# Table of Contents—
## Resource Coordination Program Description

- **Introduction** ................................................................. 14-3
  - Goals ................................................................. 14-3
  - Objectives ............................................................ 14-3
- **Governance and Accountability** ............................................... 14-4
- **Organization/Committee Structure** ........................................ 14-4
- **Roles, Reporting, and Resources** .......................................... 14-8
- **Resource Coordination Program Scope** .................................... 14-14
- **Program Components** .......................................................... 14-14
- **Medical Necessity Denials** ...................................................... 14-20
- **Appeals Process** ............................................................. 14-20
- **Technology Assessment and Medical Policy Development** ................ 14-20
- **Clinical Criteria** ............................................................. 14-21
- **Delegation**—Refer to *Quality Management Program Description 2019, Section IX, J, M, and O.*
  See page 33 for details on the following UM delegates: ....................... 14-21
  - CVS Caremark
  - Landmark Health, LLC
  - Delta Dental
- **Resource Coordination Incentives** ........................................... 14-22
- **Confidentiality** ............................................................... 14-22
- **Resource Coordination Program Evaluation** .................................. 14-22
Section 14

Introduction

It is the responsibility of the resource coordination department at Capital District Physicians’ Health Plan, Inc. (CDPHP®) to ensure value-based care is available to all members across the full continuum of care. This is accomplished through planning, coordinating, monitoring, and managing health care services to ensure appropriate, cost-effective care while contributing to the overall goal of member wellness. Annually the health plan evaluates the needs of its enrolled population and uses that information to assess whether current programs need modification to better address the needs of its membership.

In 2019, CDPHP will transition to a fully integrated and cohesive population health management (PHM) model. Front end analytics will allow for a proactive approach to finding members who may need support and tailored interventions will be offered at each health stage. PHM will enhance the adaptability of our current day programming and thus increase our ability to offer services to all our members. This strategy will allow for continued focus on improving quality of care and health care outcomes for our members.

The resource coordination department activities are established in accordance with the CDPHP mission statement.

**Mission Statement**

We provide quality health care at a reasonable cost for our subscribers and operate CDPHP as a model for the delivery, financing, and administration of health care services.

**Program Goals:**

- To promote healthy lifestyles and improve health outcomes.
- To engage members in programs to mitigate risk factors that negatively affect members’ health.
- To promote preventive health services.
- To ensure timely and equitable access across the continuum of care for all members.
- To promote judicious use of health care resources across all levels of care.
- To provide an integrated approach to managing the health care needs of our most complex members.
- To incorporate process improvement principles and methods into resource coordination department activities.
- To systematically measure, assess, analyze, and evaluate the effective utilization of the medical care delivery system and services provided to members.
- To promote optimal utilization of health care services while protecting and acknowledging members’ rights and responsibilities, including the members’ rights to appeal utilization management denial decisions.
- To support appropriate care delivery by primary care practitioners (PCPs) to their full scope of practice using consultation and treatment by specialists when medically necessary and clinically appropriate.

**2019 Program Objectives:**

- Develop a comprehensive strategy for population health management that addresses our members’ needs.
- Include comprehensive care management programming that will include high-risk health management services, inpatient care coordination and concurrent review, prior authorization, member appeal and complaint resolution, and chronic condition support.
- Collaborate with high volume hospital partners to provide a unique member experience for CDPHP members, while ensuring appropriate utilization, quality transitions of care and appropriate care management as needed.
- Provide a well-structured utilization management (UM) program and make utilization decisions affecting the health care of members in a fair, impartial, and consistent manner.
- Expand the reach and efficiencies of our care management programs through the use of our highly integrated, member-centric information technology systems.
- Provide efficient management of care through the implementation of sound, clinically based medical necessity criteria, including MCG®, Care Advance Enterprise Standard Clinical Content Package; Hayes: Medical Technology Directory, Health Technology Brief, Genetic Test Evaluation Program, and Technology Prognosis; NYS LOCADTR 3 and internally developed medical necessity/medical appropriateness criteria.
- Provide oversight and evaluate effectiveness of the utilization management and care management programs of our delegated partners.
- Meet established performance goals for all utilization management activities while ensuring compliance with regulatory and accreditation standards and requirements.
- Engage the utilization management committee in assisting the Plan to develop and implement policies and programs to reach utilization goals.
- Enhance member awareness and participation in CDPHP population health programs.
- Establish targeted member outreach to impact Healthcare Effectiveness Data and Information Set (HEDIS) measures.
- Offer care management services to targeted employer groups based on group size, to assist members to optimize their health plan benefits.
- Evaluate and implement programs that enhance the ease and efficiency of medical practice and improve the quality of care our members receive.

Revised January 2020
• Use a standardized methodology to identify potential utilization outliers (both over- and underutilization) and design interventions as needed.
• Enhance efficiencies in all resource coordination processes.
• Engage our participating acute care hospitals and skilled nursing facilities in reducing the inpatient readmission rate.
• Audit for coding compliance and educate providers as appropriate.
• Expand our partnerships with community-based organizations to better serve our Medicaid members.
• Expand the scope of our Medicaid programs to include newly carved-in populations.
• Expand access to quality, culturally competent care and support for our most vulnerable populations.
• Continue a multifaceted approach to improving the health literacy of our members.
• Partner with local performing provider systems (PPSs) to support the Delivery System Reform Incentive Payment (DSRIP) initiatives.
• Engage CDPHP members in health risk mitigation activities.

Governance and Accountability

CDPHP is a not-for-profit corporation. The board of directors is the governing body responsible for managing the affairs and business of the corporation, as well as maintaining overall accountability and responsibility for the quality management program.

The president and CEO of CDPHP reports directly to the board of directors. The board of directors has assigned the utilization management committee (UMC) the responsibility to develop, review, implement, and recommend enhancements to the resource coordination program. The committee reports through the quality management committee (QMC) to the board of directors.

The overall development, review, and revision of the program description is coordinated by the senior vice president, medical affairs operations, a medical director whose primary focus is utilization management and the UMC.

Organization/Committee Structure

The committee structure of CDPHP includes several committees that contribute to the resource coordination department activities. These committees include: the quality management committee (QMC); utilization management committee (UMC); policy committee; joint health services committee (JHSC); behavioral health UM committee, HARP-UM committee, quality stakeholder advisory group (QSAG), HARP-quality stakeholder advisory group (QSAG); and the pharmacy and therapeutics (P&T) committee. The activities of all committees are reported up through the QMC. The actions of the QMC are then directly reported to the board of directors by the executive vice president, medical affairs/chief medical officer. The executive vice president, medical affairs/chief medical officer then has responsibility to report to the QMC the results of the board of directors’ review of the committee report. Each of these committees has been assigned a CDPHP medical director and supporting staff.

Quality Management Committee (QMC)

The board of directors has designated the QMC as the responsible entity for the oversight and management of all quality-related activities. The QMC is chaired by a medical director, appointed by the executive vice president/chief medical officer and is comprised of fully credentialed physicians representing primary care and specialties from our community. Representatives from CDPHP adjunct providers, network physicians, community business leaders, and vice president behavioral health and medical integration also serve as committee members. The committee members are bound by a confidentiality and conflict of interest agreement, which is renewed at least annually.

The committee members are appointed by the executive vice president/chief medical officer, subject to board approval, for a three-year term and may be reappointed once. The senior vice president of health care quality, director of health care quality, director of clinical quality and behavioral analytics, accreditation and quality program manager, director of behavioral health, behavioral health specialist director of provider services, and member services supervisor are CDPHP representatives on the committee.

