Paramount Care, Inc.
(Paramount Elite; Medicare Parts C & D)

QUALITY IMPROVEMENT
PROGRAM DESCRIPTION

2015
# TABLE OF CONTENTS

Mission and Values ................................................................. Page 1
Quality Improvement Program Overview .................................. Page 2
Organizational Structure .......................................................... Page 4
  Accountability ........................................................................ Page 4
  Governing Body ................................................................. Page 5
  Organizational Chart ........................................................... Page 6
  Medical Advisory Council .................................................... Page 7
  Physician Affairs Council ..................................................... Page 8
  Pharmacy and Therapeutics Working Group ......................... Page 9
  Technology Assessment Working Group ............................... Page 10
  Medical Policy Steering Committee ....................................... Page 11
  Associate Medical/Clinical Directors .................................... Page 12
  President and Executive Team ............................................. Page 13
  Administrative Staff .......................................................... Page 13
  Quality Improvement Staff ................................................ Page 15
  Interdepartmental Coordination of Quality ............................ Page 17
  Integration of Quality Improvement with Goals .................... Page 17
Scope of Activities ................................................................ Page 18
  Improvement of Clinical Quality .......................................... Page 18
    Clinical Practice Guidelines ............................................. Page 18
    Care Management ......................................................... Page 19
    Behavioral Health Care ................................................ Page 20
    Promotion of Member Wellness ....................................... Page 20
    Quality of Care .......................................................... Page 20
    Patient Safety ............................................................. Page 21
    Health Literacy/Limited English Proficiency ....................... Page 21
    Health Equity and Culturally Appropriate Care .................. Page 22
    Healthcare Effectiveness Data & Information Set® .............. Page 22
    Medicare Health Outcomes Survey .................................. Page 22

---

2015 QI Program Description
Paramount Care, Inc. (Elite)
Quality Improvement among Practitioners & Providers...............................Page 23
Practitioner Incentive Programs...............................................................Page 23
Member Satisfaction with Practitioners................................................Page 23
Public Reporting of Performance............................................................Page 23
Practitioner Credentialing ....................................................................Page 23
Facility Contracting and Assessment ....................................................Page 24
Delegation Oversight ............................................................................Page 24
Improving Quality in Administrative Operations ....................................Page 24
Access and Availability of Clinical Services ........................................Page 24
Utilization of Health Care Services .....................................................Page 26
Member Advisory Council ...................................................................Page 26
Member Privacy and Confidentiality of Personal Information ..........Page 26
Complaints, Grievances, and Appeals ................................................Page 27
Consumer Assessment of Healthcare Providers & Systems® ............Page 28
Member Satisfaction of Paramount Services .......................................Page 28
Physician/Office Manager Satisfaction with Paramount ....................Page 28
Service Organization Audit .................................................................Page 29
Business Continuity and Disaster Recovery .........................................Page 29
Support of Community Health Status and Public Health Goals ..........Page 29
External Quality Improvement Programs .............................................Page 29
Index ........................................................................................................Page 30
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.
QUALITY IMPROVEMENT PROGRAM OVERVIEW

It is inherent to Paramount’s philosophy that quality improvement is not the responsibility of any single individual or department, but the duty of every employee and contracted provider. Paramount is committed to using a continuous quality improvement cycle in managing all clinical and administrative services. Clinical monitors address all demographic groups, care settings and types of service. Indicators of performance are measured across all pertinent products, reaching beyond the assurance of high quality care and service. Paramount is also dedicated to satisfying customer expectations, and to respecting all people by listening to and supporting them.

PURPOSE

The Quality Improvement Program provides a formal process by which Paramount and its participating providers and practitioners strive to continuously improve the level of care and service rendered to members and customers. It utilizes objective and subjective indicators to measure and evaluate the quality and safety of clinical services provided to members. The program addresses both medical and behavioral health care, and the degree to which they are coordinated. It defines the systematic approach used to identify, prioritize and pursue opportunities to improve services, and to resolve identified problems. The Quality Improvement Program is reviewed, updated and approved by the Medical Advisory Council and Board of Directors at least annually. It is distributed to applicable regulatory bodies and other stakeholders, as requested.

OBJECTIVES

Specific program objectives have been developed to guide quality improvement activities. The objectives of the Quality Improvement Program, as approved by the Board of Directors are as follow.

- To continuously improve the caliber and delivery of clinical and administrative services to Paramount customers through systematic monitoring of critical performance indicators, identifying barriers to improvement, and implementing specific strategies to improve processes and outcomes
- To annually evaluate the efficiency and effectiveness of the Quality Improvement Program, including its structure, methodology, and results
- To evaluate at least annually the efficiency and effectiveness of performance from any subcontracted agents or service providers, also known as delegated entities
- To assure that all members are treated with dignity and respect, and are provided with appropriate, understandable education and information to accept responsibility and actively participate in personal health care decisions
- To use evidence-based guidelines as the basis for all clinical decision-making
- To support public health goals, as appropriate for the populations served, by integrating them into clinical quality improvement activities
- To maintain regulatory compliance related to Paramount quality assurance and performance improvement activities
- To cultivate comprehensive patient safety practices among Paramount providers and staff, including coordination of care
- To identify disparities in health care delivery to members, and intervene to reduce them by delivering culturally and linguistically appropriate care and services
DOCUMENTATION

Three annually published documents describe Paramount’s continuous quality improvement cycle.

- Quality Improvement Program Description: A comprehensive explanation of the health plan’s Quality Improvement Program **structure** and **objectives**, including accountability and reporting relationships; outlines resources dedicated to improvement activities
- Quality Improvement and Care Management Work Plan: Documents the improvement **process** to be implemented in the calendar year through detailed **performance goals/targets** and timetables, addresses clinical and administrative improvement activities throughout the organization and specifies operational accountability; offers rationale for project selection and task priorities
- Quality Improvement and Care Management Program Evaluation: Presents formal assessment of the **outcomes** of the prior year’s quality improvement activities; compares **results** with baseline rates and benchmarks available at the time those activities were planned (two years prior); identifies barriers to success; includes recommendations for subsequent years

Numerous other evaluations and assessments which inform quality improvement are routinely performed and published as well. They are identified throughout this document, and an itemized schedule is included in the annual work plan.

RELATIONSHIPS OF BUSINESS ENTITIES, PRODUCTS AND PRODUCT LINES

To remain successful, Paramount’s total book of business includes multiple product lines spread across five business entities. New products are continually in development to meet the demands of the ever-changing marketplace. Except as defined for certain government regulated products, Paramount operations and staffing are transparent as to product distinctions. Quality improvement, in particular, crosses all entities, product lines, and products, with exception of workers’ compensation.
ORGANIZATIONAL STRUCTURE

ACCOUNTABILITY

As the governing body of Paramount Care, Inc. (PCI), the Board of Directors bears overall responsibility for assuring that Paramount members receive high quality care and service. Two subcommittees, effective since 1992, are responsible for developing and recommending to the Board of Directors all policies associated with quality improvement. Paramount's Medical Advisory Council (MAC) is responsible for achievement of high quality delivery of medical and behavioral care, and directs quality improvement initiatives associated with clinical care, patient safety and medical utilization. The Physician Affairs Council (PAC) is responsible for achieving high levels of quality involving Paramount's practitioners. Aspects of quality improvement overseen by the PAC include credentialing, contracting, and network development.

As illustrated below, the Medical Advisory Council and the Physician Affairs Council function as subcommittees of the Board of Directors. Administrative Staff is responsible for monitoring and implementing operational quality improvement activities and reports to the President, who is accountable to the Board of Directors.

The Chairman of the Medical Advisory Council and the Chairman of the Physician Affairs Council serve as members of the Board of Directors. The President of Paramount also serves as a member of the Board of Directors.
GOVERNING BODY

As the governing body, it is the responsibility of the Board of Directors to appoint qualified administrative and clinical personnel to direct the operations of the managed care plan. The Board of Directors, with recommendations from appropriate clinical personnel, act on all major contracts and other arrangements affecting the delivery of health care services. The Board of Directors actively supports the Quality Improvement Program as demonstrated by ongoing involvement in the policy making process of the organization.

Responsibilities
The Board of Directors has ultimate responsibility for policy setting and operation of the managed care organization, including but not limited to the following.

