td>
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<td>- Enhanced Maternal Care Program</td>
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<td>co-morbidity management</td>
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ADD ON SPECIALIZED SERVICES/RESOURCES

- Prenatal to Cradle Incentive Program (All risk levels)

- Preventive service incentives for members, i.e., drawings for Cleveland Browns' sports memorabilia, tickets, and special events for adult and pediatric members receiving annual well visits

- Preventive and clinical service incentives for providers, i.e., monetary reward for new member visits; incentive for Community Behavioral Health Centers for completing seven day post behavioral health discharge visit

- Antepartum skilled home care for administration of progesterone therapy, intravenous hydration, etc.

- Two post-partum visiting nurse services post discharge

- Two NICU graduate visiting nurse services post discharge

- Skilled, private duty nursing, respite, home health aides services for medical and behavioral health needs

- Additional transportation assistance for members in care management

- Post-partum Depression Screening

- Written and/or telephonic service reminders for individual member identified gaps in preventive or clinical services, i.e., immunization and breast cancer, and cervical cancer
screening reminders; prenatal and postpartum visit reminders; medication adherence; diabetes screening reminders

**INTENSIVE:**
Members stratified as intensive and enrolled in case management receive all risk level services listed above plus:

- Home visits at least every six months, if member agreeable
- Reoccurring In-person visits at least every 90 days

**HIGH:**
Members stratified as high and enrolled in case management receive all risk level services listed above plus:

- Home visits at least annually, if member agreeable
- Reoccurring In-person visits at least every 180 days

**MEDIUM:**
Members stratified as medium and enrolled in disease management receive all risk level services listed above plus:

- Comprehensive disease management assessments and follow up, as indicated

**LOW:**
Members stratified as low receive all risk level services listed above plus:

- Disease specific mailings, as appropriate

**MONITORING:**
Members stratified as monitoring receive all risk level services listed above.

### Behavioral Health

**ALL RISK LEVELS:**
- Care management/disease management including co-morbidity management
- Linkage to appropriate behavioral health services and
- Community Behavioral Health Centers
- Patient Centered Medical Homes
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**ADD ON SPECIALIZED SERVICES/RESOURCES**

- Preventive service incentives for members, i.e., drawings for Cleveland Browns’ sports memorabilia, tickets, and special events for adult and pediatric members receiving annual well visits
- Preventive and clinical service incentives for providers, i.e., monetary reward for new member visits; incentive for Community Behavioral Health Centers for completing seven day post behavioral health discharge visit
- Skilled, private duty nursing, respite, home health aides services for medical and behavioral health needs
- Additional transportation assistance for members in care management

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<td>- Contracted primary care and specialty providers</td>
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• Written and/or telephonic service reminders for individual member identified gaps in preventive or clinical services, i.e., immunization and breast cancer, and cervical cancer screening reminders; prenatal and postpartum visit reminders; medication adherence; diabetes screening reminders

**INTENSIVE:**
Members stratified as intensive and enrolled in case management receive all risk level services listed above plus:
• Home visits at least every six months, if member agreeable
• Reoccurring In-person visits at least every 90 days

**HIGH:**
Members stratified as and enrolled in case management receive all risk level services listed above plus:
• Home visits at least annually, if member agreeable
• Reoccurring In-person visits at least every 180 days

**MEDIUM:**
Members stratified as medium and enrolled in disease management receive all risk level services listed above plus:
• Comprehensive disease management assessments and follow up, as indicated

**LOW:**
Members stratified as low receive all risk level services listed above plus:
• Disease specific mailings, as appropriate

**MONITORING:**
Members stratified as monitoring receive all risk level services listed above, as appropriate
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|                    | • Patient Centered Medical Homes |
|                    | • Federally Qualified Health Centers |
|                    | • Contracted primary care and specialty providers |
- Skilled, private duty nursing, respite, home health aides services for medical and behavioral health needs
- Additional transportation assistance for members in care management
- Written and/or telephonic service reminders for individual member identified gaps in preventive or clinical services, i.e., immunization and breast cancer, and cervical cancer screening reminders; prenatal and postpartum visit reminders; medication adherence; diabetes screening reminders

**INTENSIVE:**
Members stratified as intensive and enrolled in case management receive all risk level services listed above plus:
- Home visits at least every six months, if member agreeable
- Reoccurring In-person visits at least every 90 days

**HIGH:**
Members stratified as and enrolled in case management receive all risk level services listed above plus:
- Home visits at least annually, if member agreeable
- Reoccurring In-person visits at least every 180 days

**MEDIUM:**
Members stratified as medium and enrolled in disease management receive all risk level services listed above plus:
- Comprehensive disease management assessments and follow up, as indicated
| **LOW:** | Members stratified as low receive all risk level services listed above plus:  
|          | - Disease specific mailings, as appropriate |
| **MONITORING:** | Members stratified as monitoring receive all risk level services listed above. |
| **Healthy Adult** | **ALL RISK LEVELS:** |
|          | - Health and wellness tools on the member portal |
|          | - Electronic Health Risk Assessment |
|          | - 24/7 nurse advice line |
|          | - Personalized call center representative |
|          | - Transportation assistance |
|          | - Transitions of care |
|          | - Care management/disease management |
|          | - STEPS2CARE mobile application |
|          | - Online community resource guide |
|          | - Quarterly member newsletter |
|          | - Patient Centered Medical Homes |
|          | - Federally Qualified Health Centers |
|          | - Contracted primary care and specialty providers |

Paramount 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.

**Case Identification**

Mechanism used for identification of members for care management:

Members may be recommended to CM by telephone, email, letter, fax, or the interdepartmental electronic case management review from the following sources:

- Member Services
- Administrative data
- Health Care Providers
- Utilization Management and Acute Care Coordinators
- Member self-referral
- Disease Management referrals to Care Management
- Care Management referrals to Disease Management
- Ohio Department of Medicaid (ODM) Programs and reports SSI, CCR, Prior Authorizations, FFS data (Snapshot),
- Internal Reports-Polypharmacy, OB report, Inpatient Census Report, Daily ER Reports, Utilization Report from Amisys
- Advantage new member screening.
- Advantage Disease Specific Reports.
- ProMedica Call Center Daily Report (24/7 Line)
- Pharmacy Specialty Drug Reports
- Referrals from pharmacy UM staff
- Health Risk Assessment- Included in new member packet
- Predictive Modeling which also will identify costly members
- Prenatal Risk Assessment
- Pathways
- Members are identified for disease management/care management via disease management analyzer based on administrative data.

**Case Evaluation for Care Management:**

**Assessment:**

The following components of care management must be addressed in the MCP’s model of care:

**Assessment**

Description of the process for conducting or arranging for an assessment that is appropriate for the member’s unique needs and circumstances.

Paramount Advantage incorporated the ODM pediatric and adult needs assessment into the care management process on February 1, 2016. The Pediatric and Adult Needs Assessment has been built within the electronic care management software system. All members with a risk stratification of high or intensive are required to have the Needs Assessment completed. Identification of one or more clinical, social or safety need
enables the care manager to quickly open a case. The needs assessment may be completed by licensed staff or para-professionals. Standardized assessments may be completed by providers/community partners based on their readiness and an agreed upon data sharing process. Once identified, the need(s) will be reflected in the care plan.