Additional plan staff serve as ad hoc staff to the committee as needed. Additional plan staff participate on the committee as needed. The QMC meets at least six times per year. Contemporaneous minutes are recorded for all committee activities. The QMC reports regularly to the board of directors, which has ultimate responsibility for the quality management program. The QMC is accountable to and receives recommendations from the board.

Responsibilities of the Quality Management Committee include:

• Review, approve, and make recommendations for the QM program, including all pertinent quality-related activities, the annual Work Plan, and annual Program Evaluation.
• Review, approve, analyze, evaluate results, make recommendations and policy decisions, institute needed actions, and ensure appropriate follow-up regarding pertinent quality activities, including but not limited to HEDIS, Quality Assurance Reporting Requirements (QARR), and all clinical and service initiatives. QI activities include, but are not limited to the following:
Member satisfaction, including complaints/grievances/appeals monitoring and satisfaction survey results, practitioner availability
Appointment accessibility
Member accessibility to the Plan
Clinical quality and safety measures
Utilization monitoring
Pharmaceutical management, including MTMP, MedCheck
Credentialing/recredentialing
Oversight of first-tier downstream entities (FDRs) and other delegated activities
Practitioner medical record and office site reviews
CMS Quality Improvement Project (QIP) and Chronic Care Improvement Projects (CCIP)
Quality Improvement Strategy (QIS) for Marketplace Qualified Health Plan (QHP)
Preventive health, complex case management, chronic conditions and disease management program initiatives, including clinical practice guideline development
Establishment of clinical quality indicators and quality teams or subcommittees to address specific clinical issues
New York State Performance Improvement Projects (PIP) as required
Medicaid and HARP Performance Improvement Quality Matrix reporting as required
Recommend and monitor continuity and coordination of care initiatives
Provider profiling and incentive programs
Accreditation, certification, and regulatory compliance
Development of initiatives to address health equity based on identified health literacy, and cultural and linguistic needs of our membership
• The QMC submits regular reports of QM activities to the board of directors

Utilization Management Committee (UMC)
The UMC has the responsibility to develop, review, implement, and recommend enhancements to the resource coordination program.

Committee responsibilities include, but are not limited to:
• Develop, review, revise, and approve resource coordination policies.
• Monitor utilization trends for institutional, professional, and ancillary practitioners.
• Identify and ensure implementation of appropriate interventions to address opportunities for improvement identified through monitoring activity.
• Develop or select industry-standard medical necessity/medical appropriateness screening criteria used for UM decision-making.
• Monitor consistency of application of medical necessity criteria, including inter-rater evaluation process for physician and non-physician reviewers, to develop and oversee implementation of interventions to address identified opportunities for improvement.
• Monitor timely resolution of UM determinations and service indicators.
• Evaluate for potential over- and underutilization on a plan-wide, product-specific, and practitioner-site level, with recommendation of corrective action as appropriate.
• Evaluate results to recommend interventions and corrective actions for plan-wide and practitioner-specific opportunities for improvement. These are identified through ongoing monitoring of care, service, and utilization indicators.
• Evaluate requests for new technology and/or new uses for existing technology.
• Recommend revisions to the member benefit package.
• Monitor progress toward achieving established performance goals.
• Monitor member and provider satisfaction with the resource coordination services and processes.
• Serve as a liaison between participating practitioners and CDPHP on all clinical and utilization-related issues.

A medical director chairs the committee, who has a primary focus on UM. The committee membership is appointed by the executive vice president/chief medical officer, subject to CDPHP board of directors’ approval, and consists of participating board-certified physicians representing primary care and the high-volume specialties. The committee meets bi-monthly and minutes are reported through the QMC to the board of directors. The senior vice president of medical affairs operations serves as staff to the utilization management committee. Additional Plan employees serve as ad hoc staff to the committee as needed.

Policy Committee
The policy committee is charged with the development, review, revision, and implementation of medical, behavioral health, pharmacy, utilization management, and reimbursement policies. Industry norms and clinical research are included in the evaluation of each clinical issue. The committee reviews and researches potential and actual coverage and contract issues, provides continuity in contract interpretations, and ensures the implementation of associated policies (e.g., technology assessment and policy development). New practice patterns and member and provider requests for new services are evaluated to determine potential benefit and contract coverage and related policy changes. The committee ensures consistency between member health programs and utilization policy.

Revised January 2020
14-5
The committee is an interdepartmental team consisting of a medical director and representatives from finance, government programs, configuration, internal operations, medical affairs, healthcare network strategy, pharmacy services, business development, special investigations unit, application management, and resource coordination.

Minutes are reported to the UMC and upward through the QMC to the board of directors. The committee is supported by provider consultants and workgroups as needed to lend clinical or operational expertise to the review activities.

**Joint Health Services Committee**

CDPHP entrusts others to deliver specified services to its members and thus has entered into mutual agreements to perform precise activities. Separate documents clearly delineate the Plan's oversight and responsibility for individual delegated activities.

These include the functions and methodology used to evaluate and assess delegated activities on a regular basis in accordance with CDPHP policies and procedures. The CDPHP board of directors and QMC have delegated to the joint health services committee the responsibility to monitor delegation oversight and coordination of delegated activities regarding first downstream entities (FDRs) and all other delegates.

The CDPHP Joint Health Services Committee consists of all CDPHP delegates: pharmacy vendor (CVS/Caremark); Medicare complex care coordination vendor (Landmark Health, LLC); program oversight of NYS DOH Health Homes for Medicaid Select and HARP members; physician and hospital online directories vendor (Healthsparq dba Clarus Health System); Child Health Plus, Essential Plan and Medicaid dental vendor (Delta Dental); Medicare preventive dental vendor (Delta Dental); credentialing and recredentialing at specific sites. The senior vice president, health care quality and the accreditation and quality program manager co-lead the joint health services meeting and other members include representatives from the delegated entities and the CDPHP delegation team, including a medical director, quality, behavioral health, resource coordination, care management, credentialing, customer service, government programs, corporate compliance, IT security, and network services staff. CDPHP delegates develop agendas in consultation with and approval by the CDPHP delegation team.

Through approval of a delegate's activities, annual evaluation, and routine reporting, CDPHP will identify any deficiencies in the delegate's processes, clinical care, and services provided to health plan members. The health plan will work with the delegated agency to correct deficiencies identified, and if the deficiencies are not corrected, the health plan may revoke the delegation arrangement. The committee meets quarterly and submits results of its activities to the quality management committee (QMC) and the board of directors.

**Joint health services committee responsibilities include, but are not limited to:**
- Approve written delegation agreements, quality management evaluations, programs, and work plans.
- Approve pre-delegation assessment evaluation audit.
- Review quarterly reports containing results of delegated activities including any corrective action plans as indicated.
- Conduct annual oversight of all delegates through annual reporting requirements.
- Monitor delegate requests for member experience and clinical performance data.
- Ensure delegates’ adherence to CDPHP policies, procedures, and QI goals.
- Pursue corrective action plan (CAP) for areas not meeting standards and consider delegate termination where applicable.

Refer to the CDPHP Quality Management Program Description 2019 for details regarding the delegated functions for each UM delegate.

**Behavioral Health Utilization Management Committee**

Participating providers, representing the behavioral health specialties, provide advice and recommendations concerning utilization management related to behavioral health, as well as expert opinions on behavioral health issues. Discussions include the development, approval, and review of policies; recommending procedures for benefit coverage by assessing technologies, medical interventions, and drugs in terms of efficacy and safety; recommending revisions to the member benefit package; monitoring utilization trends; development/selection of industry standard medical necessity/clinically appropriate screening criteria used for UM decision-making; and monitoring timely resolution of UM determinations and service indicators.