1. The Board of Directors annually reviews the specific goals and objectives of the plan, including a description of the services provided. This includes the Quality Improvement Program, Quality Improvement and Care Management Work Plan, Quality Improvement and Care Management Program Evaluation, and review of quality improvement progress reports.
2. The Board of Directors is responsible for assuring the appropriate organizational structure of the plan and also establishing appropriate councils that report to the Board.
3. The Board of Directors establishes and maintains a clearly defined system of financial management that includes an annual, independent audit of financial/operational performance, as well as internal audit procedures.
4. The Board of Directors has adopted a systematic continuous quality improvement program to assure clinical and administrative quality.
5. Long range plans, consistent with the mission, are set by the Board of Directors through a formal three-year planning process.
6. The Board of Directors assures that all plan operations and service deliveries are conducted in accordance with the spirit and intent, as well as all regulatory requirements, regarding non-discrimination including race, color, religion, gender, sexual orientation (preference), national origin, ancestry, marital status, age, Vietnam era veteran status, physical handicap or need for health services.

Meeting Schedule and Minutes
The Board of Directors meets on a bimonthly basis and maintains records necessary to demonstrate the appropriate discharge of duties.

Administration
The Board of Directors is responsible for electing, appointing or employing officers and/or administrators to direct the clinical and administrative activities of the plan. The following sections outline the roles of the Medical Advisory Council (page 7), Physician Affairs Council (page 8) and Associate Medical/Clinical Directors (page 12). The organizational chart on the next page further illustrates these assignments. The Board has designated several physicians and other practitioners currently licensed in the states of Ohio and/or Michigan as Associate Medical/Clinical Directors.
MEDICAL ADVISORY COUNCIL

Council Structure, Role and Function
Accountable to the Board of Directors, the Medical Advisory Council (MAC) consists of up to sixteen (16) voting members, including Paramount physicians and practitioners representing numerous primary and specialty care categories, such as but not limited to Family Medicine, Internal Medicine, Pediatrics, Geriatrics, Obstetrics/Gynecology, and Psychology.

Ex officio members, with voting privileges, include Associate Medical Director(s), Chairperson of the Pharmacy & Therapeutics Work Group, Chairperson of the Technology Assessment Work Group, Clinical Director for Behavioral Health, and Vice President-Health Services/Medical Director who chairs the Medical Policy Steering Committee.

Council members are nominated and approved by the Board of Directors to serve a two-year term and may serve multiple terms. The Chairperson is appointed by the Board of Directors and also serves as an ex officio member of that body. The Paramount Director of Quality Improvement and Senior QI Support Coordinator provide staff support. Regularly invited participants also include the Executive Director of Care Management and Manager of Provider Relations and Credentialing.

Purpose
The primary purpose of the Medical Advisory Council is to develop and recommend policies that govern Paramount's Quality Improvement, Condition/Disease Management, Utilization Management, Case Management, and Prescription Service operations. The MAC considers and evaluates all indicators of clinical and behavioral care effectiveness, patient safety, medical practice performance, and health/health care disparities.

- Deliberates benefit interpretation guidelines
- Makes coverage recommendations on medical technologies and pharmaceuticals
- Reviews indications for specific medical procedures
- Identifies and/or prioritizes opportunities for continuous quality improvement
- Evaluates and adopts clinical guideline recommendations (preventive and interventional)
- Assures consistency of UM guidelines and member and provider educational materials with clinical practice guidelines
- Provides oversight for all care management programs, including prescription services
- Evaluates the care management program annually
- Oversees compliance with clinical components of NCQA Accreditation standards
- Apprised of delegated agreements to support clinical functions and offer advice on clinical aspects of delegated activity
- Reviews operational implementation of medical policy

Meeting Schedule and Minutes
The Medical Advisory Council meets 6-8 times per year depending on agenda, with at least one meeting per quarter. Formal dated and signed minutes documenting the Council's activities, decisions, findings and recommendations are maintained for each meeting. They are available for review at the request of any regulatory or accrediting body.
PHYSICIAN AFFAIRS COUNCIL

Council Structure, Role and Function
The Physician Affairs Council (PAC) is accountable to the Board of Directors. It is composed of nine (9) voting members, including Paramount physician practitioners who represent numerous clinical specialties and types of practice such as the following.

- Primary Care Physician
- Medical Specialist
- Obstetrics/Gynecology Specialist
- Psychiatric Specialist
- Surgical Specialist

Ex officio members, with voting privileges, include a Paramount Associate Medical Director and Paramount President.

Council members are appointed and approved by the Board of Directors and serve a one-year term. Participants may serve multiple terms. The Chairperson is appointed by the Board of Directors, and serves as an ex officio member of that body as well. Support staff to the Council includes the Manager of Provider Relations and Credentialing, Credentialing Coordinator, and ProMedica legal counsel.

Purpose
The purpose of the PAC is to develop and recommend policies that govern Paramount's Provider Relations operations, such as credentialing, re-credentialing, contracting, practitioner monitoring, and network adequacy. To this end, the PAC also considers and evaluates performance indicators, and standards for access and availability of health care.

- Reviews credentials and practitioner applications prior to contract execution
- Makes recommendations regarding the adequacy of the provider panel and network contracting strategy, including the availability of providers and practitioners
- Evaluates issues related to contract non-compliance
- Makes recommendations regarding any modifications to contracting criteria
- Makes recommendations regarding the composition and ability of the provider panel to meet the cultural, ethnic, racial and linguistic needs of the membership
- Oversees ongoing activities to monitor practitioner performance
- Apprised of delegated credentialing agreements and all actions taken at the direction of the Medicaid Operations Oversight Committee
- Reviews annual access and availability of medical and behavioral health care report
- Advises staff regarding use of practitioner incentive programs

Meeting Schedule and Minutes
The Physician Affairs Council meets bi-monthly. Formal, dated and signed minutes documenting the Council's activities, decisions, findings and recommendations are maintained for each meeting. They are available for review at the request of any regulatory or accrediting body.
PHARMACY AND THERAPEUTICS WORKING GROUP

The Pharmacy and Therapeutics (P&T) Working Group is a permanent subcommittee of the Medical Advisory Council (MAC). The P&T Working Group recommends policy action related to pharmaceutical management to the MAC, which in turn is accountable to the Board of Directors. The P&T Working Group participates in formulary decisions.

Working Group Structure, Role and Function

The Pharmacy and Therapeutics Working Group includes up to fifteen (15) members representing clinical specialties and expertise such the following. Additional positions may be added as determined to be appropriate.

- Internal Medicine
- Infectious Diseases
- Endocrinology
- Rheumatology
- Psychiatry
- Oncology
- Geriatric Medicine
- Hospital Pharmacy
- Retail Pharmacy
- Advance Practice Nursing
- Physician Assistant- Cardiology

Paramount’s Medical Director/Vice President-Health Services, Director of Pharmacy, and Pharmacists are also voting members. Paramount’s Executive Director of Care Management and Director of Quality Improvement are regularly invited guests.

The purpose of the P&T Working Group is to develop policies, procedures and programs that will:

- Minimize the adverse events and side effects of pharmaceuticals
- Maximize the therapeutic outcomes of pharmaceuticals
- Evaluate and promote use of cost effective pharmaceuticals
- Provide direction for delegated pharmacy benefits management activities

Specific functions include reviewing and making recommendations in regard to the following.

- Requests for prescription drug benefit changes
- Formulary development, review and maintenance
- Criteria for utilization management tools (prior authorization, step therapy, quantity limits)
- Practice guidelines as they relate to pharmaceuticals
- Responsibilities delegated to pharmacy benefits manager
- Drug utilization review (DUR) activities
- Care management programs, e.g., Asthma, Chronic Heart Failure, Hyperlipidemia, and Adherence programs

Meeting Schedule, Quorum, and Minutes

The P&T Working Group meets bimonthly. A quorum is met when at least half the voting members are present. Formal, dated and signed minutes of working group business are maintained, and reported to the Medical Advisory Council. They are available on request to any regulatory or accrediting body.
TECHNOLOGY ASSESSMENT WORKING GROUP

The Technology Assessment Working Group (TAWG) is a subcommittee of the Medical Advisory Council. It is responsible for review, evaluations, and recommendations to the MAC for approval, issues relating to new medical technology, behavioral health procedures, devices or new applications of existing technology. TAWG is also responsible for development and annual review of internal prior authorization criteria for utilization management. The MAC is in turn accountable to the Board of Directors.