- **Components included in the assessment tool/mechanisms for all other stratification levels and sources from which the care management team will draw information to complete the assessment:**

  Care Managers will utilize internal and external data from members/caregivers, providers, community partners, claims; Fee for Service claims data, member services, call center, pharmacy, Disease Management and Utilization Management data (i.e., emergency room, inpatient, post-acute, and other utilization management information).

- **Triggers for completion of more in-depth or disease specific assessments (i.e., when the member is not connected to a PCMH or the member is displaying risk factors for placement in a higher stratification level.**

  Paramount Advantage incorporated the ODM pediatric and adult needs assessment into the care management process on February 1, 2016. The Pediatric and Adult Needs Assessment has been built within the electronic care management software system. All members with a risk stratification of high or intensive are required to have the Needs Assessment completed. Identification of one or more clinical, social or safety need enables the care manager to quickly open a case. The needs assessment may be completed by licensed staff or para-professionals. Standardized assessments may be completed by providers/community partners based on their readiness and an agreed upon data sharing process. Once identified, the need(s) will be reflected in the care plan.

  Care Managers will utilize internal and external data from members/caregivers, providers, community partners, claims; Fee for Service claims data, member services, call center, pharmacy, Disease Management and Utilization Management data (i.e., emergency room, inpatient, post-acute, and other utilization management information).

  Triggers include:
  - Social determinants of health
  - Acute care utilization (ER, inpatient, readmissions)
  - Diagnoses/conditions
  - High cost members
  - Disease management algorithms
  - Stratification levels
  - Population streams
Additionally, any time during the assessment process, clinical judgment and/or data elements may prompt a more in-depth assessment.

For example:
- Members scoring three (3) or higher on the PHQ2 assessment would trigger a task for completing the PHQ9 assessment.
- Members identified with a pregnancy during the case management evaluation will trigger for completion of the maternity specific assessment. If the member is identified with pregnancy needs/complications, the member would be transferred to a specialized obstetric case manager.

- **Methods for using clinical (or other) data provided by the PCMH or other partners/providers to prevent duplication of assessment and to assist with identification of priorities for the member.**

  Paramount Advantage will assess the provider/partner’s willingness and capabilities to accept care management responsibility for specific functions of the care management role. Based on the provider readiness assessment results, Paramount Advantage will transfer responsibility to the provider/partner for medical/behavioral care management functions, as defined.

  - Case managers will collaborate with the PCMH or other partners/providers to identify the member’s highest priority needs.
  - Wrap around social and safety support is provided by the plan for members attributed and engaged with a NCQA accredited provider.
  - The provider/partner assumes responsibility for medical and/or behavioral health care.
  - The plan and provider working together enables highly coordinated service support for the member with collective development of goals.
  - Bi-directional communication methods include telephone calls, on site care conferences, faxes, FTP site data transfers, with documentation and integration in the electronic medical record. The goal is direct migration into the electronic medical record as outlined in the Care Management Information Systems Review Plan.

Non-accredited or less mature PCMH and non PCMH providers;
- Paramount Advantage will deliver ongoing oversight and management of care management services.
- Provider relations and the care management departments will continue to educate and encourage provider readiness as outlined in the Provider Readiness Assessment Strategy plan.

Paramount Advantage will continue to track and monitor all accredited and non-accredited providers/partners.
- Outcomes, quality indicators, and medical oversight activities contained within the provider agreement including minimum performance standards,
pay for performance metrics, member satisfaction, and medical costs through ongoing audits and performance evaluations.

Results from the needs assessment identifying the member’s highest priority needs are shared with the provider/partner based on agreed upon data sharing process.

- Some providers will have the capability for electronic medical record transfer of data.
- Others may require pdf format loads via secure email or loaded to an FTP site for data sharing.

As provider information technology processes mature, Paramount Advantage will incorporate enhanced data sharing methodology into practice.

Timely data sharing with provider/partner will reduce the risk for duplication of services and improve communication between the health care team, promoting transparency.

Paramount Advantage’s focus is collaboration with member and provider to prevent the need for the member to tell their story over and over.

To support the member centric process, the case manager will incorporate the PCMH/provider/partnership’s assessment findings into the electronic care management software. This will ensure that the efforts of the interdisciplinary team are integrated to promote comprehensive and targeted care through new and established provider/partner relationships.

Open communication and bi-directional data sharing will promote a cohesive member care plan that strives to improve member outcomes and satisfaction, while reducing the burden of duplicative services and potential fragmentation.

- The mode (e.g. In-person, telephonic, etc.), and anticipated timeline by which the MCP will complete the assessments.

Paramount Advantage utilizes the following modes of communication: In-person interaction, telephone calls, and letters to engage members and complete the assessment process. Once identified for potential case management services, the member’s preferred mode of communication is considered.

Anticipated initial assessment timelines follow:

**Intensive Risk Stratification**
- Immediate telephonic or in-person visit attempts for members identified with emergent needs to begin the assessment process.
• Initial needs assessment for a member with intensive risk stratification should be completed within 30 calendar days after notification of eligibility for case management services, unless there is a delay which is beyond Paramount Advantage’s control, including (NCQA 2016 Standards);
  o Member is hospitalized during the initial assessment period
  o Member cannot be reached through telephone, letter, e-mail or fax
  o Natural disaster

• All members classified in the Intensive Risk stratification are considered Complex according to NCQA standards.

• Assessments completed by providers/community partners will be incorporated into the care management assessment process.

Anticipated initial assessment timelines follow:

High Risk Stratification

• Immediate telephonic or in-person visit attempts for members identified with emergent needs to begin assessment process.

• Initial needs assessment for a member with high risk stratification should be completed within 45 calendar days after notification of eligibility for case management services, and annually, thereafter.

Anticipated Ongoing/Follow up Assessment Timelines:

Intensive Risk Stratification

• Comprehensive general assessments (Start of Care Assessment) should be completed within 30 calendar days of identification of intensive case management risk stratification.

• Disease/condition specific assessments should be completed within 60 calendar days from case open date. Clinical assessments completed by provider/partners will be integrated into Paramount Advantage’s assessment and plan of care process.

• Case Next Review/Follow-up Assessments are completed at least quarterly.

High Risk Stratification

• Disease/condition specific assessments should be completed within 60 calendar days from case open date. Clinical assessments completed by provider/partners will be integrated into Paramount Advantage’s assessment and plan of care process.

• Case Next Review/Follow-up Assessments are completed at least quarterly after the case is open.

If the member has an identified urgent need (such as a call from member services or the primary care physician), immediate telephonic contact or in-person visit is attempted.

In-person visits are conducted for members:
  o During an inpatient psychiatric admission, as appropriate.
With a prolonged medical hospitalization, as appropriate.

During the initial and ongoing assessment process within community settings (i.e., provider offices, clinics, CMHCs, libraries, etc.) and/or member’s home, as agreed upon by the member.