The committee members are responsible for sharing information relative to trends in the behavioral health industry and exchanging ideas on how to effect better outcomes with specific populations. Their scope includes all CDPHP lines of business except Medicaid HARP.

The primary goal is to impact the behavioral health community by moving them toward the fulfillment of the CDPHP health value strategy. The committee meets four times a year, is chaired by the CDPHP vice president, behavioral health and medical integration, and includes representatives from psychiatry, psychology, social work, pediatrics, and substance abuse treatment. Committee minutes are reported to the UMC, QMC, and then to the board of directors.
HARP Utilization Management Committee

The HARP-UM committee consists of participating providers, representing behavioral health specialties, and provides advice and recommendations concerning utilization management related to behavioral health for the members of the CDPHP Medicaid HARP product, and provides expert opinions on behavioral health issues. Discussions include the development, approval, and review of policies; recommending procedures for benefit coverage by assessing technologies, medical interventions, and drugs in terms of efficacy and safety; recommending revisions to the member benefit package; monitoring utilization trends; development/selection of industry standard medical necessity/clinically appropriate screening criteria used for UM decision-making; and monitoring timely resolution of UM determinations and service indicators. The committee meets four times a year, is chaired by the CDPHP vice president, behavioral health and medical integration, and includes representatives from psychiatry, psychology, social work, pediatrics, and substance abuse treatment.

The committee shall submit results of its activities to the utilization management committee, which reports through the quality management committee to the board of directors.

HARP Quality Stakeholder Advisory Group

The HARP quality stakeholder advisory group (QSAG) is chaired by the vice president behavioral health and medical integration, and led by the behavioral health quality specialist. Stakeholders in an advisory capacity are members, family members, peer specialists, providers, plan subcontractors, regional planning consortium (RPC), and/or other member-serving agencies. The committee meets at least quarterly, reports to the HARP-UM committee, and maintains records documenting attendance, findings, recommendations, and actions. It is responsible for carrying out the planned activities of the HARP behavioral health quality management program and is accountable to and reports regularly to the HARP behavioral health UM committee concerning BH QM activities for the Medicaid HARP line of business only.

The HARP QSAG members review and provide input on service or clinical quality monitors, preventive and clinical practice guidelines, and care management activities. They provide expert opinions on behavioral health issues, encourage and promote communication between CDPHP and the BH provider network, review and provide input for satisfaction surveys, share information relative to trends in the behavioral health care industry, and share ideas and recommendations for effecting better outcomes with specific populations. The committee's mission is to exchange ideas on how to effect better treatment outcomes and review the findings of BH-specific quality improvement initiatives, performance improvement projects, and focused studies.

Quality Stakeholder Advisory Group

The quality stakeholder advisory group (QSAG) is chaired by the vice president behavioral health and medical integration and led by the behavioral health quality specialist. The committee meets at least quarterly, reports regularly to the behavioral health UM committee, and maintains records documenting attendance, findings, recommendations, and actions. It is responsible for carrying out the planned activities of the behavioral health quality management program and is accountable to and reports regularly to the behavioral health UM committee concerning BH QM activities for all lines of business except HARP.

The QSAG members are responsible for sharing information relative to trends in the behavioral health industry and exchanging ideas on how to effect better outcomes with specific populations. The QSAG shall review the findings of BH-specific quality improvement initiatives, performance improvement projects, and focused studies.

Pharmacy and Therapeutics (P&T) Committee

The role and function of the pharmacy and therapeutic (P&T) committee is to ensure that the most clinically appropriate and cost-effective drugs will be available for the plan's members. The committee recommends the adoption of policies regarding evaluation, selection, and therapeutic use of drugs, recommends or assists in the formulation of programs to meet the pharmaceutical needs of practitioners, and recommends and maintains the plan's formularies in accordance with pharmacy policies and procedures.

The P&T committee consists of practicing physicians and pharmacists, appointed by the plan's board of directors, who represent a cross-section of primary care physicians and specialties from the plan's practitioner panel. The members of the P&T committee are bound by a confidentiality and conflict of interest agreement, which is renewed annually and as necessary. A staff medical director from the plan chairs the committee. Up to five pharmacists from participating pharmacies may be invited to attend meetings as consultants to the committee. Other plan partners may also be invited to attend the committee meetings as consultants. The plan's medical affairs representatives, the senior vice president of clinical integration and chief pharmacy officer, director of pharmaceutical care programs, managed care pharmacists, and representatives from the plan's pharmacy benefits management company serve as presenters and consultants to the committee. The P&T committee meets every other month with a recess in August. Committee minutes are forwarded through the QMC to the board.
Roles, Reporting, and Resources

Executive Vice President, Medical Affairs, Chief Medical Officer
Reports to the president/CEO and board of directors for the overall strategic direction, leadership, management, development, and operations of the medical management plan, quality improvement, and resource coordination initiatives in accordance with regulatory, accreditation, and corporate objectives. Responsible for ensuring delivery of high-quality, cost-effective medical services to CDPHP members.

Senior Vice President, Primary Care Services
Reports to the executive vice president, chief medical officer. Serves as a liaison between the physician community and the Plan’s management. In addition to participating in the daily activities of a medical director (as needed), provides oversight to the physician engagement team to promote and monitor the progress of the Enhanced Primary Care program (EPC). Assists the executive vice president, chief medical officer with the implementation of the Plan’s medical management, quality improvement, and resource coordination initiatives, along with other key strategic initiatives in accordance with regulatory, accreditation, and corporate policies and strategic plan. Also participates in medical advisory committees, including functioning as chairman of the pharmacy and therapeutics committee.

Physician Engagement Specialist
Reports to the senior vice president, primary care services. Responsible for introducing, presenting, and promoting health value initiatives to network providers at their office or other preferred locations. Establishes and maintains relationships with physician practices to engage and successfully implement medical affairs’ health value initiatives (e.g., physician quality and efficiency pilots, quality gain-sharing projects, and other partnering opportunities for providers).

Vice President Medical Affairs, Senior Medical Director
Reports to the executive vice president, chief medical officer. Responsible for providing direct oversight to the other medical directors as well as the medical policy analyst. Provides oversight of utilization management including resource coordination policy development via the pre-policy development and policy committees, and retrospective review of UM determinations for consistency and corrective action where applicable. Also provides oversight of the training and mentoring of the UM staff in order to promote consistency and ensure inter-rater reliability. Additionally, serves as the chairperson on the utilization management committee, which is comprised of participating providers from various medical specialties who provide input and recommendations regarding medical policy and utilization management activities. As part of UMC, monitors utilization trends to address both over- and underutilization of resources and uses this information to contribute to strategic planning for CDPHP.

Medical Directors
Reports to the vice president medical affairs, senior medical director. Responsible for assisting with ensuring compliance with the plan’s quality management, pharmacy, and resource coordination programs. Responsibilities will be carried out by participating as active member in medical advisory committees, providing leadership to and serving as a liaison between the physician community and the plan’s management.

All medical directors share actively in day-to-day UM case review and determinations as well as the appeals process. This includes clinical oversight of complex cases, interfacing with providers to gather complete information, and making suggestions for case management interventions when appropriate.