Working Group Structure, Role and Function
The Technology Assessment Working Group consists of eleven (11) voting members including Primary and Specialty Care Practitioners, and Registered Nurses. Paramount department representation includes Utilization Management, Case Management, Claims, Provider Relations, and Pharmacy as needed. Additional specialists and sub-specialists are added in consultation, as needed, for input and recommendations relative to the technology being discussed. Additional positions may be added when appropriate.

Staff support to this working group comes from the Supervisor-Claims Provider Appeal/Data Analyst, Claims Appeal Analyst, and Health Services Administrative Assistant.

The purpose of the Technology Assessment Working Group (TAWG) is to critically review and evaluate new and emerging technology, behavioral health procedures, devices and new applications of existing technology and clinical services. When coverage is recommended and InterQual® criteria are not available, TAWG develops medical necessity criteria and evaluates the criteria on an annual basis, or more frequently as new information becomes available. TAWG makes recommendations to the MAC for inclusion in the benefit package to keep pace with changes and to ensure that members have coverage for safe and effective care.

TAWG will evaluate the new technology utilizing the following resources, as applicable: Centers for Medicare and Medicaid Services policy, HAYES Medical Technology Directory®, the Food and Drug Administration (FDA), current medical/behavioral health scientific literature and practicing subspecialty physician input along with industry standards. Coverage determinations will be based on the following criteria: safety, efficacy, cost and availability of information in published scientific literature regarding controlled trials.

Meeting Schedule and Minutes
The Technology Assessment Working Group meets monthly, or more frequently as the need arises. Formal, dated and signed minutes documenting the Working Group’s activities, decisions, findings and recommendations are maintained, and reported to the Medical Advisory Council. They are available for review by any regulatory or accrediting body upon request.

InterQual® is a registered trademark of McKesson Health Solutions LLC
HAYES Medical Technology Directory® is a registered trademark of Hayes, Inc.
MEDICAL POLICY STEERING COMMITTEE

Paramount’s Medical Policy Steering Committee is an operational entity charged with the task of implementing medical policy decisions. Due to this essential and critical role, the committee reports to the Medical Advisory Council.

**Purposes**
- Sustain a venue by which provider reimbursement/coverage guidelines can be discussed and determined
- Develop and maintain medical policy reimbursement/coverage guidelines
- Defining reimbursement issues and payment methodology
- Establish financial support as well as software capability for each policy presented

**Committee Composition and Individual Roles**
- **Vice President-Health Services/Medical Director** – Responsible for the direction of medical/healthcare services including provider contracts, medical expense, federal and local coverage standards, Hayes, local contracts, utilization issues, and new technology.
- **Associate Medical Director(s)** – Responsible for providing supplemental information regarding specific medical procedures or services (e.g., current medical studies).
- **Claims Director** – Responsible for the evaluation and impact of the policy as it relates to claims processing, and support of the medical policy through existing claims procedures.
- **Executive Director of Care Management** – Responsible for the evaluation and impact of the policy as it relates to the Utilization Department, and the support of the medical policy through existing utilization policies and procedures.
- **Provider Relations/Credentialing Manager** – Responsible for the evaluation and impact of the policy as it relates to the Provider Relations department, and support of the medical policy through their existing policies and procedures.
- **Benefit Administration Manager** – Responsible for the evaluation of the medical policy as it relates to AMISYS configuration, specifically for pricing and benefits.
- **Finance/Medical Expense Analyst** – Responsible for analysis of the issue by determining the financial impact on the plan.
- **Claims Provider Appeal/Data Analyst Supervisor** – Responsible for issues that may affect the medical policy as it relates to the bundling (software) edit logic; and coordination of agenda items to be presented to the Medical Policy Steering Committee.

**Meeting Schedule and Minutes**
The Medical Policy Steering Committee meets monthly. Formal dated and signed minutes documenting the committee's activities, decisions, findings, and recommendations are maintained for each meeting, and reported to the Medical Advisory Council. They are available for review at the request of any regulatory or accrediting body.
ASSOCIATE MEDICAL/CLINICAL DIRECTORS

A team of Associate Medical/Clinical Directors serves as expert consultants retained by the health plan. The team reports to Paramount’s Medical Director/Vice President-Health Services, and represents clinical specialties such as the following. Additional consultants are engaged as needed.

- Family Medicine
- Pediatrics
- Dentistry
- Vision Care
- Internal Medicine
- Geriatrics
- Podiatry
- Psychiatry

Role of the Team

Associate Medical/Clinical Directors guide the development and integration of Medical/Behavioral, Care Management and Quality Improvement Programs. As an aggregate body, the Associate Medical/Clinical Directors are involved in all clinically related activities. They provide medical/clinical expertise for utilization and case management questions as they arise in daily operations. The team also assists their peers with interpretation of policies adopted by the Board of Directors.

Individual Responsibilities

On an individual basis, Paramount Associate Medical/Clinical Directors assume responsibility, relevant to their specialty or expertise, for several specific functions.

- Serve as Physician/Dental/Behavioral Health Reviewers as needed to evaluate appropriateness of requests for out-of-plan referrals and other pre-certifications
- Review and critique health education materials developed for physicians and members, and assure consistency of content with approved clinical guidelines
- Review clinical appeals from physicians and members
- Enhance direct communication with providers (e.g., prescription drug profiling, performance feedback, medical expense profiling)
- Participate in selection or development of clinical practice guidelines
- Advise nurse case managers on clinically pertinent aspects of care
- Investigate reported quality of care cases and take/recommend action as appropriate
- Review and critique the Quality Improvement Program Description, Annual Quality Improvement and Care Management Work Plan, Annual Quality Improvement and Care Management Program Evaluation, Care Management Program Description, and individual Condition/Disease Management Program Evaluations
- Contribute to implementation of regulatory agencies’ quality programs
- Provide input into development and review of Medical Policy Guidelines for claims payment

Associate Medical/Clinical Directors also influence Quality Improvement activities by actively participating in leadership roles as described with MAC, PAC, P&T, TAWG and the Medical Policy Steering Committee.
**PRESIDENT AND EXECUTIVE TEAM**

The President of Paramount reports to the Board of Directors. Through oversight of Administrative Staff, the President directs Paramount in its mission and objectives to promote delivery of high quality health care and service to plan members in all markets. As illustrated by the company's organizational chart (page 6), Paramount’s Vice Presidents for Health Service and Operations are directly accountable to the President. Paramount’s Vice President for Finance reports to the President of Paramount, but is accountable to ProMedica system leadership.

**Vice President of Health Services, Medical Director** – Accountable for utilization of medical, behavioral, and pharmaceutical care, case management, quality improvement, condition (disease) management, patient safety, and wellness promotion.

**Vice President of Operations** – Accountable for Paramount’s provider network and contracting, regulatory compliance, claims operations, member enrollment, and state and federally funded products.

**Vice President of Finance** – Responsible for Paramount’s financial and underwriting functions, decision support, and subrogation. Accountable to ProMedica’s Senior Vice President of Finance.

Others accountable to the President are the Director of Marketing, Manager of Member Services and Provider Inquiry, Manager of ProMedica’s Call Center, and the Executive Director for the workers’ compensation product (HMS). The Directors of Information Systems and Human Resources report to the President but are accountable to ProMedica leadership.

**ADMINISTRATIVE STAFF**

Paramount's leadership team is responsible for coordinating interdepartmental and cross-product activities, including operations and service improvement activities. Administrative Staff consists of Paramount’s president, vice presidents, directors, and most managers. The team usually meets monthly. All health plan leaders are responsible for consistently administering plan policies, procedures, and practices within their department(s). Key positions linked to quality management, along with their other accountabilities and reporting relationships, are listed below.

**Director, Quality Improvement** - Reports to VP Health Services/Medical Director - Provides ongoing and documented assessment of all aspects of quality improvement processes and outcomes; manages clinical improvement interventions; manages accreditation process to ensure compliance with NCQA standards; responsible for HEDIS® reporting, CAHPS® and other surveys; facilitates quality of care investigations; publishes newsletters, practice guidelines and educational materials; and contributes to corrective action planning for regulators upon request.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA). Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of Agency for Healthcare Research and Quality.
Executive Director, Care Management - Reports to VP Health Services/Medical Director – Leads utilization, case management, and disease management functions to ensure coordinated delivery of high quality, safe, cost-effective and integrated health care to all Paramount members; facilitates oversight of delegated clinical functions; and assures member satisfaction with health care.