This process has proven to be very successful in increasing member engagement with case management services, including but not limited to post discharge follow-up and transition of care.

Telephonic interaction is conducted as defined below:

- A minimum of three telephonic attempts are made within 10 business days.
- Calls are made at different times of the day and on multiple days.
- When possible, HIPAA compliant voice mail messages are left requesting a return call.
- Case managers actively search for updated contact information through provider offices, hospital face sheets, and/or clinical information within systems when phone numbers or addresses are incorrect or no longer in service.

An unable to reach letter is sent to the member:

- Immediately when there is not a working number identified.
- Following at least three unsuccessful telephonic attempts.

The “Unable to Reach” letter explains that the case manager has been attempting to contact the member for case management and requests the member contact the case manager.

- The process the Paramount Advantage will follow in order to complete assessments for members who cannot be reached or who refuse to participate in assessments.

If the member is unable to be reached, they will be re-stratified to a medium, low, or monitoring risk level based on clinical and administrative evaluations completed by provider partners and/or the plan.

Paramount Advantage will collaborate with community partners for member outreach to assist with increasing member engagement with case management services.

For example, the case manager will coordinate with the community health worker for those pregnant members actively working within the Pathways programs. The Pathways outreach worker will encourage member participation with case management.
Assessments completed by Pathways and/or other provider/partners will be integrated into Paramount Advantage’s assessment process and documented within the electronic medical record. The Needs Assessment can be initiated based on assessments completed by provider/partners.

Additional contact attempts will be made as new utilization and clinical data becomes available.

- How Paramount Advantage will use the assessment to develop and update the care plan, as well as confirm the appropriate risk level is assigned to each member.

**Care Plan Development**

- Care plan initiation based on at least one problem identified in the needs assessment.

- Problems are prioritized based on member/caregiver preference, need, 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 by case manager with specific target dates and timeframes for re-evaluation based on the required minimum contact schedule or more frequently, 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.

- Provider/partner input, assessment results, and clinical data are incorporated into the care plan, as appropriate.

- Need for community resource referrals and support are included in the care plan.

- Initial care plan is shared with members and providers/partners of the interdisciplinary health care team.

- Care plans provided by PCMH providers become the active care plan with social and safety enhancements by Paramount Advantage.
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.

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 initial care plan.

**Care Plan Updates**

- Occur as member makes progress towards goals, is no longer interested in working towards goal, or goal is completed.

- Internal and external utilization management transitional care plans are included in the modification of the overall care plan process for continuity of care.

- Modified based on changing priorities.

- Focus on member/caregiver preference and progress.

- Problems, interventions, and goals may be accepted, rejected, or modified by case manager with specific target dates and timeframes for re-evaluation based on the required minimum contact schedule or more frequently, as appropriate.

- Ongoing assessments and new data including over/under utilizations, and gaps in care to identify new problems, interventions, and goals.

- Psychosocial/cultural/medical barriers that impede the member’s ability to meet goals and comply with care plan are identified and communicated to provider.

- Providers are notified that inhibit member’s ability to adhere to the treatment plan.

- Care plans updates provided by PCMH providers become the active care plan with ongoing social and safety enhancements by Paramount Advantage.

- Changes with provider/partner input, assessment results, and clinical data are incorporated into a care plan update.

- Updated care plans are shared with members and providers/partners of the interdisciplinary health care team.

- Updated provider/partner input, assessment results, and clinical data are incorporated into the care plan, as appropriate.
Need for ongoing community resource referrals and support are included in updates to the care plan.

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.

Care plan conferences including family/caregiver and other provider/community partners are conducted, as appropriate. Needs identified through this collaborative approach are included to update the care plan.

**Confirming Risk Levels**

Risk levels are initially assigned according to the risk level hierarchy described in detail on page 13 of the Model of Care. The overall risk assignment follows the hierarchy that uses Disease Management program results and supplements the remaining membership with analytic output from the predictive modeling tool. This data-driven process is completed initially to set a risk baseline for each member.

The initial risk assignment can be modified by the Care Manager, based on a comprehensive assessment of the member, including, the severity of their unique needs, such as patterns of utilization; chronic vs acute disease process and social determinants of health. The Care Manager will verify or adjust the risk level based on clinical expertise, objective and nonobjective data, and personal interaction with the member. The Care Management team will be expected to perform ongoing review of the Population Stream, Risk, and Status, especially as new data becomes available to insure members are appropriately stratified.

For example, a male member assigned to the Healthy Adult population stream with a Monitoring risk level, and an inactive status, who is admitted to the hospital with an initial or untreated diagnosis of diabetes ketoacidosis, would be referred by the Transition of Care or Acute Care teams to case management. Based on the case management evaluation and assessment results, the member would be re-assigned to the Chronic Conditions population stream; the risk level and status re-evaluated with a probable assignment of intensive or high risk and a status of engaged or outreach and coordination, based on successful contact with the member.

Describe how the assessment data will be stored and made available to the interdisciplinary team in order to coordinate care.

Assessments are stored electronically within the care management software for a minimum of ten years. Based on provider and member preferences, assessments are shared using the following methods:

- Attached to a secure email
- Attached to secure messaging within the member/provider portal
- Faxes
- Mailing
- In-person visit
Develop an individualized care plan for each member based on the most recent assessment. The scope and depth of the ICP will vary based on the member's risk stratification level and needs. Include the following components:

For members assigned to the intensive and high risk stratification levels

Automated problems, interventions, and goals are embedded in each assessment and are generated based on answers selected. Additionally, the Case Manager can add customized problems, interventions, and goals based on member preference and prioritization of needs and readiness to change. The Case Manager will then individualize and prioritize the care plan with provider input in collaboration with the member, caregiver, family, and their level of participation.

All problems, interventions, and goals are prioritized with short and long-term time frames and measurable outcomes. As the care plan evolves, the Case Manager will document progress toward meeting goals.

How the ICP goals will be person-centered, developed with the member, and based on his/her strengths and preferences for care (e.g., cultural considerations).

Member’s health literacy, cultural preferences, strengths, and barriers to care, are evaluated during the initial and ongoing assessment process, and incorporated into the Individualized Care Plan.

Nested or multiple interventions are automatically available within the care management software to further enhance the care plan by the entire interdisciplinary Health Care Team.

See below for cultural consideration workflow:

- Member alert is generated in the care management software after identification.
- Member has Cultural Preferences that may impact care.
- Automated Problems, Interventions, and Goals are created stating: Cultural considerations.
- Problem: Treatment plan may be affected due to cultural beliefs.
- Intervention: Assist member in developing a plan to make lifestyle changes consistent with cultural and/or religious beliefs.
- Goal: Member treatment plan will reflect cultural beliefs.

The care plan can be further edited to include member specific detail. If additional cultural considerations are identified through communication with the member and/or provider, the case manager will modify the care plan to incorporate the feedback. The case manager will
review the care plan with the member to insure that the member is in agreement with the care plan.

Development and/or contribute to a single care plan with goals that are congruous with the priority issues identified by the PCMH, PCP, etc. in order to support the provider-patient relationship.