Senior Vice President, Medical Affairs Operations
Reports to the senior vice president, primary care services. In conjunction with the UMC, responsible for the overall development, direction, monitoring, and evaluation of an effective clinical resource coordination program for all lines of business. This will include a system of prospective, concurrent, retrospective, and active utilization management programs administered through a care management/chronic condition support model that promotes appropriate, cost-effective delivery of health services. Responsible for an active ambulatory review and coding program that includes pre- and post-payment review of the appropriateness for care delivery; interventions with providers and members in the management of effective utilization initiatives.

Director, Utilization Management
Reports to the senior vice president, medical affairs operations. Responsible for the development and execution of processes to assess the medical appropriateness of benefit utilization by CDPHP membership and the supportive correct coding. This position oversees prospective review, concurrent review, and retrospective review and coding functions. Through ongoing assessment of utilization trends, the director will make suggestions regarding benefit package revisions, facility and vendor contracting opportunities, and changes to prior authorization requirements. The director will also evaluate utilization trends and trigger coding audits as appropriate.

Manager, Utilization Review
Reports to the director, utilization management. Responsible for the oversight of prior authorization and assessment of the medical appropriateness of benefit utilization. This includes services rendered by both participating and non-participating providers. Processes address prior authorization review, close review of all out of network requests, and timely closure of all cases to ensure prompt payment of claims. Collaborates with providers to ensure appropriate utilization of member benefits. Works closely with medical directors to identify a corrective plan of action if aberrancies are identified. Ensures that all processes comply with all regulatory and accreditation standards.
**Utilization Review Nurse**
Reports to the manager, utilization review. Responsible and accountable for coordinating prior authorization of services and using established criteria to determine case outcome. Cases that are complex in nature or do not meet medical necessity criteria are forwarded to a medical director for review and decision. Focus to include non-par utilization.

**Manager, Utilization Review & Ambulatory Review and Coding**
Reports to the director, utilization management. Responsible for the oversight of prior authorization and assessment of the medical appropriateness of benefit utilization and coding. This includes services rendered by both participating and non-participating providers. Processes address prior authorization review, close review of all out of network requests, and timely closure of all cases to ensure prompt payment of claims. Ensures appropriate utilization of members’ benefits and appropriate coding. Works closely with medical directors to identify a corrective plan of action if aberrancies are identified. Ensures that all processes comply with all regulatory and accreditation standards.

**Supervisor, Ambulatory Review and Coding**
Reports to the manager, utilization review and coding. Responsible for attaining procedure and diagnosis coding accuracy and consistency on referred cases. Performs and coordinates the clinical component of the provider appeal function. Supports provider audit functions including assessment of coding, practice trends and evaluation of programs, and recommends areas for improvement. Researches new technology or services and recommends updates to medical policies.

**Manager, Inpatient Programs**
Reports to the director, utilization management. Responsible for the oversight and assessment of medical appropriateness related to inpatient services; including hospital, skilled nursing facility and physical rehabilitation facilities. This includes services rendered by participating and non-participating facilities. Oversight of the inpatient care coordinators and partnering with facility personnel to ensure that members are moving along the continuum of care in a timely manner, monitoring for potential quality of care issues, and identifying and referring members as appropriate to case management. Works closely with medical directors to identify a corrective plan of action if aberrancies are identified. Ensures that all processes comply with all regulatory and accreditation standards.

**Inpatient Care Coordinator**
Reports to the manager, inpatient programs. Responsible for assessing the medical necessity of inpatient admissions and continued stay by adhering to MCG®. Collaborates with the inpatient manager and medical directors as necessary to meet care coordination needs for CDPHP members. Works collaboratively with facility personnel to ensure that members are moving along the continuum of care in a timely manner, monitoring for potential quality of care issues, and identifying and referring members as appropriate to case management. Responsible for on-site and/or telephonic utilization at inpatient hospitals, skilled nursing facilities, and physical rehabilitation facilities.

**Director, Care Management**
Reports to the senior vice president, medical affairs operations. Responsible for the development and execution of innovative care management programs that target our most at-risk members, increasing the quality of health care our members receive, and reducing overall health care costs for those members. The program design complements the medical home model and is modified to meet the unique needs of each diverse member population. Oversees case management, HARP case management, and Medicaid long-term services, and the medical affairs triage line.

**Manager, Care Management and Medicaid Long Term and Support Programs (LTSS)**
Reports to the director, care management. Responsible for the execution of day-to-day activities of CDPHP care management and Medicaid long term services programs, including oversight of all regulatory requirements and departmental metrics. Responsible to track and trend all reporting for care management.

**Supervisor, Care Management**
Reports to the manager, care management and Medicaid LTSS. Responsible for the execution of day-to-day activities of the complex care management program. This includes hiring and training care management staff, monitoring daily program activity, enforcing policies and procedures, and collaborating with physicians, NYSDOH, and vendors and ensuring that the needs of CDPHP members are met during the case management episode of care.

**Manager, HARP Utilization Management and Case Management**
Reports to the director, care management and the director, behavioral health operations in a matrix position. Responsible for the oversight of day-to-day activities of the HARP case management program including compliance of all regulatory requirements and departmental metrics. Responsible to track and trend all reporting for HARP case management and utilization management.
**Supervisor, HARP Case Management**

Reports to the manager, HARP case management. Responsible for the execution of day-to-day activities of the HARP case management program. This includes hiring and training case management staff, monitoring daily program activity, enforcing policies and procedures, collaborating with physicians and vendors, and ensuring that the needs of HARP members are met during the care management episode of care.

**Registered Nurse, Case Manager**

Reports to the supervisor, care management and/or supervisor HARP case management. Responsible for coordinating the care of CDPHP members who meet case management criteria across the continuum of care. Ensures and facilitates the achievement of quality, clinical, and cost outcomes and procures and coordinates services and resources needed by the members and their families. Provides face-to-face or telephonic assessments, and develops an individualized plan of care addressing both medical needs and social determinants of health.

**Social Worker Case Manager**

Reports to the supervisor, care management and/or supervisor HARP case management. Responsible for assessing the psychosocial and financial needs of CDPHP members and their families, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for community-based services to meet specific members’ needs.

**Certified Diabetes Educator**

Reports to the supervisor, care management. This role is performed by health care professionals with specialized credentials consistent with the particular profession’s scope of practice. Diabetes self-management education is the interactive, collaborative, ongoing process involving the person with diabetes or pre-diabetes. The process includes:

- Assessment of the individual’s specific education needs.
- Identification of the individual’s specific diabetes self-management goals.
- Education and behavioral intervention directed toward helping the individual achieve identified self-management goals.
- Evaluation of the individual’s attainment of identified self-management goals.
- Proper documentation of all education encounters.

**Certified Asthma Educator (AE-C®)**

Reports to the supervisor, care management. Promotes optimal asthma management and quality of life among individuals with asthma, their families, and communities by advancing excellence in asthma education. The process includes patient education, symptom management, identification of triggers, and development of self-management goals and asthma action plans.

**Behavioral Health Case Manager**

Reports to the supervisor, care management and/or supervisor, HARP case management. Responsible for coordinating recovery-oriented care of CDPHP members with mental health, substance use disorder, and comorbid medical disorders who meet criteria for episodic or complex case management. Provides face-to-face or telephonic assessments, referrals, and benefit-related counseling to members. Works collaboratively with the member and all applicable internal and external resources, including hospital clinical staff, to plan and monitor care options and to offer treatment recommendations to address members needs and decrease probability for inpatient readmission. Monitors member utilization of services (over and under), as well as outcomes in the inpatient facility setting and in the community.