Director, Pharmacy Program - Reports to VP Health Services/Medical Director – Directs all pharmaceutical operations including oversight of delegated services to pharmacy benefits manager (PBM); and facilitates prescription drug services with members and providers.

Clinical Director, Behavioral Health - Reports to VP Health Services/Medical Director – Leads operational integration of behavioral and medical health care; supervises UM decision making associated with behavioral health care; and advises interdisciplinary care management teams.

Director, Regulatory Compliance - Reports to VP Operations - Ensures the Medicare Advantage (Elite) product maintains compliance with federal regulations and mandated reporting; responsible for Medicare Star Ratings and risk adjustment; directs state and other federal aspects of regulatory compliance including HIPAA, Marketplace/Exchange, and Delegation Oversight.

Director, Claims - Reports to VP Operations - Accountable for timely and accurate administration of electronic and paper claims; monitoring EDI transmissions (electronic data interface); and implementing plan medical policies in accordance with current federal and state requirements.

Director, Marketing - Reports to President – Leads strategic marketing plans and new product development; ensures compliance with federal and state insurance regulations for sales and brokerage; and manages website, social media activity and public communications.

A few other director positions, as shaded in the illustration on page 6, lead departments dedicated to functions that are unique to other products (e.g., Medicaid, Workers’ Compensation) or which are accountable to other corporate entities (e.g., HR, IT, Finance). Additional leaders are listed below.

Manager, Case Management – Reports to ED Care Management
Manager, Disease Management – Reports to ED Care Management
Manager, Referral Management – Reports to ED Care Management
Manager, Provider Relations & Credentialing - Reports to VP Operations
Manager, Contracting & Network Management – Reports to VP Operations
Manager, Regulatory Compliance - Reports to VP Operations
Manager, Medicare Compliance - Reports to VP Operations
Manager, Delegation Oversight - Reports to VP Operations
Manager, Enrollment - Reports to VP Operations
Manager, ProMedica Call Center - Reports to President
Manager, Member Services & Provider Inquiry - Reports to President
Manager, Decision Support Services – Reports to VP Finance
QUALITY IMPROVEMENT STAFF

The Vice President-Health Services/Medical Director is designated as the senior physician executive responsible for Paramount's quality improvement program. Reporting to him, the Director of Quality Improvement is responsible for evaluating health care needs of the membership in order to develop and implement relevant clinical initiatives, preventive health services and population-based condition/disease management programs. To meet these responsibilities, the Quality Improvement department is involved in developing and implementing quality improvement policies and procedures, producing and evaluating quality related data, conducting statistical analyses to identify real and potential quality problems, producing specific quality improvement initiatives based on those findings, and reporting findings and outcomes.

All Quality Improvement department staff members who are responsible for development and/or implementation of quality improvement initiatives have the appropriate and necessary education, and experience. The following positions report to the Director of Quality Improvement. Descriptions include tasks associated with all products, not only Paramount Care, Inc.

- The Senior Quality Improvement Coordinator, a licensed nurse, is responsible for documenting clinical quality improvement activities to assure compliance with regulatory agencies’ quality requirements; assists with implementing activities required for compliance with Medicaid requirements; conducts chart reviews for HEDIS® hybrid measures and other studies as necessary.

- The Quality Improvement/HEDIS® Analyst II is responsible for producing and submitting accurate HEDIS® reports in compliance with NCQA and regulatory guidelines for all accredited products; preparing prescribed files for CAHPS®, QHP-ESS, and Health Outcomes Survey (HOS) samples; preparing practitioner performance reports; identifying member gaps in care; and acting as liaison with HEDIS® software vendor and HEDIS® Auditor. This coordinator maintains AHIMA credential(s).

- The Quality Improvement Project Coordinator III provides support to assure compliance with National Committee for Quality Assurance (NCQA) accreditation; compiles and edits QI program documents; assists in statistical and quantitative analyses; coordinates patient safety and health equity projects; performs HEDIS® internal audits; acts as liaison with NCQA for accreditation; facilitates conduct of CAHPS®, ESS, and HOS surveys; and leads other projects.

- The Wellness & Publications Coordinator is responsible for published communication with members, providers, and employer groups; web-based member educational materials; and collaborates with marketing department to facilitate wellness initiatives for employer groups.
• Quality Improvement Support Coordinators (1.5 FTEs) provide logistical support to quality improvement and condition management activities, facilitate meetings of the Medical Advisory Council, and provide administrative support for quality of care function.

• Quality Improvement [Program] Coordinators (3.5 FTEs) develop, implement, and evaluate clinical quality improvement activities as approved by the Medical Advisory Council, including review of practice guidelines; act as liaisons with community-based organizations; participate in clinically-based performance improvement projects and facilitate associated regulatory reporting; collaborate with Associate Medical/Clinical Directors or other practitioners to implement QI initiatives; participate in annual HEDIS® chart reviews; and serve as inter/intradenpartmental resources for quality improvement. These coordinators are generally assigned to programs for which their professional experience and education are most suitable, and maintain licenses and credentials as appropriate.

• The Medical Records Coordinator is responsible for implementing and tracking Paramount medical record review activities, including HEDIS® hybrid data collection and abstraction, and other chart audits associated with quality improvement activities. This coordinator maintains AHIMA credential(s).

• The Quality Improvement Data Analyst assists with various QI activities such as coordinating HEDIS® data chases; loading, validating, manipulating and reporting multi-source data for QI and other departments; and creating ad hoc reports and databases.

• The HEDIS/Quality Improvement Coordinator assists with the annual HEDIS® project and clinical database management; and preparation of practitioner performance reports and member gaps in care reminders. This coordinator maintains AHIMA credential(s).

Numerous positions that reside in other departments include responsibility for tasks identified as quality management or quality assurance particular to a given function or area of production.
INTERDEPARTMENTAL COORDINATION OF QUALITY

Interdepartmental coordination is facilitated by each vice president (i.e., each division's vice president meets regularly with department directors/managers to coordinate activities). Additionally, all department directors meet monthly (Administrative Staff meetings) to coordinate activities across divisions. Management retreats (including operational management staff) are held three times each year for the purpose of strategic planning, goal setting, addressing service issues, developing plans for product expansion, corporate training, etc.

In developing and prioritizing quality improvement initiatives, directors and managers rely on information from other departments, as well as the annual program evaluation. Following are some of the most commonly referenced information sources and reports.

<table>
<thead>
<tr>
<th>CAHPS®, HOS &amp; ESS Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Member Service Mini-Survey</td>
</tr>
<tr>
<td>Member Appeals</td>
</tr>
<tr>
<td>Member Services Phone/e-Mail/Chat Line Performance Metrics</td>
</tr>
<tr>
<td>Member Complaints/Grievances</td>
</tr>
<tr>
<td>Family/Membership Advisory Councils</td>
</tr>
<tr>
<td>Delegation Oversight Analyses</td>
</tr>
<tr>
<td>Regulatory Audits/Reports</td>
</tr>
<tr>
<td>Quality of Care Summary</td>
</tr>
<tr>
<td>Health Equity Assessment</td>
</tr>
<tr>
<td>Employer and Group Feedback</td>
</tr>
<tr>
<td>HEDIS® Data and Trend Analyses</td>
</tr>
<tr>
<td>Practitioner/Office Manager Surveys</td>
</tr>
<tr>
<td>Provider Appeals/Inquiries</td>
</tr>
<tr>
<td>Access and Availability Report</td>
</tr>
<tr>
<td>Call Center/Nurse Line Reports</td>
</tr>
<tr>
<td>Case Management Satisfaction Survey</td>
</tr>
<tr>
<td>Prescription Drug Utilization Data</td>
</tr>
<tr>
<td>Medical Advisory Council</td>
</tr>
<tr>
<td>Physician Affairs Council</td>
</tr>
<tr>
<td>Status Reports from Contracted Vendors</td>
</tr>
<tr>
<td>Care Management Program</td>
</tr>
</tbody>
</table>

Other multi-departmental groups, some with defined charters, also contribute to the high quality exhibited by Paramount. They include the Product Review Committee (PRC), Strategic Implementation Group (SIG), NCQA Oversight Team, Disaster Recovery/Business Continuity (DR/BC) Team, Service Excellence Council, Internal Error Resolution Process (iERP) Team, Financial Improvement Group and Revenue Optimization (FIGARO) Team, and Medicare Stars Work Group. Ad hoc groups with interdepartmental participation are frequently formed to coordinate individual projects, e.g. new product development or implementation of new information technology.