The process will vary based on the maturity of the PCMH and non-PCMH providers/partners. It will be evolving with high emphasis on relationship building strategies, which support the provider/member effort to contribute to the development of a single care plan.

**PCMH process:**
- Level 3 mature PCMHs: For members attributed and connected to the PCMH, Paramount adopts the PCMH medical care plan, communicates additional medical issues and fills gaps related to identified social and safety needs.
- Level 2 mature PCMHs: For members attributed and connected to care through the PCMH, Paramount will work/collaborate with the PCMH to develop one comprehensive care plan addressing all aspects of care.
- Oversight is provided to all levels of PCMH accreditation, with increased oversight and support to level two PCMHs, as needs and/or opportunities are identified.

**Non-PCMH process:**
- Bi-directional data sharing of assessment findings (clinical, social, and safety) between the provider and the plan to enable the care manager to support the provider’s efforts and align messaging.
- The plan and provider working together enables highly coordinated service support for the member with collective development of a single member-centric care plan with congruent goals.

**Health Home process:**
- The Health Home collaborates with the integrated health care team for care plan development.
- The Health Home assumes responsibility for maintaining the care plan.
- During the care conference, the Health Home staff and behavioral health case manager collaborate related to priority issues and conditions and incorporate needs into the shared care plan.
- The care plan is then integrated into the member file within the case management software system.

For medium, low, and monitoring levels, describe how a plan will be developed which identifies primary and preventative services that are appropriate to a member’s age, gender, and condition. Include additional components that may be a part of the member’s ICP.

Care planning for members identified in the medium, low, and monitoring risk levels will be developed through the output of customized algorithms built in the Care Management
software. The algorithms will be based on the most current Infant, Pediatric, Adult, and Senior Adult Preventive Health Guidelines, based on age, gender, and condition, in conjunction with current clinical practice guidelines, adapted from nationally recognized sources. Social determinants will be incorporated to the individual care plan when identified.

For all stratification levels, describe the process Paramount Advantage will follow to ensure the ICP is updated as needs change and to address gaps in care. Include MCP timeframes for initial ICP development and updates.

For all risk levels, gaps in care are addressed utilizing a multidisciplinary approach which includes data streaming based on primary and preventive guidelines. Processes for the specific stratification levels follow:

**Intensive Risk:**
- The ICP will be updated after all assessments and member interactions, as needs are identified.
- Care plans will be re-evaluated and updated as new data is available and/or with changes in clinical condition or identification of social determinants of health.
- For example, following a transition of care from inpatient to outpatient setting, a post discharge assessment will be completed and additional needs will be incorporated.
- Care plans will be individualized and prioritized with provider input and collaborative efforts including the member, and as appropriate, caregiver and family, based on their preferred level of participation.
- A minimum contact schedule of every 30 calendar days has been established; however, the case manager will increase the contact schedule based on complexity and/or identified individual need.
- For example, an OB member with multiple pregnancy related needs may have weekly contact during the initial months of case management. The Accountable Point of Contact (APOC) will coordinate outreach efforts with members of the health care team to prevent duplication and fragmentation of care/services and maximize member outcomes. The APOC assumes responsibility for updating the comprehensive care plan with input from health care team members.

**High Risk:**
- The ICP will be updated after all assessments and member interactions as needs are identified.
- Care plans will be re-evaluated and updated as new data is available and/or with changes in clinical condition or social determinants.
- For example, a noncompliant member with behavioral health needs is identified; a behavioral health case manager links the member with community resources, including outpatient psychiatric services. The care plan would be updated with new or changed information, as appropriate.
- Care plans will be individualized and prioritized with provider input and collaborative efforts including the member, and as appropriate, caregiver and family, based on their preferred level of participation.
• A minimum contact schedule of every 60 days has been established; however, the case manager may increase the contact schedule based on identified individual need.

• In the example above, to insure that the member is engaged with services and following through with treatment recommendations, the care team could initially increase the frequency of contact until the member exhibits a more stable behavior.

• The Accountable Point of Contact (APOC) will coordinate outreach efforts with members of the health care team to prevent duplication and fragmentation of care/services and maximize member outcomes. The APOC assumes responsibility for updating the comprehensive care plan with input from health care team members.

Medium Risk:

• Care plans will be re-evaluated and updated as new data is available, with identified condition gaps in care, when medium acuity rules trigger, and/or with changes in clinical condition or social determinants.

• Care plans will be individualized based on priority goals agreed upon by the member and health care team, as appropriate.

• A minimum contact schedule of every 90 days has been established for member and care plan reassessments; however, the care manager may increase the contact schedule based on identified individual need.

Low Risk:

• Data driven care plans will be developed and updated based on low risk disease management identification and age, gender appropriate gaps in care.

Monitoring Risk:

• Data driven care plans will be developed and updated based on ongoing automated individual member evaluations.

Documentation and storage of the ICP and how it will be made available to members of the interdisciplinary care team.

Individualized Care Plans are developed, documented and stored electronically within the care management software for a minimum of ten years. Based on provider and member preferences, care plans are shared using the following methods:

• Attached to a secure email
• Attached to secure messaging within the member/provider portal
• Faxes
• Mailing
• In-person visit
• Verbally
• Care conferences
• Automated integration into the provider electronic medical record is being explored.

Care plans for Health Home enrollees that are followed by Paramount behavioral health case managers are created, reviewed and maintained by the Health Home with Paramount
input. The care plan is then attached to the member record within Paramount’s care management software system.

**Care Transitions**

Paramount has implemented a Transition of Care (TOC) team as part of the Utilization Management (UM) process. The workflow is designed to assure minimal disruption to member’s established relationships with providers and existing plans of care when transitioning from one care setting to another as per following:

**Utilization Management (UM):** The UM team performs medical necessity reviews for all inpatient, skilled nursing facility, long term acute care hospital, acute inpatient rehabilitation, and home health care admissions to assure appropriate care in the most appropriate and least restrictive setting. The medical and behavioral health UM teams work closely with hospital staff and/or medical care managers to identify complex, at risk members who require additional attention to insure a comprehensive, safe, and viable discharge plan. The UM teams notify the TOC team of all complex and/or at risk members prior the discharge.

**Coordinating Care:** Paramount requires notification of hospitalizations within one business day of admission. The notification initiates the dialogue with the facility’s utilization review and discharge planning teams regarding the current plan of care, as well as the anticipated discharge and/or transition care plans. The MCP UM team notifies the appropriate care coordination team/coordinator (TOC, medical or behavioral health case management, or disease management) for inclusion in transition and discharge planning efforts.

**Outreach:** The TOC coordinator, pharmacy coordinator, disease, or case manager contacts at-risk members or their designees along with the appropriate providers to determine the discharge goals. Additionally, members discharged from skilled home health care services are assessed to identify needs, insure appropriate services are in place, and to provide support.

The collaborative plan of care strives to optimize member outcomes and prevent future readmissions or emergency room utilization.

**Ohio Department of Rehabilitation and Corrections (ODRC):** Paramount is notified by the ODRC of members enrolling in Paramount Advantage that have met the identified clinical indicators requiring a transition plan.