**Supervisor, Medicaid Long Term and Support Programs (LTSS)**

Reports to the manager, care management and Medicaid LTSS. Responsible for day to day oversight of the case management program activities and utilization management for LTSS. Performs quality assurance assessment and call monitoring on open complex cases and provides feedback to staff. Responsible to track and monitor monthly care management metrics and provides feedback to staff on a monthly basis.

**Registered Nurse Assessor Long Term and Support Programs (LTSS)**

Reports to the supervisor, Medicaid LTSS. Responsible for conducting the initial assessments and reassessments for members enrolled in a Medicaid LTSS program using the Uniform Assessment System (UAS). Responsible for developing, monitoring, and revising the members individualized Person Centered Service Plan (PCSP) and proposed services within the Plan’s benefit package to meet the member’s needs, in conjunction with the care manager.

**Medicaid Special Programs Registered Nurse Case Manager**

Reports to the supervisor, Medicaid LTSS. Responsible for coordinating the care of CDPHP members who meet case management criteria across the continuum of care, ensuring and facilitating the achievement of quality, and clinical and cost outcomes. In addition, responsible for coordinating requests for prior authorization received for all LTSS services via the telephone line, fax machine and mail.

**Care Coordinator Long Term and Support Programs (LTSS)**

Reports to the supervisor, Medicaid LTSS. Responsible for working collaboratively with the Medicaid LTSS case manager, to provide expertise in conceptualizing and implementing effective outreach and engagement initiatives, with a population that can be hard to reach. Assists with member and provider outreach calls, coordination of required six month provider visits and in-home assessments. Outreach may include, but is not limited to member communication regarding gaps in care and preventive health opportunities, member and provider education, communication campaigns, and medical management referrals.
Manager, Chronic Conditions Program
Reports to the senior vice president, medical affairs operations. Responsible for the implementation, coordination and general management of chronic conditions program. This program falls within the CDPHP coordinated and cohesive Population Health (PH) strategy. In addition, designs programming and campaigns that positively impact the health of people with chronic conditions. Collaborates in the annual CDPHP population analysis process, evaluates existing programming and plans appropriate changes. Works closely with other PH programs and provides expertise on chronic condition management solutions. Represents both the PH strategy and the chronic condition programs and attends meetings for assigned committees, workgroups and teams. Participates in program data collection, reporting and analysis and is responsible for the execution of day-to-day activities of the chronic conditions team.

Chronic Condition Nurse
Reports to the manager, chronic conditions program. Responsible for making targeted outreach to members related to health condition and chronic condition management. The goal of interactions is to help identified members understand their chronic condition and motivate each member to maximum engagement in their health care plan. Determines with each member, the number of interactions and frequency of interaction necessary for each individual member to attain their highest health status. Acts as a clinical resource to the chronic condition coordinator and together, they prepare outreach campaign messaging and scripts for mail, e-mail, text and phone messaging campaigns.

Chronic Condition Coordinator
Reports to the manager, chronic conditions program. Responsible for and in collaboration with clinical staff, prepares materials for chronic condition outreach campaigns and plans and executes outreach campaigns throughout the year. Makes targeted and scripted outbound calls to members and outreach may include, but is not limited to, member communication about gaps in care, member education, communication campaigns, and medical management referrals.

HIV RN Specialist
Reports to the manager, chronic conditions program. Responsible for monitoring, tracking and reporting the viral load on all members identified with HIV. Develops processes for identifying new cases and obtaining viral load data. Builds relationships with local care providers and community partners and collaborates in coordinating care, as required by NYS AIDS Institute. Provides a heightened level of support to those members who need it, with the goal of ensuring members are receiving appropriate treatment. Acts as the clinical resource for all HIV campaigns and related messaging and provides member/community education when appropriate. Outreach includes, but is not limited to, health education related to other chronic health conditions and member communication about gaps in care.

Medical Policy Analyst
Reports to the vice president medical affairs, senior medical director for the overall development, monitoring, implementation, and evaluation of policies and procedures for resource coordination. Responsible for policy development of external resource coordination policies and procedures, ensures compliance with documentation standards, review dates, and regulatory requirements, research of evolving medical and behavioral health technologies and new applications to existing technologies, actively participates on the policy committee, maintains an annual review schedule for existing external resource coordination policies, and stays up to date with current medical trends, technology, and treatment modalities. Interfaces with internal departments to ensure policies can be operationalized and to provide continuity in policy interpretation.

Senior Vice President of Clinical Integration and Chief Pharmacy Officer
Reports to the president/CEO. Responsible for managing all aspects of clinical and administrative pharmaceutical management and pharmaceutical benefit management (PBM), including contract negotiations and management. Oversees the development and implementation of clinically appropriate quality monitoring programs and coordinating the requirements of key constituents and stakeholders, leading to recommendations and implementation of action plans to maintain quality and recognition for all aspects of the Plan’s business.

Director, Pharmaceutical Care Programs
Reports to the senior vice president of clinical integration and chief pharmacy officer. Responsible for developing programs, policies, and benefit designs to address the pipeline of biotech and specialty drugs. Serves as the clinical thought leader for pharmaceutical care and drug therapy services and programs, including medication therapy management and the coordination with case management, chronic condition support, and population health and wellness initiatives. In addition, responsible for engaging with physicians, pharmaceutical companies, and other contributors to review innovative therapies introduced to the market to understand, translate, recommend, and educate internal and external stakeholders.

Director, Pharmacy Care Management
Reports to the director, pharmaceutical care programs. Responsible for the development and execution of clinical pharmacy services across the membership. Works across departments to focus efforts on improving the health and quality of care of our members through proper medication use. In addition, collaborates with primary care providers, specialists, pharmacists, and other care team members to foster relationships and strategies to improve the quality and overall cost of care as it relates to use of pharmaceuticals. Also, oversees the post-graduate pharmacy residency training program.
Manager, Formulary and Clinical Pharmacy Operations
Reports to the senior vice president of clinical integration and chief pharmacy officer. Responsible for assisting the senior vice president of clinical integration and chief pharmacy officer in the management of pharmacy benefits and clinical functions, including formulary management, DUR clinical safety reporting and analysis, new drug evaluation, and coordination of the Plan's pharmacy and therapeutics committee. Serves as the lead and business owner in the following functional areas: formulary and pharmacy policy development processes for the commercial lines of business, supervision of managed care pharmacists and technical staff, prior authorization request and medical exception process, and National Committee for Quality Assurance (NCQA).

Manager, Medicare Pharmacy Programs
Reports to the director, pharmaceutical care programs. Responsible for all pharmacy program oversight for Medicare, including policies, formulary development, benefit and program designs, compliance and delegation, DUR clinical safety reporting, Medicare Stars, and medication therapy management. Serves as the lead and business owner for the following functional areas for the Medicare line of business: formulary and pharmacy policy development, including formulary utilization management and CMS formulary submissions; manager of pharmacy staff, including Medicare managed care pharmacists, as well as clinical consultant pharmacists for medication therapy management, medical exception process, and procedures; Medicare Stars Part D requirements and medication therapy management requirements; management; medical exception process and procedures.

Manager, Medicaid Pharmacy Programs
Reports to the director, pharmaceutical care programs. Responsible for all pharmacy program oversight for Medicaid, including policies, formulary development, compliance with state requirements, DUR activity and reporting, and support of pharmacy-related Medicaid member care coordination needs. Serves as the lead and business owner for the following functional areas for the Medicaid line of business: formulary and pharmacy policy development, Department of Health (DOH)-required report submissions, DOH formulary submissions, assurance of web site posting accuracy as required, assurance that medical exception process standards are met, and clinical pharmacist support of pharmacy care coordination needs within the Medicaid membership. Works across departments to address and support other company and DOH initiatives as well.