INTEGRATION OF QUALITY IMPROVEMENT WITH GOALS

Communication is critical to assure that each employee is aware of how his or her contributions meld into Paramount's overall goals for member service and continuous quality improvement. A variety of methods are used to share information and keep all employees focused on these goals. Appropriate horizontal communication is encouraged to improve interdepartmental problem solving and to assist in prompt problem resolution for improved customer service and satisfaction.
SCOPE OF ACTIVITIES

IMPROVEMENT OF CLINICAL QUALITY

Clinical Practice Guidelines for Medical, Behavioral, and Preventive Care
Paramount recognizes that use of evidence-based clinical guidelines improves health outcomes. Following are commonly accepted medical, behavioral and preventive care guidelines, adopted by the Medical Advisory Council to guide Paramount providers in the delivery of care. Many of the standards and protocols contained within these guidelines are integral to the plan's process of monitoring the caliber of care delivered by participating practitioners. Although the value in using these guidelines is high, Paramount providers are not obligated to apply them in all circumstances.

- **Adult and Senior Preventive Care Guidelines** based on “Guide to Clinical Preventive Services”, US Preventive Services Task Force (USPSTF) 2012; additional recommendations from American College of Obstetricians and Gynecologists (ACOG); and AHRQ Recommendation on Urinary Incontinence Screening and Education for Seniors, 2010


- **“Standards of Medical Care for Patients with Diabetes Mellitus”**, American Diabetes Association (ADA), 2014 (Updated by ADA annually) Note: Includes pre-diabetes (Readopted February 2015)


- **Depression Guideline** based on the “Recommendation on Depression Screening in Adults, Adolescents and Children”, USPSTF, 2009 (Readopted 2014)

- **“Clinical Guideline for the Management of Heart Failure”**, American College of Cardiology/American Heart Association (ACCF/AHA), 2013 (Readopted 2014)

- **Cholesterol Management Guideline** based on the “National Cholesterol Education Program (NCEP)” Expert Adult Treatment Panel III, 2004 (Readopted 2014)


- **Chronic Obstructive Pulmonary Disease Guideline** based on “Global Initiative for Chronic Obstructive Lung Disease (GOLD)”, NHLBI/WHO, 2013; including “Pocket Guide to COPD Diagnosis, Management and Prevention”, 2013 (Readopted 2014)

- **Tobacco Cessation Guideline** based on “Smoking Cessation Clinical Practice Guideline”, USPSTF, 2009; including “Five A’s for Intervention” and “Five R’s for Cessation”, US Public Health Service (PHS), 2008 (Readopted 2014)
Care Management

Note: Refer to Paramount’s Care Management Program Description for detailed information about case management (for members with routine and complex needs), utilization management, condition (disease) management, and the prescription drug program. The following is only a brief synopsis of these functions as they contribute to the Paramount Quality Improvement Program.

Paramount integrates condition (disease) management and case management, along with targeted services such as internal and external pharmacy management, care navigation, telehealth monitoring and home care visits, into its comprehensive care management program. The broad continuum of interventions and services are determined and administered by an interdisciplinary care management team, as defined by risk level severity and whether the member has acute or complex needs. The Medical Advisory Council, in conjunction with the care management team, continually evaluates and adjusts its care management program to meet member and population needs, changing regulatory requirements, and evolving NCQA standards. Members are identified for care management in many ways, including risk profiling, claims-based profiling and stratification software, and internal and external referral sources. Medical, behavioral health, pharmacy, laboratory and demographic data are incorporated into these care management identification algorithms.

Paramount administers numerous Steps2Health™ 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 assessments are integral components of the Steps2Health™ programs. Paramount’s condition management programs are considered opt-out programs.

Case management program objectives include wellness promotion, member health and self-management education, help with access to services, care coordination and community resource support. Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s holistic needs through communication and available resources to promote high-quality cost effective outcomes (CMSA, 2012). Duties such as inpatient discharge planning, facilitation of services, patient advocacy, and care planning are an integral part of the process in both complex and routine case management. Systematic post-discharge follow-up assesses for possible gaps in health care transition such as medications, durable medical equipment, self-care, and physician or therapy appointments. In-home comprehensive physician assessments are conducted to evaluate select members’ behavioral health, medical, pharmaceutical, functional, and psychosocial needs for potential risk. Those found at high risk for poor health outcomes are referred to case management to facilitate prompt coordination of care with the primary care physician.
Routine case management focuses on individuals with chronic disease conditions at low to moderate risk for developing serious health outcomes. These members typically require ongoing monitoring and education to help manage their conditions, but do not require intense attention. This may include members in an inpatient care setting with concerns for post-discharge continuity of care, and members with inappropriate emergency room or hospital utilization.

Complex case management is provided to members who have experienced a critical event, a diagnosis requiring extensive use of resources, or are otherwise identified at high-risk for complications or death. Through intense telephonic services, and face-to-face visits as needed, these members (or their family/caregivers) receive assistance navigating the healthcare system to ensure appropriate delivery of care and services, including community resources. Where available, ambulatory care navigators may supplement care management.

Behavioral Health Care
Paramount strives to maintain coordination of care for members’ physical and mental health, while recognizing that one or the other may be a dominant factor in quality of life. The quality improvement program described here has evolved to ensure that mental and behavioral health is targeted just as intensely as is physical health. That said, there are differences between the conditions and modes of treatment that require specialization. A dedicated team of behavioral health care professionals, led by a full-time Clinical Director (doctoral-level psychologist), facilitate care management for members with behavioral health needs. Paramount does not operate a centralized triage service since all members have direct access to behavioral health care providers. Primary care referrals are encouraged however, as a means to coordinate care especially where medication is concerned. State law requires parity for medical and behavioral care benefits. More information about mental and behavioral care is found in the CM Program Description.

Promotion of Member Wellness
Education and self-management are essential factors in achieving and maintaining one’s well-being, but it is also important to recognize their status quo in order to set goals. Health assessment tools (electronic and printed) are available to all Paramount members, along with a wide array of interactive resources for members addressing topics such as weight management, smoking cessation, blood pressure control, nutrition, and physical activity. Paramount’s vendor is NCQA-certified for health appraisal and self-management tools, and URAC-accredited as a health content provider.

Quality of Care
Quality of Care (QOC) is defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. On a continual basis, clinically-related complaints and concerns are evaluated, and intervened upon as necessary according to a defined procedure, as a means to maintain the high level of quality in care received by Paramount members. QOC complaints regarding specified providers are monitored and included in re-credentialing and contracting.
Besides complaints from members and providers, and information mined from electronic data, all employees are responsible for reporting perceived quality of care concerns. Issues are referred to and documented by designated staff within the Quality Improvement department and reviewed by an Associate Medical/Clinical Director. Reports are investigated for actual or potential problems, tracked, monitored, and when appropriate, corrective action is initiated. A Quality of Care report is prepared for the MAC annually to inform their evaluation of patient safety. It summarizes the investigations and outcomes of the prior year’s QOC cases, analyzes administrative data to identify possible quality of care patterns, and offers recommendations for improvement.

**Patient Safety**

Paramount promotes a comprehensive strategy to assure patient safety by partnering with members, physicians, practitioners, hospitals, ancillary providers and pharmacies. Members’ education and risk-awareness are central to this on-going program, along with assessment of providers’ patient safety initiatives. Medication safety, including drug recalls, market withdrawals, and so forth are monitored on a continual basis and addressed as part of the delegated services delivered by Paramount’s contracted pharmacy benefits manager (PBM). In addition, Paramount pharmacists and P&T regularly review concurrent and retroactive drug utilization reports from the PBM.

Continuity and coordination of care are recognized as integral elements of patient safety, by omission and commission. The QOC process is another key factor in assuring patient safety.