Evaluating risk for readmission for members transitioning between care settings and how it will be used to determine the intensity of post-discharge follow up with the member.

Paramount utilizes several data sources and member/provider outreach to evaluate members at risk for readmissions, including but not limited to the following:
**Evidence-based Hospitalization Risk Assessments:** The medical and behavioral health TOC coordinators complete this assessment on at risk members based on utilization patterns and clinical judgement. The TOC coordinator utilizes the assessment while collaborating with current hospital or facility staff, providers, as well as the member or guardian to identify gaps in care and address those gaps in order to mitigate the potential for readmission.

**Opportunity Score:** Includes algorithms classifying members into a risk-stratified hierarchy based on individual scores from the following weighted components: Compliance, Cost, Lifestyle, Risk and Utilization.

**Multiple Admissions and Readmissions Reports:** Identifies members who have had two or more admissions in the past six months.

**Member Utilization Report (MUR):** Includes the most recent two years’ claims data from the claims payment system. This report provides the opportunity to identify diagnosis, medications, services, under/over utilization patterns, and member providers. Paramount’s TOC team or care manager reviews the MUR and intervenes when there is a change in the pattern of physician visits, or a new diagnosis. In addition, a medication review is performed and will indicate potentially dangerous interactions, etc.

**Fee for Service Snapshot Report (FFS):** Includes two years of historical claims data from Medicaid fee-for-service. This report provides the opportunity to identify diagnosis, medications, services, under/over utilization patterns, and member providers.

**Bi-weekly inpatient (acute, SNF, LTAC, and Rehab) and Transition of Care Reports:** The utilization manager, care manager, or TOC team initiates post follow-up discharge contact via phone or letter for all members discharged from an inpatient setting. This outreach is performed to initiate member contact and identify medical and/or psycho-social needs or barriers post discharge.

**Psychiatric Discharge Outreach:** Most members who are hospitalized from a psychiatric setting are immediately referred to a behavioral health case manager for additional post discharge follow up. The intensity of the follow up contact is determined through risk level data analysis identification and stratification. Additionally, immediate needs are identified through the post discharge assessment and behavioral health case manager’s clinical judgment.

**Designation of staff that will communicate with the discharging facility and inform the facility of the MCP’s designated contacts.**

The medical and behavioral health utilization management coordinators are assigned to specific facilities, providing the name and contact information of the utilization management coordinator, TOC coordinator, social worker and/or care manager, including direct phone
numbers, queue line number, and fax information. Modes of communication vary depending on facility preference, ease and/or efficiency:

- Direct phone call,
- Fax
- Secured email

Process to ensure timely notification and receipt of admission dates, discharge dates and clinical information is communicated between MCP departments, care settings, and with the primary care provider, as appropriate.

Within 24 hours of receipt, the utilization management coordinators will provide the discharge team, social services, member/caregiver, primary care, or other providers, as needed, with pertinent clinical information regarding transition needs via the care management software or telephonic communication.

Process to ensure participation in discharge planning activities with facilities, including making arrangements for a safe discharge placement and facilitating clinical hand-offs between the discharging facility and the MCP.

Paramount coordinates transitions of care to avoid potential adverse outcomes by performing the following:

- Creation of a focused and collaborative provider education outreach program. The program will educate providers regarding the requirements for transition of care and their contribution to successful transitions in order to optimize member outcomes, prevent emergency room utilization, and prevent readmissions post discharge.

- Obtain report of hospital admissions within one business day of the admission in order to assess appropriate care planning and begin transition of care planning needs.

- Monitor transitions from members’ usual care setting to the hospital and discharge from the hospital to the next setting through transition of care risk assessment, utilization management, and care management activities. Provide a consistent primary contact or team responsible for supporting the member through transitions between care settings.

- Perform and actively participate in care and discharge planning activities in collaboration with the care setting. When indicated, medical and social/environmental information (i.e., current problem list, medication regimen, allergies, advance directives, baseline and current physical and cognitive function, etc.) will be requested.

- The treatment/transition plan will be available to providers and communicated to the member or designee. Note: The patient will have an up-to-date proactive
treatment/transition plan that would reflect the preferences of the patient and family.

- Analyzing and comparing specific facility performance rates for admissions, readmissions, and emergency room utilization and their performance at least bi-annually. Corrective action plans will be implemented for under-performing facilities, while best practices are recognized.

- The care manager works with the hospital staff, including the discharge planner to assist with identifying gaps in care, offering provider and covered services/benefit information and assisting in the formulation a comprehensive discharge plan.

- Care 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 insure appropriate follow up, engagement in services, and safe, successful care transitions.

- Paramount has established letters of agreement with CMHCs which incentivize them to arrange follow-up appointments within seven days of a behavioral health care discharge. The objective of this incentive program is to increase member engagement in outpatient services, insure gaps in care are addressed rapidly and mitigate issues with medication compliance with the ultimate goal of reducing readmissions and supporting the member in their journey to improved mental health stability.

**Process for obtaining discharge/transition plans**

- Creating a focused provider education outreach program to inform the providers of expectations regarding requirements for TOC and their contribution to a safe and successful care transition in preventing emergency room utilization and/or readmissions post discharge.

- Members of the health care team work with the facility’s discharge planning/utilization review teams for high risk members. The discharge plan is requested upon providing the authorization number for the admission.

- Provider Outreach: Discharging facilities and/or agencies that have not provided comprehensive discharge plans or medication regimens are contacted to proactively facilitate a safe and successful transition.

**Timely follow up process with the member and the member’s primary provider to ensure post discharge services have been provided.**

**Member Outreach:** The member is contacted within 1-14 days of discharge notification and appropriate evidence-based assessments are performed, as indicated. Assistance for follow-up appointments is provided at this time.
Additionally, provider outreach will be performed to address all identified areas of concern.

**New Members:** Members of the health care team work with the members’ PCP or other providers to facilitate continuation of the current treatment plan, for members discharged 30 days prior to the MCP enrollment effective date. These efforts include care coordination for high readmission conditions and patients, enhanced discharge planning, and self-management and education during the post-discharge transition period.

**Members transitioning from another MCP** – Case Manager works with discharge MCP to receive report in order to facilitate a safe and seamless transition to Paramount.

Members are scheduled to be seen within seven days of a behavioral health care discharge for a follow-up visit by the CMHC.

MCP’s scheduled contact with the member is based on risk stratification. If the MCP is unable to reach members classified in the intensive, high, and medium stratification levels, the providers/partners will be contacted to confirm the member completed the post discharge visit and is engaged in services.

**Ohio Department of Rehabilitation and Corrections (ODRC):** Care managers contact members identified through the ODRC process and schedule appropriate outpatient appointments, develop transition plans, and complete video conferences prior to their release. Transition plans are:

- Reviewed with the member.
  
  - Include education about Paramount’s case management program, condition specific information, community resources, transportation, support services, etc.
  
  - Are modified as appropriate and the final copy submitted to the ODRC. Members agreeing to case management are referred based on the member’s geographical location for continued assessment and on-going case management services. Members refusing case management services receive at least three outreach attempts within the first five days of release to reinforce the transition plan.