Managed Care Pharmacists
Report to either the director, pharmaceutical care programs, manager, formulary and clinical pharmacy operations, or the manager, Medicare pharmacy programs. Responsible for assisting the senior vice president of clinical integration and chief pharmacy officer with clinical and operational functions. The clinical functions include formulary management, coordination of the P&T committee, pharmacy policy development and maintenance, drug utilization reporting and analysis, medication therapy management, review of medical exception requests, pharmacy benefit design and marketing, the physician incentive program, establishment of cost-management programs, pharmacy data analysis, and serving as a pharmacy resource for internal clients such as case management. The operational functions include, but are not limited to: configuration of the pharmacy benefit designs, coordination of benefits, claims adjudication testing, enrollment and group set-up, and member/pharmacy/practitioner notifications. Establish relationships with physician practices to engage and successfully implement medical affairs’ health value initiatives as they relate to pharmaceutical care, quality, and efficiency.

Supervisor, Pharmacy Benefit Specialist
Reports to the manager, formulary and clinical pharmacy operations. Responsible for the oversight of day-to-day activities within the pharmacy operations department. This includes training staff and monitoring daily pharmacy turnaround times and phone statistics to meet regulatory requirements, enforcing policies and procedures, and generally ensuring that the needs of CDPHP members are met while conducting prior authorization duties.

Vice President Behavioral Health and Medical Integration
Reports to the senior vice president, medical affairs operations. Responsible for directing all clinical aspects of the administration of the behavioral health benefit including policies and procedures and utilization management of inpatient and outpatient services to treat psychiatric and substance use disorders. Assesses health needs of the membership and plans for early identification and prevention of BH illnesses. Creates and implements solutions that promote data-driven, evidence-based and patient-centered care informed by social determinants of care. Develops ways to measure and report outcomes for both the Plan and the network providers, including performance benchmarking. Implements initiatives to improve the adoption of evidence based medicine by the BH network to ensure quality outcomes, as evidenced by HEDIS and New York State (NYS) quality measures. Addresses the shortage of psychiatric providers through the promotion of promote the integration of BH with primary care tele-psychiatry.

Director, Behavioral Health Operations
Reports to the senior vice president, medical affairs operations to provide for the administration of a comprehensive managed behavioral health care program. Responsible for budget, direct and indirect supervision of employees, strategic partnering with behavioral health providers to ensure a robust network for both inpatient and outpatient services, oversight of utilization of services with special attention to preventing over- and underutilization, and integration of behavioral health into all facets of medical management activities. Provides strategic operational oversight of the following: clinical
administrative operations of the program, quality control, utilization management, customer service, and workflow. Monitors clinical performance of the unit through regular reviews of clinical documentation, regular clinical supervision meetings, and attendance at psychiatric reviews.

**Manager, Intake Crisis Children’s Medicaid Behavioral Health**
Reports to the director, behavioral health operations. Responsible for the administrative and clinical leadership of the behavioral health services provided to Medicaid recipients under age 21. In addition, responsible for the coordination of crisis services within the community to ensure that resources are available for all CDPHP members and particularly CDPHP Medicaid members (including HARP and under age 21). Monitors the behavioral health access center’s phone and authorization metrics, and daily program activity, training staff, and enforcing policies and procedures. Works with internal departments and oversees the crisis training for CDPHP.

**Clinical Intake Specialist**
Reports to the manager, intake crisis children’s Medicaid behavioral health. Serves as the entry point for members, providers, and internal behavioral health inquiries. Uses established guidelines to conduct telephonic assessments, collect information, create authorizations, and assist with appropriate referrals. Under the clinical supervision of the behavioral health medical director, assesses overutilization of outpatient mental health and substance abuse treatment through ambulatory quality review of medical records.

**Supervisor, Behavioral Health Care Coordination**
Reports to the director, behavioral health operations. Responsible for oversight of the execution of day-to-day utilization review and care coordination of members’ behavioral health needs during hospitalization. Provides identification of potential quality of care issues and development of plans at health care facilities that will reduce the potential for unplanned readmissions and provide access to services along the health care continuum. Oversees the training and education of the inpatient behavioral health care coordinators, monitoring their daily activity, enforcing policies and procedures, and ensuring appropriate application of MCG®; and NYS LOCADTR 3, patient placement criteria. Works collaboratively with many departments within CDPHP to meet the needs of members during inpatient confinement and immediately following.

**Behavioral Health Care Coordinator**
Reports to the supervisor, behavioral health care coordination. Responsible for assessing the medical necessity of inpatient admissions and continued stay using MCG®; NYS LOCADTR 3, patient placement criteria, as well as assessing discharge planning needs for CDPHP members. In addition, responsible for on-site and/or telephonic utilization review duties at inpatient psychiatric and substance abuse facilities for concurrent review and medical necessity. In addition, responsible for ensuring that a comprehensive discharge plan is in place prior to discharge.

**Quality Specialist, Behavioral Health**
Reports to the director, behavioral health operations. Responsible for overall administration, evaluation, planning, and implementation of behavioral health HEDIS and NCQA metrics. In addition, responsible for the execution of day-to-day activities of CDPHP behavioral health NCQA and HEDIS, including the development, implementation, and evaluation of outreach to providers and targeted member outreach. Works in a collaborative role with quality, care management, medical and behavioral case management, pharmacy, and the physician engagement team.

**Director, Credentialing and Appeals**
Reports to the senior vice president, health care quality. Responsible for the overall management, administration, evaluation, and planning of the member and provider complaints, grievances, and appeals (CGA) department, and the credentialing department. Ensures that processes are effectively implemented for all CDPHP products, including management of daily operations, staff performance management, achievement of regulatory timelines, and oversight of critical issues including, but not limited to all functions of CGA and the physician credentialing process. In addition, responsible to ensure delegation management and delegation oversight is completed within CDPHP requirements. Provides expertise and general support to teams in reviewing, researching, investigating, negotiating, and resolving all types of complaints, appeals, and grievances, as well as credentialing applications. Oversees appeals and grievance issues, implications, and decisions and analyzes and identifies trends for all complaints, appeals, and grievances. Communicates with appropriate parties such as state, federal, NCQA accreditation, and HEDIS as it relates to CGA, credentialing, and re-credentialing functions.

**Project Oversight Manager, Appeals**
Reports to the director, credentialing and appeals. Responsible for the preparation and presentation of regulatory audits. Implements policy and procedure updates as well as appeal/complaint reference tools. Provides staff education, delegation oversight, manages regulatory reports, submits appeals quarterly reports, maintains appeals correspondence library, implements NYs mandates, performs quality assurance checks, and monitors staff workload.

**Clinical Appeals Specialist**
Reports to the director, credentialing and appeals. Responsible for ensuring that a member/provider appeal and grievance process that meets state, federal, accreditation, and other regulatory requirements is used. Using knowledge of clinical nursing and medical practice, reviews medical necessity and renders determinations about appropriateness of care and
expedited cases within established criteria and contract requirements. Cases that are complex in nature or do not meet medical necessity criteria are forwarded to a medical director for review and decision. Responsible for tracking, trending, and monitoring appeals and grievances and external reviews and making recommendations for change. Also responsible for oversight of the external review process.