**Health Literacy/Limited English Proficiency**

Although the prevalence of Limited English Proficient (LEP) communicators among Paramount members is very low in total, there are a few pockets where 4-7% of the population prefers to speak a language other than English, often Spanish with a large portion of bilingual adults speaking English “less than well”. Paramount associates who work directly with members and potential members are educated on use of telephone interpreting services, whether in the office or in the field. Selected member materials are available for listening on-line (508 compliant) or have been professionally translated into Spanish. Many public-access health education resources (electronic media and print) are available in alternate languages and formats for use by case managers, health educators and providers. At least annually, practitioners are advised of Paramount-supplied services to optimize patient/provider communications, and reminded of their obligation to meet patients’ communication needs free of charge. Interpreter services arranged by Paramount are tracked monthly.

Ohio’s older adult population has a higher level of education than do adults under 65 years of age (ACS 2009-2013), but barriers such as diminished vision, concentration and cognition may influence the ability to read and comprehend information related to one’s health and well-being. Paramount addresses health literacy as a tool for improving members’ health outcomes, patient self-management and safety. Readability of written communications, careful selection of patient education materials, assuring website content is audible and readable (i.e., 508 compliant), educating providers about the role of health literacy in “patient compliance”, and encouraging patient-provider communication techniques, e.g., teach back method, are some of the interventions used.
Health Equity and Culturally Appropriate Care
Members’ race, ethnicity, and language/communication preferences (REaL) are captured when provided with enrollment data, and confirmed or supplemented during regular communication with Paramount staff. The new member portal (due to launch in mid-2015) will enable members to enter or correct their own demographic profile. In addition to REaL data, information gleaned from member services and care management enables Paramount to conduct ongoing assessment to identify potential needs of all our members. County and Community Health Assessments available throughout the service area also inform Paramount’s efforts to recognize diversity and assure the delivery of culturally appropriate services and care.

Practitioners’ self-reported spoken languages other than English are captured and published as a searchable field in the on-line directory. To date, Paramount has not identified any notable gaps with the provider network in meeting members’ spoken linguistic needs or culture-associated requests for health care delivery.

Healthcare Effectiveness Data & Information Set
HEDIS® is a growing set of performance and outcome measures originally developed in response to employers’ need to compare health plans, now serving as the industry standard. Through detailed specifications for deriving performance measures, HEDIS® provides commonly accepted methods for evaluating and trending health plan performance. Although many measures are captured as a hybrid of claims data and medical record reviews, most are collected as administrative-only data from claims, enrollment records, and supplemental data files such as lab results. Results of the annual measurement are utilized for a myriad of internal and external performance indicators as described throughout the QI & CM Work Plan and Evaluation.

To generate, manage and submit HEDIS® data, Paramount utilizes NCQA-certified software. Paramount capitalizes on highly skilled QI department staff (full time and seasonal) to abstract electronic and paper records for hybrid measures directly into the laptop-loaded application. Collaboration with providers such as ProMedica Laboratory enables Paramount to download clinical test results as a supplemental file. The reporting process and results undergo a rigorous external audit by an NCQA-approved auditor each year. Data are then submitted to NCQA for each of Paramount's accredited product lines.

Health Outcomes Survey
The Medicare Health Outcomes Survey (HOS) is a two-part, longitudinal evaluation of members’ physical and mental health, and changes during a two year period. HOS has been collected for nearly 20 years, in accordance with CMS and NCQA requirements. Results of some HOS items are included in HEDIS®, while several others are utilized in the Medicare Parts C & D Stars Quality Rating system. It is conducted per protocol, by an external CMS-approved survey vendor.
QUALITY IMPROVEMENT AMONG PRACTITIONERS AND PROVIDERS
Physicians, non-physician practitioners, hospitals, ancillary facilities, and all other types of health care providers contracting with Paramount are expected to maintain optimal levels of quality in their practice or service. The Physician Affairs Council (PAC, see page 8), sets performance expectations for participating (i.e., contracted) physicians, defines network composition and panel size, and exercises peer review for contract compliance and practice performance. Measurable performance indicators are established during contracting with some health care provider organizations. Coordination of services among all types of practitioners and providers across and between health care settings is monitored and supported through a variety of mechanisms.

Practitioner Incentive Programs
Since primary care is at the root of Paramount's health care delivery system, it is essential to systematically assess and recognize the ability of these practitioners to manage patient care effectively and appropriately. Paramount administers a Diabetes Quality Incentive Program with primary care physicians. The program reflects American Diabetes Association guidelines for diabetes control that are measured by HEDIS, namely: A1c < 8.0%, BP < 140/90, nephrology monitoring/therapy, and dilated eye exam. For 2015, Paramount will reimburse PCPs $200 for each adult member with diabetes for whom claims are received with diagnosis and procedure codes meeting all four criteria.

Member Satisfaction with Practitioners
To supplement complaint/grievance data and relevant results from our CAHPS surveys (page 26), Paramount works with participating physician groups to evaluate member (i.e., patient) satisfaction with their practitioners. For example, our sister organization ProMedica Physicians (PPG) shares with us their CG-CAHPS® physician satisfaction survey findings, obtained for the NCQA Physician Practice Connections® recognition program. Opportunities for improvement are identified at practitioner, group, and aggregate levels.

At publication, Paramount is establishing plans to conduct a member survey specific to behavioral health care services. Still-present biases regarding mental illness yielded very few responses in the past, driving Paramount to expand the target sample beyond recipients of behavioral health care. Early objectives are to inquire about access, availability, satisfaction, and other experiences.

Public Reporting of Performance
Paramount encourages members and practitioners to avail themselves of publicly reported information on provider performance. Although these sources are not suitable for credentialing, many do offer valuable consumer information. Examples include CMS’ “Hospital Compare” and “Nursing Home Compare”, NCQA, The Joint Commission (TJC), URAC, and various professional licensing boards. Paramount’s e-directories offer hyperlinks to these licensing boards. Paramount also identifies those achieving special recognition in the provider directory or newsletters.

Practitioner Credentialing
All physicians and non-physician practitioners participate in a 3-year credentialing cycle and are subject to ongoing review for sanctions and complaints. Key quality-related elements of the recredentialing review include accessibility to patients, member satisfaction with the practitioner, and performance on a variety of administrative and clinical measures.
Physician Affairs Council (PAC) decisions about re-credentialing are based not only on the physician meeting objective criteria, but on peer review of utilization and quality indicators, and recommendations from delegated credentialing entities. Consideration is also given to these other important factors.

- Member complaints and rate of disenrollment from the practice
- Quality of care issues (number, severity, and responsiveness to correction)
- Review of referral compliance and corrective action issues
- Findings from routine, mid-cycle monitoring

**Facility Contracting and Assessment**

A three (3) year assessment cycle, utilized to confirm good standing with state and federal regulatory bodies and current accreditation status, provides assurance that facility providers meet high levels of quality in the care, patient safety and services they render to Paramount members. Provider facilities include, but are not limited to, hospitals, nursing homes, home health agencies, laboratories, and freestanding surgery centers. They are often referred to as organizational providers.

**Delegation Oversight**

Paramount is ultimately accountable for members’ health and well-being, even when decision making authority is transferred (i.e., delegated) to entities such as health care providers, a physician hospital organization (PHO), contractors/vendors, or a benefit management organization. To meet this obligation, Paramount relies on an interdepartmental committee to perform rigorous, monthly oversight. The processes for ongoing performance monitoring and auditing of each delegated entity are critical to assure delivery of consistent, uniform, high quality health care and service to our members. Delegated entities are assessed prior to contracting to determine capability and are required to provide Paramount with monthly reports of agreed-upon content or data, culminating in a comprehensive annual assessment. All agreements stipulate protected health information requirements and provisions for corrective action/termination.

**IMPROVING QUALITY IN ADMINISTRATIVE OPERATIONS**

Management of non-clinical processes and operations relies on both objective outcomes and the subjective experiences of stakeholders. Fiscal measures and productivity rates abound with regard to the former, but are outside the scope of Paramount’s QI program. The latter however, garnered from surveys and other resources, contributes greatly to improvement opportunities.

**Access and Availability of Clinical Services**

Health care accessibility and provider availability are evaluated for each type of primary care and high volume specialties, including but not limited to obstetrics/gynecology and behavioral health as described below. The comprehensive Access and Availability of Medical and Behavioral Health Care Report is presented annually to MAC and PAC for evaluation. The standards defining objectives for access and availability are reviewed annually as well. Timeliness and appropriateness of health care delivery are related characteristics measured as utilization criteria (below).
Access is defined as the extent to which a member can obtain available services at the time they are needed. This refers both to telephone/electronic access and the ability to obtain timely appointments. Access standards have been developed and adopted in accordance with NCQA Standards and include access to medical care from PCPs and specialists, as well as behavioral health care. Paramount publishes the access standards in newsletters, on the website, in member handbooks, and in provider manuals to ensure that members and providers are aware of these expectations. Compliance is assessed from patient satisfaction survey results, complaints/grievances, HEDIS® access measures, CAHPS® and ESS survey data, and other vehicles. When reported after-the-fact, access and availability are handled by the quality of care process described earlier.