**Care Management Staffing Model:**

A care manager and a multi-disciplinary team must be assigned to a member/family based on the member’s needs. The staffing model must address the following components:

The factors that will be considered when determining when a care manager will be assigned and who will be assigned as the primary care manager:
• The following factors will be taken into consideration when assigning a care manager:
  □ Population Stream
  □ Risk stratification including algorithms of utilization, predictive modeling, disease management, risk scores and social determinants.
• Member’s demographics
• Maternal/child population stream:
  • RNs and outreach coordinators with specialized training in obstetrics/gynecology, Newborn Intensive Care and pediatric care will be assigned to members in the intensive and high stratification levels.
  • Nurses and Health educators with experience and/or specialized training in pregnancy and women’s health will be assigned to members in the medium stratification level.
• Behavioral Health population stream:
  • Social workers, licensed professional counselors, and RNs/Health Educators with specialized behavioral health training will be assigned as care managers for the intensive, high and medium stratification levels.
• Chronic condition population stream:
  • RNs, outreach coordinators, health educators and coaches with condition/disease specific training, skills, and certification will manage members at the intensive, high and medium risk stratifications.
  • Members are assigned to case managers and outreach coordinators who live within the member’s geographic region to enhance the in-person interactions and assist with linkage to community resources and providers.

**Process for determining the composition of the care team and how the roles and responsibilities will be delineated amongst the care team members that are responsible for, or are contributing to, care management in order to assure no duplication of, or gaps in services.**

• Within specific regional/geographic areas the care management teams for intensive and high risk stratifications are comprised of:
  • The Accountable Point of Contact (APOC).
  • The APOC is a Registered Nurse or a Social Worker.
  • An outreach coordinator can be a Licensed Practical Nurse (LPN), a Social Worker (SW), or a certified staff.
  • Care management (CM) support coordinator.
- **APOP**
  - Is in charge of the overall care management for the member.
  - Completes assessments with member and provider input.
  - Creates and updates the care plan with member and provider input.
  - Oversees the care team interactions with member and providers.
  - Communicates with the outreach coordinator pre and post in-person interaction regarding care plan topic for review and determines educational information to be shared with member.
  - Manages day-to-day calls with members and providers.

- **Outreach coordinator**
  - Works directly with the APOP.
  - Completes the Needs Assessment for newly identified members.
  - Does in-person visits for existing members in intensive and high risk stratification with appropriate pre and post engagement with the APOP to identify the priority needs.
  - Follow up calls with member/providers.

- **CM support coordinator**
  - Assists with scheduling in-person visits under the direction of the APOP and outreach coordinator.
  - Confirms in-person visit times with members.
  - Prints care plan and educational material to be taken to the In-person visit.
  - Contacts providers and facilities for documentation related to member visits, recent admission and/or discharge; attaching documentation into care management software for team review.

- **Health Educators/Outreach Coordinators**
  - Manage members in the medium and low risk stratifications.
  - Completes comprehensive/condition specific assessments for members in the medium risk level.
  - Perform telephonic reminders for individual clinical and preventive gaps in care.
  - Creates and updates the individualized care plan for members in the medium risk stratification.

Within the care management software, calendar reminders for member outreach can be viewed by team members coordinate outreach and prevent duplication of outreach attempts and services.

**The methods that will be used to exchange information within and across the team.**

The direct care management team will have access to the care management software. Messages and referrals can be sent bi-directionally within the software to provide
individualized updates and to communicate needs and plans for future interaction/interventions.

- Member/provider portal is available with secure messaging capabilities as an option for direct communication.
- Faxes
- Mailing
- In-person visits
- Verbally
- Care conferences
- Automated bi-directional interfaces and/or integration with the provider electronic medical record, according to provider/partner readiness.

How Paramount Advantage ensures that staff who are completing care management functions are operating within their professional scope of practice, appropriate for the member’s health care needs, and following the state’s licensure/credentialing requirements.

- Job descriptions identify roles of team members.
- Verification of employee licensure/certification.
- Initial training/onboarding and annual review for all care management team staff of the various care team levels, roles, and responsibilities.
- Chart audits conducted at least quarterly with 100% review of new team members until the end of their introductory period to ensure staff are utilizing clinical expertise, knowledge, and experience, are operating within their scope of practice, and managing the member’s health care needs appropriately.

The processes used to maintain a staffing ratio within the range specified in Appendix K, Provider Agreement:

- Determining initial and ongoing volume/percentage of members identified with intensive and high risk stratification.
- Assigning an Accountable Point of Contact based on member need and scope of practice.
- Identifying provider/partner readiness.
- Defining case management activities transferrable to the providers/partners based on member attribution and engagement.
- Collaborating on needed wrap around services.
- Calculating numerator and denominator of unique members enrolled in intensive and high risk case management weekly.
- Reconciling and validating intensive and high risk rates and engagement status indicators to determine staffing ratios weekly.
- Monitoring internal/delegated care management staff activities for members stratified at intensive and high risk.
- Confirming provider/community partner eligibility to participate in the staffing ratio.
- Monitoring provider/community partner involvement rates through documentation within the member’s electronic record.
- Analyzing staffing ratio based on combined rate calculations of internal/delegated entities and provider/community partners.
- Adjusting staffing, as appropriate, based on analysis results, including expansion of additional provider/community partners.
- Paramount Advantage will use the staffing ratio results defined above to complete the ODM staffing ratio document.

The process employed to ensure and attest that care managers and MCP employed/delegated members of the care management team are not related by blood or marriage to the member or any paid caregiver, financially responsible for the member or empowered to make financial or health related decisions on behalf of the member.

- An attestation statement will be signed at hire and annually by the care team members stating the employed/delegated care manager is not:
  - Related by blood or marriage the member or any paid caregiver.
  - Financially responsible for the member.
  - Empowered to make financial or health related decisions on behalf of the member.
- The signed attestation statement is stored electronically and maintained for ten years.
- The signed attestations statements are available for review, upon request.

The methodology used to assign consistent and appropriate caseloads for care managers that assures the health safety and welfare for members, considering each of the following factors:

- Paramount will analyze metrics/rates from the information below to assign consistent and appropriate caseloads:
  - Population
    - Specialty, including but not limited to:
      - Adult Aged Blind and Disabled
      - Children with Special Health Care Needs
      - Offender program
      - Adult Extension
  - Acuity status mix based on:
    - Opportunity scores are determined through proprietary algorithms developed within an evidenced based analytical tool which includes:
      - Health status (episodic care)
      - Likelihood of hospitalization
      - Compliance with guidelines and screenings
- Lifestyle risk (social determinants and health risk assessment)
- Utilization (avoidable admissions, readmissions, ambulatory emergency room, etc.)
- Cost scoring (Medical and pharmacy per member per month costs, prospective risk score)
- Clinical laboratory results
- Population streams, risk stratification and engagement level
  - Care manager qualifications, years of experience, and responsibilities
    - Job descriptions define care managers roles and responsibilities.