Senior Appeals Analyst
Reports to the director, credentialing and appeals. Responsible for the timely and accurate research, investigation, documentation, and response to all non-clinical member/provider complaints, grievances, and appeals. Works closely with the corporate compliance department to assist in the research, investigation, and response to all government regulatory agencies or related external entity complaints. Completes weekly quality review on randomly selected appeals, provides educational coaching, and tracks and trends errors to determine root cause. In addition, responsible for providing coverage and assists with logging and triaging complaints, appeals, and grievances as needed.

Senior Quality Complaints Coordinator and Delegated Vendor Analyst
Reports to the director, credentialing and appeals. Responsible for the timely research, documentation, grade determination, and response letters to members and providers for administrative quality of care and quality of service member complaints according to regulatory processing timelines. In addition, responsible for the complaint, grievance, and appeal oversight of Delta Dental.

Medicare Appeals Analyst
Reports to the director, credentialing and appeals. Responsible for the timely and accurate triage, research, investigation, and documentation of Medicare appeals and grievances. In addition, responsible for tracking, trending, and monitoring Medicare appeals and grievances and coordinating responses to CDPHP internal departments and external regulatory agencies as it relates to determinations made within the Medicare process.

Resource Coordination Program Scope
The resource coordination program includes the monitoring and evaluation of services delivered across the health care continuum. This includes behavioral health care and substance abuse services. Below is a list of services included in the scope of the CDPHP resource coordination program:

- Prior authorization and review
- Admission review/concurrent review
- Retrospective review
- Member appeal and complaints
- Member outreach and engagement
- Medical and behavioral health case management
- Long Term Supports and Services Program (LTSS)
- Care transitions
- Chronic condition support
- Technology assessment and medical policy development
- Ambulatory review and code auditing
- Behavioral health services
- Appropriateness of plan-wide, product-specific, and individual practitioner/practice site utilization
- Pharmacy and formulary management
- Consistent application of medical necessity/medical appropriateness criteria in UM decision-making
- Member and practitioner/provider satisfaction with the resource coordination department and related services and processes
- Clinical criteria development and/or selection
- Delegation oversight

Program Components
Requests for authorization of care and clinical services are performed by the CDPHP resource coordination department staff using approved resource coordination policies; MCG®; Care Advance Enterprise Standard Clinical Content Package; Hayes: Medical Technology Directory, Health Technology Brief, Genetic Test Evaluation Program, and Technology Prognosis; LOCADTR 3 patient placement criteria and the clinical experience of the professional nursing staff, licensed mental health clinicians, pharmacists, medical directors, physician consultants, and the utilization management committee.

After reviewing medical information provided by the requesting physician, hospital, and/or office medical records and, when appropriate, physician-to-physician communication, the member's individual needs and the limitations of the local delivery system are considered and a medical necessity determination is made. UM determinations may be made on a prospective, concurrent, or retrospective basis for services requested or rendered by participating and non-participating practitioners and facilities.
Prior Authorization

Participating CDPHP physicians are required to obtain prior approval for certain elective medical and surgical services by contacting the resource coordination department prior to scheduling the services. Each request is reviewed for compliance with the CDPHP resource coordination policies and/or MCG®, NYS LOCADTR 3 patient placement criteria, to ensure medical appropriateness and benefit availability.

CDPHP-participating hospitals are required to notify the Plan of all admissions within 24 hours of admission, unless otherwise indicated in the provider’s contract, or the next business day for admissions that occur on a holiday or weekend.

Inpatient Review Process

The inpatient care coordinators are responsible for conducting a comprehensive review of all elective, urgent, and emergency admissions to participating and non-participating acute care, rehabilitation, and skilled nursing facilities. The focus of the inpatient review process is to determine the most appropriate level of care and setting by reviewing medical information related to the admission and continued stay. The organization adheres to the appropriate timeframes for timeliness for UM decision making, in accordance with the Review Process for Resource Coordination policy. Staff assists in coordinating discharge planning, researching, and identifying alternatives to current care for medically necessary services, and coordinating and referring cases to case management, chronic condition program, readmission avoidance, and other specialized programs as appropriate. Discharge planning and care coordination discussions with the PCP, attending physician, specialty consultants, ancillary service staff, hospital case management staff, and/or medical director occur as needed. Inpatient care coordinators are also responsible for identification and referral to the quality management department of any potential quality of care issues identified.

Admission Review

Review of inpatient admissions at both participating and non-participating facilities is conducted either on-site at the facility or by telephonic review. Inpatient care coordinators review clinical data and compare against established criteria, which include the CDPHP resource coordination policies, MCG®, and NYS LOCADTR 3, patient placement criteria. Cases not meeting defined criteria are referred to a medical director for review and determination of the medical necessity of care in the current setting.

Concurrent Review

Concurrent review of inpatient admissions at participating and non-participating facilities is also performed, using CDPHP resource coordination policies, MCG®, and NYS LOCADTR 3, patient placement criteria to determine the need for continued inpatient services. In addition to inpatient services, concurrent review is performed on other ancillary services including, but not limited to home care, hospice, and other services that require intensive case management intervention. Discharge planning and care coordination decisions may be discussed with the PCP, attending physician, specialty consultants, ancillary service staff, hospital case management staff, and/or medical director. If the inpatient care coordinator does not have sufficient information to justify the continued services, the case will be referred to a medical director for further evaluation and determination.

Retrospective Review

Retrospective review of health care services rendered in participating and non-participating facilities is conducted in cases of non-notification and select provider services to ensure medical necessity. Medical information related to the case is evaluated against CDPHP resource coordination policies and MCG®, and NYS LOCADTR 3, patient placement criteria to determine the appropriateness of services and level of care. In addition, all reviews assess the quality of health care services rendered. Cases not meeting criteria are referred to a medical director for review and determination.

Case Management—High-Risk Health Management

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual’s health needs. Education, coordination, and communication in relation to available resources are used to promote appropriate, cost-effective outcomes. CDPHP has a team of clinical staff that employs an integrated approach for managing high-risk members across the health care continuum. The goal of the case management program at CDPHP is to address the needs of the whole person, while assisting members with developing a self-management plan and identifying member-centric prioritized goals. Complex case management involves evaluation of the family needs, emotional problems, financial concerns, or social determinants that influence the health of the member. It encompasses effective communication with the patient, family, behavioral health case manager, medication therapy management (MTM), PCP, and specialty care provider (when appropriate) as a team.
Case management is available to all CDPHP members. Operating within Health Insurance Portability and Accountability Act (HIPAA) regulations, members are specifically identified for case management through multiple sources, which may include physician referral, predictive modeling software, the precertification process, inpatient continued stay review, community organizations, and the chronic conditions programs. Case management is also offered in community locations within neighborhoods where large numbers of Medicaid enrollees reside. Community-based face-to-face case management has demonstrated a significant increase in member engagement and greater opportunities for enrollment into case management services for high-risk populations. Recognizing the benefit of these face-to-face meetings, CDPHP expanded this service to all lines of business with continued success. As a result, case management will continue to partner with key stakeholders to increase face-to-face interventions across all lines of business.

Members may self-refer for case management services. To streamline the referral process, CDPHP has a secure and confidential line that members and providers can use to make a referral to the case management and chronic conditions programs. A member of the clinical team will facilitate enrollment into the appropriate program tailored to meet the member’s individualized needs. Complex medical case managers are working collaboratively with behavioral health case managers to identify and co-manage members with dual medical and behavioral health conditions. Co-management of dual diagnoses is targeted toward reduction of ER and hospitalizations for complex co-morbid cases, in addition to ensuring continuity of care for those with intensive care needs.