<table>
<thead>
<tr>
<th>MEDICAL/SURGICAL</th>
<th>PCC STANDARD</th>
<th>NON-PCC STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Assessments, Physicals, or New Visits</td>
<td>95% of members can access care within 20 days</td>
<td>95% of members can access care within 40 days</td>
</tr>
<tr>
<td>Routine Follow-up Visits</td>
<td>95% of members can access care within 14 days</td>
<td>95% of members can access care within 45 days</td>
</tr>
<tr>
<td>Symptomatic Non-urgent Visits</td>
<td>95% of members can access care within 1 working day after NCP contact</td>
<td>95% of members can access care within 30 days</td>
</tr>
<tr>
<td>Urgent Medical Problems</td>
<td>95% of members can access care within 1-2 days</td>
<td>95% of members can access care within 1-2 days</td>
</tr>
</tbody>
</table>

**BEHAVIORAL HEALTH**

| Routine Assessments or Care for New Problems | 95% of members are offered access to care within 14 days |
| Routine Follow-up Visits                   | 95% of members are offered access to care within 30 days |
| Urgent Care                                | 95% of members are offered access to care within 1-2 days |
| Immediate Care for Non-life Threatening Emergency | Immediate Care. Not to exceed 4 hours |

**DENTAL (Paramount Advantage only)**

| Routine Care                             | 95% of members can access care within 40-60 days |
| Routine Follow-up                         | 95% of members can access care within 14-45 days |
| Symptomatic / Non-Urgent                 | 95% of members can access care within 7-14 days |
| Emergency Care                            | 95% of members can access care within 73 hours |

**TELEPHONE ACCESS ALL PROVIDERS**

| Access to Care After Hours               | 95% of members will find access to care after hours acceptable |
| Return Phone Calls from Provider Office During Office Hours | 95% of members will find return phone calls during office hours to be acceptable |

Availability is the extent to which the plan has secured the services of practitioners and providers of the appropriate types and number distributed geographically to meet the needs and preferences of the membership. Paramount monitors availability through several methods, but predominantly using GeoAccess analysis against defined parameters. Targets have been set for the percent of primary care physicians with open practices and the continued recruitment of providers in all regions.

2015 QI Program Description
Paramount Care, Inc. (Elite)
Utilization of Health Care Services

A valuable tool for managing health care quality is a reliable system by which to balance the volume, distribution, timeliness, and appropriateness of services and resources delivered to members. Overutilization is wasteful and can even be harmful, such as excess exposure to radiation due to repeated diagnostic procedures. Underutilization can be an indication of poor use of resources, carelessness or other signals of less than acceptable health care quality.

To avoid unnecessary burden on providers, Paramount does not require pre-authorization for members to obtain care from in-plan (i.e., network) specialists. Referrals are encouraged, however, as a means to assuring communication and coordination of care between PCP and specialist. Annually, Paramount publishes a detailed Care Management Program Description, as approved by the MAC. CM work plans and evaluation are incorporated into the respective QI documents with trending and benchmarked analysis for a wide range of indicators.

Member Advisory Council

A valuable source of member input is the Member Advisory Council. The group is comprised of Paramount members from multiple products who volunteer to participate on the council. The purpose of the council is to obtain member feedback on various issues, such as product changes, benefit modifications, website usability and proposed marketing campaigns. The Manager of Member Services and Provider Inquiry facilitates these gatherings.

Member Privacy and Confidentiality of Personal Information

Paramount respects its members’ right to privacy and is committed to protecting personal health information. Policies and procedures have been established to prevent unauthorized access to, and use or disclosure of member information in accordance with HIPAA. Paramount maintains physical, electronic and procedural safeguards to protect members’ health information.
Internally, only authorized personnel who provide services to members and work with their accounts have access to protected health information (PHI), e.g., for regular health plan operations. Employees are trained and frequently reminded to properly handle PHI, to secure e-mail transmissions, to report a potential breach, and are required to sign an attestation annually agreeing to abide by Paramount confidentiality policies. Reports of suspected violations are managed through the complaint/grievance process, in accordance with state and federal laws and regulations.

Providers and third parties who perform contracted or delegated services are required to abide by terms set forth in their contract with Paramount and/or a separate Business Associate Agreement. Transmission of PHI must be secured using accepted health information industry procedures such as encryption and passwords, transport layer security, limited access portals and signature-required delivery/shipment of packages. Paramount reserves the right to share member information as allowed by law, i.e., Paramount can use and disclose PHI for treatment, payment and health care operations activities. A member’s written authorization is required prior to use or disclosure of PHI for any other purpose. Rights and responsibilities concerning PHI are shared with stakeholders at least annually by way of the formal Notice of Privacy Practices (NPP), preceding/during private conversations, as posted on the website, and in written publications and correspondence.

Complaints, Grievances, and Appeals
Paramount maintains detailed policies and procedures specific to complaint, grievance and appeal processes, ensuring compliance with complex state and federal regulations and legislation. All members or their authorized representatives have the right to appeal an adverse or unacceptable decision associated with her or his care or service. Appeals, sometimes called reconsiderations, are categorized and addressed in accordance with a variety of criteria outlined in NCQA standards.

- Behavioral or Non-Behavioral (e.g., Medical, Dental, Pharmaceutical) Health Care
- Denials Due to No Medical Necessity or Not a Covered Benefit
- Denials Made Pre-Service (Urgent/Expedited or Not), Concurrent or Post-Service

Housed within the member services department, the appeals team fully investigates all administrative (coverage) appeals before presenting them to designated representatives from Administrative Staff (always including a Registered Nurse) for a determination. All clinical (medical necessity) appeals are evaluated by a non-subordinate Medical Director, Clinical Director, Associate Medical Director or Pharmacist that was not responsible for the original denial.

The complaint, grievance and appeals process is an important component of the Paramount quality improvement program. Through appropriate trending and analysis of appeals, complaints and grievances, the plan differentiates between isolated problems and issues that are pervasive or systemic in nature. Reports of these findings, with recommendations for mitigation and/or improvement are reviewed by leadership quarterly. Complaints received from newly enrolled members are distinguished in order to identify possible opportunities to increase member understanding of their rights, benefits and Paramount procedures. Reports pertaining to health care access or its delivery are handled as quality of care issues. This function is not delegated to contracted providers, but coordination of parallel investigations and/or collaborative resolution is utilized as appropriate.
Consumer Assessment of Healthcare Providers and Systems
Medicare CAHPS® surveys are utilized by Paramount, in conjunction with HEDIS®, to evaluate member satisfaction with the overall health care experience annually. An NCQA and CMS prescribed protocol defines sampling and administration of the survey, identifies approved vendors, requires an external audit of the process and outcomes, and specifies data submission to NCQA and other entities as required by CMS. As permitted, custom questions are added to generate greater specificity to some responses, and to enable broader analyses. Rigorous analysis of annual results incorporates benchmarking, trending, statewide comparison, and identification of new opportunities for improvement.

Member Satisfaction with Paramount Services
A vendor-conducted mini-survey is administered monthly to gauge member satisfaction with customer service more often than is possible through CAHPS alone. The sample is weighted in favor of members who have recently contacted the Member Service Call Center, but also reflects the general membership. Findings are trended, compared with annual CAHPS results, and shared with leadership, the Service Excellence Council (SEC) and Member Advisory Council. Live Chat services are monitored through a short survey that pops-up after communication is concluded. Individual results, where identifiable, are shared with staff. Call center productivity per se does not fall within the scope of Paramount’s QI program.

Case Management (CM) and Disease Management (DM) are other services for Paramount members that are evaluated with input from recipients. Participation in CM varies in duration, so the annual survey is conducted in two ways: upon discharge from CM and annually for members continuing with CM (in spring). Developed, implemented and analyzed internally, the mail survey explores several aspects of the member’s CM experience, both routine and complex. Members enrolled in DM programs are assessed at each telephonic contact for satisfaction with and input for the program. Reasons for members opting out of DM programs are also evaluated for program improvement opportunities. Further explanation about reporting, use of results, and evaluation of findings is available in the Care Management Program Description.