- Department leadership for the care management team includes:
  - Executive Director, Care Management
  - Clinical Director, Behavioral Health
  - Director of UCM Southern Region
  - Managers of Behavioral Health/Case/Disease/Utilization Management

- Case managers must be Registered Nurses or Licensed or Master Prepared Social Workers.
  - Minimum of two years previous case management experience in acute care, home health, skilled post-acute or community-based settings. Experience in managed care highly preferred.
  - Certification in case management is highly preferred.
  - Specialty skills identified for team assignment, i.e., behavioral health, adult, pediatric, transplant, obstetrics, oncology, chemical dependency, and community outreach.

- Utilization coordinators must be Registered Nurses, Licensed Practical Nurses, or Social Workers.
  - Minimum of three years of acute care, home health, or community-based experience.
  - Health Educators must be Registered Nurses, clinical certification, or Bachelor of Public Health.
  - Minimum of two years clinical experience.

- Outreach Coordinators
  - Must have Bachelor of Public Health, Licensed Practice Nurse licensure, or social work licensure.

- Assistant UM/CM coordinators
  - Require medical terminology, coding, and medical office or facility experience.
  - Provision of support staff
• Support staff requires medical terminology, coding, and general office experience.

• Location of care manager (community, MCP office, provider office)
  o Care managers are located in the MCP office, telecommuting, and/or travel to various community-based or care facility locations.

• Geographic proximity of care manager to members (if community based).
  o County assignments are aligned with the care managers’ home base within a 90 mile radius.

• Access to and capability of technology /IT systems
  o Care managers are supplied with a laptop, WiFi capability for travel.
  o Home based equipment includes docking station, monitor, keyboard, printer, document shredder, and capability to securely access MCP applications.

The methodology for case assignment is modeled as an integrated team approach. The interdisciplinary team includes an RN or Social Worker as the accountable point of contact (depending on members’ needs), an outreach coordinator, assistant CM coordinator, and utilization and support staff. To assure the health safety and welfare of the member, the accountable point of contact is determined by the population and acuity mix within a geographic location (i.e. an intensive behavioral health case would be assigned to an experienced behavioral health CM within proximity to the member’s primary location).

Staffing ratios have been established for intensive risk stratification of 1:25 for engaged members and 1:50 for passive members. High risk stratification ratio is 1:51 for engaged members and 1:100 for passive members. Passive status rates cannot exceed 0.2 in the intensive or high risk stratification categories.

Include a description of the practices Paramount Advantage follows as part of the onboarding of new staff (i.e. shadowing preceptors, staggered timeline for assigning caseloads, etc.) as well as further training, designed to enhance care management skills, that the MCP offers to existing staff, (i.e. additional credentialing or certification programs, refresher trainings, etc).

New staff participates in a general orientation which includes:
  • Introduction to the overall company mission and vision.
  • Education regarding use of computer applications and software
  • Review of specific job role and function.
  • In-depth training with subject matter experts covering components of care management such as assessments, care planning, and contact schedules.
  • Work within a test environment until successful audit of case components.
  • Completion of an orientation checklist.
• Assignment to a team leader who will oversee onboarding and assignment of member.
• 30/60/90 day post hire reviews to evaluate understanding of care management processes, progress related to job responsibilities, job performance, and to identify additional training needs.
• In-office shadowing/precepting with care team members for mentoring and observation of the team collaboration, technique, care management strategies, relationship building, process, and performance.
• Accompany team members on in-person visits for continued mentoring and observation of the in-person interaction, including safety, relationship building, member engagement, and education process.
• Participation in staff role based scenarios to improve member connectivity.
• Caseloads are built gradually with team leader engagement, ongoing audits, and staff input regarding readiness.

Existing staff are offered or participate in:
• Corporate membership to Case Management Society of America which includes:
  • Continuing education opportunities
  • Access to CMSA Today magazine
  • CMSA Resource Toolbox
  • Networking opportunities
  • Local chapter engagement including quarterly conferences
• Mandatory compliance and regulatory elements, provided on the web based learning management system are assigned to specific staff members depending on their roles.
• Access to elective educational programs are available on the web based learning management system.
• Department in-services on topics of interest and relevance, i.e., drug treatment, infant mortality, high risk pregnancy.
• Attendance at ProMedica/Paramount and/or community sponsored conferences such as 2016 Opiate Summit, Annual Infant Mortality Summit, Annual Northwest Ohio Perinatal Conference.

Onboarding and training is outlined in detail in the Managed Care Plan Staff Training plan.

**Member contact and engagement**

**Contact schedule:** How care management establishes a contact schedule with the member that is based on his or her needs and facilitates ongoing communication and engagement with the member.

• Contact schedules:
  • Contact frequencies are based on the individual member’s need and risk stratification.
• Schedules, including frequency, availability and preferred modes of contact are mutually agreed upon between the member and the care manager.
• Contact information for the care manager and team members is provided and includes availability for contacting the care manager/team between scheduled contacts if a need arises.
• Contacts may be attempted during hospitalizations for members that are difficult to reach, with prolonged hospitalizations, or according to preference, as appropriate.
• Care managers may visit homeless shelters to contact members identified as residing in a shelter to maintain regular contact and engagement.

**Minimum contacts per Appendix K of the provider agreement are provided to members in the intensive and high risk stratification levels.**

• Established minimum contact schedule:
  • Intensive cases have a minimum contact schedule of 30 calendar days.
    o In-person visit at least every 90 calendar days, more frequent in person visits are scheduled based on clinical judgment, assessment results, member need and/or preference.
    o One in-person visit will be conducted within the first 6 months of enrollment in care management in the member’s residential setting, if allowed by the member.
    o Annually thereafter, an in-person visit will be conducted in the member’s residential setting, if allowed by the member.
  • High risk cases have a minimum contact schedule of 60 calendar days
    o In-person visit at least every 180 calendar days, more frequent in person visits are scheduled based on clinical judgment, assessment results, member need and/or preference.
    o One in-person visit will be conducted in the member’s residence, if allowed by the member within the first year of enrollment in care management.
    o Annually thereafter, an in-person visit will be conducted in the individual’s residential setting, if allowed by the member.

• Process to ensure contacts are met:
  • Care team members are educated regarding required minimum member contact.
  • Contact schedule reminders for calls and upcoming in-person visits are set within the care management software program.
  • Reports are provided on a routine and ad hoc basis to provide the care management team with a tracking mechanism to monitor approaching 90/180 day upcoming deadlines based on the last in-person visit date.
  • Review of the reports and chart audits are done quarterly by team leaders to monitor compliance.

**Activities will be completed for in-person visits:**
• Visit is linked to the goals, interventions, or outcomes in the care plan.
• Visit is reported to the care manager.
• Visit is documented in the care management record to assure timely follow up.
• Visit is integrated into the plan of care.

The Case Manager assigned to the case is known as the Accountable Point of Contact (APOC). The APOC is responsible for:

• Completing in-person visits and/or coordinating visits completed by others on the care team.
• Pre and post visit collaboration with the care team member conducting the visit occurs so the member’s priority goals, interventions and outcomes are addressed.
• Timely documentation (within 24 hours) of pre and post visit collaboration.
• Educational material provided for the visit along with an updated copy of the care plan for review/modification with member and/or provider during the in-person visit.
• Post visit care conference with care team member(s) to update the individualized care plan with visit findings, including any documentation provided into the care management software.
• Developing the follow-up contact schedule in the care management software.