Physician/Office Manager Satisfaction with Paramount
Through an independent research company, Paramount routinely conducts Physician and Office Manager Satisfaction Surveys. This survey team selects offices with a large enough volume of Paramount patients to assure a valid sample. In alternating years, office managers are invited to complete the survey on-line or are interviewed by telephone; physicians initially are invited to complete the survey on-line or with a written survey. Responses to surveys are analyzed for opportunities to improve, with review by the MAC and Board of Directors.

The surveys address topics such as the following.
- General satisfaction with Paramount
- Satisfaction with Provider Inquiry, UM, CM, DM, and Provider Relations
- Satisfaction of the Prescription Drug Program
- Adequacy of hospital and physician network
- Consistency of administration of utilization policies and procedures
- Promptness and accuracy of claims payment
- Communication and education

**Service Organization Audit**

Paramount engages in the preparation of a Service Organization Control Type I (SOC I) Report. Findings contribute to identification of opportunities for improvement, even when audit results are positive. Successful examination of an organization, as set forth in the AICPA’s Statement on Standards for Attestation Engagements No. 16 (SSAE 16), *Reporting on Controls at a Service Organization*, demonstrates that adequate internal controls and safeguards are in place to process transactions and other data effectively. The SOC I audit is valuable to Paramount’s relationship with customers and other service organizations.

**Business Continuity and Disaster Recovery**

Paramount maintains a multifaceted plan for recovering and maintaining business operations in the event of an unexpected crisis. Information technology is at the center of that plan. Contingency service providers are under contract.

**SUPPORT OF COMMUNITY HEALTH STATUS AND PUBLIC HEALTH GOALS**

As part of ProMedica, and reflected in the mission statement, Paramount collaborates with community and government agencies to improve the health of both its members and the community at large. This approach is demonstrated by Paramount's delivery or support of numerous programs.

- Active participation in and support of state and community health coalitions and projects
- Active participation on governing boards of community service agencies
- Collaboration with local community centers to promote public immunization initiatives

**EXTERNAL QUALITY IMPROVEMENT PROGRAMS**

One of the goals of Paramount's Quality Improvement Program is to efficiently coordinate high priority activities with the requirements of state and federal regulatory bodies, such as the state departments of insurance and health (ODI & ODH), and the Centers for Medicare and Medicaid Services (CMS). Striving to achieve 5 Stars in the Medicare Star Rating system is such an example.
INDEX

| Access Standards                   | Page 25 | Leadership (See Administrative Staff) | Page 14 |
| Access to Behavioral Health Care   | Page 24 | Limited English Proficiency            | Page 21 |
| Access to Clinical Services        | Page 24 | Medical Advisory Council (MAC)         | Page 4, 7 |
| Administrative Staff               | Page 13 | Medical Director                       | Page 6, 7, 11, 13 |
| Annual QI & CM Program Evaluation  | Page 3  | Medical Policy Steering Committee      | Page 7, 11 |
| Annual QI & CM Work Plan           | Page 3  | Medicare Health Outcomes Survey (HOS)  | Page 22 |
| Appeals (of Adverse Decisions)     | Page 27 | Medication Safety                      | Page 9, 21 |
| Associate Medical/Clinical Directors| Page 12 | Member Advisory Council                | Page 26 |
| Availability of Behavioral Health Care | Page 25 | Member (Population) Diversity           | Page 22 |
| Availability of Clinical Services  | Page 25 | Member Privacy                         | Page 26 |
| Availability Standards             | Page 26 | Member Satisfaction with Paramount Services | Page 28 |
| Behavioral Health Care             | Page 20 | Member Satisfaction with Practitioners  | Page 23 |
| Board of Directors                 | Page 4, 5| Mental Health/Illness (See Behavioral Health Care) | Page 20 |
| Business Continuity                | Page 17, 29| Mission Statement and Values            | Page 1 |
| CAHPS®                             | Page 28 | National Committee for Quality Assurance (NCQA) | Page 3, 15, 17 |
| Call Centers                       | Page 28 | Notice of Privacy Practices             | Page 27 |
| Care Management                    | Page 19 | Objectives of Quality Improvement Program | Page 2 |
| Case Management                    | Page 19, 28| Office Manager Satisfaction with Paramount | Page 28 |
| Centers for Medicare and Medicaid Services (CMS) | Page 29 | Operational Management                 | Page 14 |
| Clinical Director for Behavioral Health | Page 6, 14| Operations Division                    | Page 6, 13 |
| Clinical Practice Guidelines       | Page 18 | Organizational Chart                   | Page 6 |
| Clinical Quality Improvement       | Page 18 | Overview of Organizational Structure   | Page 4 |
| Community Health Status            | Page 29 | Overview of Quality Improvement Program | Page 2 |
| Complaints                         | Page 20, 23, 27| Patient Safety                          | Page 7, 9, 21 |
| Condition Management Programs (Steps2Health) | Page 19, 25| Patient Satisfaction with Practitioners | Page 23 |
| Confidentiality of Personal Information | Page 26| Pharmacy and Therapeutics Working Group (P&T) | Page 7, 9 |
| Consumer Assessment of Healthcare Providers & Systems | Page 28| Pharmacy Benefits Manager (Management) | Page 9, 21, 24 |
| Continuous Quality Improvement Cycle | Page 3 | Physician Affairs Council (PAC)        | Page 4, 8 |
| Coordination of Care               | Page 19 | Physician Satisfaction with Paramount   | Page 28 |
| Credentialing                       | Page 8, 23| Practice Guidelines                    | Page 18 |
| Culturally Appropriate Health Care | Page 22 | Practitioner Credentialing              | Page 8, 23 |
| Delegation Oversight                | Page 24 | Practitioner Incentive Programs        | Page 23 |
| Disaster Recovery                   | Page 17, 29| President                               | Page 6, 8, 13 |
| Disease Management                  | Page 19, 28| Privacy of Member Information           | Page 26 |
| Documentation of Quality Improvement| Page 19 | Product Review Committee               | Page 17 |
| Evaluation of Quality               | Page 3, 20| Products and Product Lines             | Page 3 |
| Evidence-Based Clinical Guidelines  | Page 18 | ProMedica (Health System)              | Page 1, 3, 13 |
| Executive Leadership                | Page 13 | Protected Health Information (PHI)     | Page 26 |
| External Quality Improvement Programs| Page 29| Public Health Goals                    | Page 29 |
| Facility Contracting and Assessment | Page 24| Public Reporting of Performance         | Page 23 |
| Finance Division                    | Page 6, 13| Purpose of Quality Improvement Program | Page 2 |
| Governing Body                      | Page 5  | Quality Improvement among Providers     | Page 23 |
| Grievances                          | Page 27 | Quality Improvement Staff               | Page 15 |
| HAYES Medical Technology Directory® | Page 10| Quality of Care (QOC)                  | Page 20 |
| Health Assessment                   | Page 19 | Satisfaction with Paramount             | Page 23, 27 |
| Health Equity/Health Care Disparities| Page 22| Scope of Quality Improvement Activities | Page 18 |
| Health Literacy                     | Page 21 | Senior Risk Assessment                  | Page 19 |
| Health Outcomes Survey (HOS)        | Page 22 | Service Auditor’s Report                | Page 29 |
| Health Services Division            | Page 6, 13| Service Excellence Council             | Page 17, 28 |
| Healthcare Effectiveness Data & Information Set | Page 22| Staff Structure                         | Page 6, 13 |
| HEDIS®                             | Page 22 | Strategic Implementation Group          | Page 17 |
| HIPAA – Confidentiality/PHI        | Page 26 | Steps2Health Condition Management Program | Page 19 |
| Hospital Contracting and Assessment | Page 24| Technology Assessment Working Group (TAWG) | Page 7, 10 |
| Improving Quality in Administrative Operations | Page 24| Utilization Management                  | Page 19, 26 |
| Integration of QI with Goals        | Page 17 | Vice Presidents                         | Page 6, 13 |
| Interdepartmental Coordination of Quality | Page 17| Wellness Promotion                      | Page 20 |
| InterQual® Criteria                | Page 10 | Work Plan                               | Page 3 |
| Language Assistance                 | Page 21 |                                      |         |