Engagement: Strategies to actively engage members in the care management process.

• Paramount employs several strategies to engage members in the care management process which includes:
  • Allowing the member to identify their priority needs, during initial contact.
  • Thorough explanation of care management services according to the member’s literacy level.
  • Acting as a member advocate, especially related to community resources and benefits.
  • Collaborating with the member on their individualized care plan and readiness to take positive steps toward their goals.
  • Contacts may be attempted during hospitalizations for members that are difficult to reach, with prolonged hospitalizations, or according to preference, as appropriate.
  • Care managers may visit homeless shelters to contact members identified as residing in a shelter to maintain regular contact and engagement.
  • The care manager making an unscheduled visit to members’ homes when the care manager is unable to connect with the member (i.e., disconnected phones, out of minutes).
  • Coordinating with providers and community partners to assist in reaching members.
  • Written communication is used when in-person and/or telephonic outreach is unsuccessful.
Evaluation of the Model of Care:

Identifying and defining measureable goals and outcomes established for the MCP’s model of care.

- Paramount Advantage uses evidence-based guidelines, benchmarks, and industry standard metrics to measure goals and outcomes. Outcomes (CMSA, 2010) include:
  - Utilization of adherence guidelines.
  - Measurement of members’ preference for and understanding of:
    - The proposed plans for their care.
    - Their willingness to change.
    - Their support to maintain health and behavior change.
- 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
  - Enhanced Maternal Care Program metrics, including:
    - Birth weights
    - Gestational age
    - Chronic conditions
    - Previous poor outcome, including pre-term delivery
    - Substance abuse
    - Neonatal abstinence syndrome
    - Analysis of members residing in “priority communities”
    - Health Care Access Now/Northwest Ohio Hospital Council Pregnancy HUB evaluation (additional HUBs will be incorporated, as available)
  - Individual disease management program evaluations
    - Condition specific clinical outcomes
    - Utilization metrics within each program
    - Pathways HUB Chronic Condition evaluation
  - Coordinated service program evaluation
  - Annual/Bi-annual Surveys:
    - Annual Adult and Child Consumer Assessment of Health Care Providers and Systems (CAHPS).
    - Annual provider satisfaction (rotates annually between office managers and providers).
    - Bi-annual behavioral health provider satisfaction.
• Annual member satisfaction with case management.
• Utilization of evidence-based guidelines in appropriate client populations.
• Linkage to community resources (social determinants of health) to reduce:
  • Homelessness
  • Food insecurity
• Evaluation of aggregate goals within the plan of care.

Description of the indicators that will be used to evaluate the impact and effectiveness of the model of care.

• Utilization Metrics
  • Aggregate and individual emergency room utilization.
  • Aggregate and individual admission rates.
  • Aggregate and individual readmission within 30 days.
  • Overall medical cost.
  • Aggregate primary care and professional visits.
• Clinical, Utilization, Quality and Cost Goals
  • Reduction in emergency room and inpatient utilization.
  • Decreased readmission rates within 30 days.
  • Decreased medical costs per member per month.
  • Evaluate pharmacy utilization for appropriateness and intervene with providers, as indicated.
  • Increase in primary care and professional visits.
  • Improvement in HEDIS® Access to Care and Effectiveness of Care measures, including:
    • Minimum Performance standards
    • Pay for Performance measures
  • Improvement in the Enhanced Maternal Care Program clinical and social outcomes.
  • Improvement in Disease Management Program metrics.
  • Increase enrollment in the Coordinated Substance Program.
  • Increased satisfaction with care management programs and services.
  • Positively impact social determinants (i.e., food insecurity, reproductive life plans, living conditions).
  • Demonstrate improvement in outcomes within the Performance and Quality Improvement Plans.

Evaluation of the Patient Experience

Member satisfaction is a vital component to the success of the care management program. In order to ensure ongoing quality improvement efforts, the member experience is evaluated in several ways.

• Evaluating the member’s level of satisfaction with the care management program during telephonic and in-person visits through the quality of life assessment.
• Formally evaluating the member experience with a NCQA focused questionnaire utilizing a five point Likert Scale measurement to evaluate the following:
  o Did the case manager help you understand the treatment plan?
  o Did the case manager help you get the care you needed?
  o Did the case manager pay attention to you and help you with problems?
  o Did the case manager treat you with courtesy and respect?
  o How satisfied are you with the case management program?
  o Please add any suggestions for the management team that would help Paramount Advantage Case Management program improve its service.

**Frequency that the assessment/evaluation will occur.**

• Member feedback and/or complaints related to care management processes is evaluated quarterly.
• Member satisfaction with case management is assessed after 90 days of the member being enrolled in case management services, and then annually thereafter, based on inclusion criteria.
• Member satisfaction with disease management services are assessed at every contact.
• Provider/office manager surveys are conducted annually.
• Behavioral health provider survey is conducted bi-annually.
• Comprehensive evaluation of the overall effectiveness of the model of care occurs at least annually, however data will be monitored quarterly for timely identification of opportunities for improvement.

Issues or concerns identified through any of the evaluation processes are addressed and programs/processes modified, as appropriate.

**How results of measures and indicators will be used to support ongoing improvement.**

As part of Paramount’s continuous quality improvement efforts, the evaluation process includes analysis of all measures and indicators to identify additional program/process enhancements and opportunities for improvement, including needs for further staff education. Programs/processes are re-structured incorporating newly recognized components.

**RECONSIDERATION OF ADVERSE DECISIONS**

In the event of an adverse UM decision, the denial notice to the practitioner contains information on how to activate the reconsideration process. Reconsiderations may be telephonic or in writing and are conducted between the provider or health care facility and the reviewer who made the adverse determination. Reconsideration determinations are made within two (2) business days after receipt of the request. If the reviewer cannot be available within two (2) business days, the reviewer may designate another reviewer. The determination may be expedited if the seriousness of the medical condition of the member requires an expedited decision. In order to expedite the decision, the practitioner must
certify that waiting the standard two (2) business days for a determination, and therefore receipt of the requested services, will result in 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.

Verbal and written notification of the determination will be made within two (2) business days of making the decision. Information on how to appeal an adverse reconsideration decision on behalf of the member is included with the denial letter to the practitioner. The appeals process is outlined below.

THE MEMBER APPEAL PROCESS

There may be instances where either a member, a member’s Legal Representative or an Authorized Person is not satisfied with a coverage decision made by the Plan. Paramount has established policies and procedures for registering and responding to member grievances and appeals. All UM denials contain a product-line specific appeals insert that explains to the member and provider how to appeal the denial determination. The product-specific appeals processes meet all regulatory and accreditation (NCQA) requirements. Product-specific appeals information can be found on Paramount’s website: www.paramounthealthcare.com.

ADVANTAGE MODEL OF CARE REFERENCES