The goals of case management include:
- Enhanced member engagement
- Reduction of avoidable ER visits
- Reduction of readmission rates for chronic conditions
- Gap closure for those with chronic conditions
- Identification of members with dual medical and behavioral health conditions
- Enhanced health literacy
- Increased use of preventive health care services
- Removal of any barriers to accessing care
- Providing linkages to social work resources that can help address the social determinants of health

**Health and Recovery Plan (HARP)**

CDPHP has a dedicated team of medical case managers who work collaboratively with behavioral health case management to assist members with physical health, mental health, and substance use services in an integrated way. Case managers conduct face-to-face assessments and develop individualized care plans tailored toward member-centric interventions that address, medical needs, behavioral health needs, and social determinants of health.

**Embedded Case Management Program**

CDPHP provides embedded case management services on-site in select specialty practices and hospitals to facilitate face-to-face case management services, which enhances member and provider engagement. Based on the success of embedded case management in the specialty care setting, embedded case management has expanded to hospital crisis units and community behavioral health clinics.

**Community-Based Care Management and Care Coordination Program**

CDPHP provides embedded case management and care coordination services on-site at multiple community-based locations frequented by the Medicaid population. The face-to-face approach used in an environment that is familiar to the member and is effective for building relationships of trust and increases the likelihood of ongoing engagement in case management. Case management works collaboratively with community health specialists to expand our outreach capacity for linking members with resources within the Plan and linkage to primary care when applicable. Ongoing case management is offered to members with chronic conditions.

**Care Advance Enterprise**

CDPHP uses Care Advance Enterprise (CAE), a Trizetto application, to facilitate care management programs. CAE is a member-focused tool that houses data from disparate systems, applies business and clinical rules to the data, then automates manual tasks to streamline workflows and enhance productivity.

CAE has a number of applications. Clinical Care Advance (CCA) is used by CDPHP staff, primarily by care managers. CDPHP has created assessments, forms, letters, and care plans using clinical guidelines.

Within CCA, campaigns are created. Campaigns allow CDPHP to define a distinct member population (e.g., diabetics who have had a recent visit to the emergency department) and apply an automated action (e.g., send a letter or send names to a queue for a care manager to conduct outreach). Additional information (e.g., member biometrics data) is also housed in the tool and available for trending, analytics, and utilization reporting.
Readmission Avoidance Program Transitions of Care

Transitions of care are an integral part of a patient’s journey throughout a health care system. CDPHP offers a transitions of care program initiated during all inpatient admissions. Managing transitions effectively from the primary/specialty care into hospital care and from hospital into primary/specialty care are essential.

CDPHP uses data analytics to stratify members for the transitions of care program using the CDPHP readmission report, all members are stratified into high, medium and low risk and receive outreach based on stratification and risk. Members at our high-volume hospitals within our core counties are visited by a CDPHP Registered Nurse within 24 hours of admission. The goals of the program include:

- Offering case management support as part of the members’ discharge plan as needed for complex care.
- Perform a social determinants of health assessment that will impact the ability to receive care such as: housing, transportation, lack of family support, etc.
- Arrange for a 7-day follow up appointment with the members’ PCP and/or specialist
- Relays pertinent clinical information, discharge instructions, and current medication list to the primary care provider or specialist

Members admitted to lower volume facilities or those that are medium risk receive telephonic outreach within 24-48 hours post discharge and lower risk members are offered an autodialed call to allow for an opportunity to speak with a registered nurse (RN) if a concern arises. CDPHP strives to use analytic support to identify the most high need individuals for the transition program, although allows for contact with nursing support regardless of risk status.

Chronic Conditions Program

The chronic conditions (CC) program is a health coaching program that targets people who are living with HIV, asthma, chronic obstructive pulmonary disease (COPD), diabetes and/or hemophilia. Support for other chronic conditions (CAD, ESRD) is in the planning phase.

The program provides one-on-one telephonic education and support from an RN to members identified as high priority. The program also provides voice messaging (from providers) and mail education and support to members who are identified as medium to low priority. Text messaging and portal chat will be added as communication modes as these options become available.

The program focuses on condition specific education to help each member understand the steps they need to take to manage the condition and maintain their best health. As part of the health coaching program, other CDPHP services and benefits are also discussed and promoted whenever appropriate. For example: CaféWell virtual programs, Zipongo, food scripts, CDPHP Smoke-Free®, Propeller Health, MedCheck, Rx for Less, and DOH-approved incentives.

Member Appeals and Complaints

The appeals process provides the member or the member’s designee, physician, ancillary service provider, or facility an opportunity to have a medical necessity or benefit denial reviewed in compliance with the member contract. CDPHP ensures that all member complaints, grievances, and appeals are documented, acknowledged, investigated, tracked, handled, and resolved in a timely and fair manner, and in compliance with the member contract and regulatory requirements.

Ambulatory Review and Coding

The CDPHP ambulatory review and coding process includes pre- and post-payment review of complex hospital and physician claims to evaluate for medical necessity, benefit availability, quality of care, and appropriateness of coding. It also involves periodic provider/specialty targeted audits to analyze coding abnormalities, report findings, and identify opportunities for improvement.

Over- and Underutilization

As a managed care organization, CDPHP uses several resources to monitor and identify potential over- and underutilization at the plan-wide, product-specific, and individual practitioner levels. These Plan resources include utilization data from resource coordination data management, enrollment, HEDIS and other data, including member satisfaction survey results. When potential over- or underutilization is identified, CDPHP will implement appropriate plan-wide, product-specific, or practitioner-specific actions to address the identified issues and will re-measure to ensure resolution of the identified issues.

CDPHP has established reporting packages to assist with identifying variation in practice patterns. The reports are monitored monthly and findings are reported to the UMC annually. The UMC approves recommended corrective actions.

Behavioral Health Care Services

The CDPHP behavioral health department administers a comprehensive behavioral health care program inclusive of triage, referral, assessment, prospective, concurrent, and retrospective review for benefit determination, as well as episodic and complex case management services.
The behavioral health department is led by mental health clinicians who hold master's degrees, as well as a board-certified psychiatrist and addictionologist licensed to practice in New York State. In addition, the behavioral health department has arranged to use board-certified clinical peer reviewers when the clinical situation being reviewed is out of scope for the behavioral health medical director.

The behavioral health staff uses approved resource coordination policies, MCG®; and NYS LOCADTR 3, patient placement criteria when reviewing for sites of service and levels of care, based on medical necessity. All cases not clearly meeting the established criteria are reviewed by the behavioral health medical director or clinical peer reviewer. All determinations are made in accordance with established turnaround time and member/provider notification standards.

**Program Components**

- **Triage and assessment** – CDPHP has established a behavioral health access center to assist members and providers with securing behavioral health services inclusive of mental health services, as well as alcohol and substance abuse services. The access center is staffed from 8 a.m. to 6 p.m., Monday through Friday, with after-hours on-call staffing seven days per week. Staff verify eligibility, collect relevant clinical information, and determine the urgency of the situation to ensure that members are directed to the most appropriate provider/setting. Department protocols are in place to ensure that callers in crisis are appropriately handled.

- **Elective behavioral health services**—Outpatient services and requests for durable medical equipment for the treatment of a behavioral health condition are reviewed for medical necessity and contractual limitations by the clinical intake specialist under the supervision of a licensed behavioral health clinician and the behavioral health medical director.

- **Admission review**—Elective inpatient and residential behavioral health services must be medically necessary. This review and prior authorization process is conducted by the behavioral health care coordinator. Emergency admissions require notification by the admitting facility within 24 hours of the admission. Upon notification of admission, an admission review is conducted.

- **Concurrent review**—Members admitted for inpatient behavioral health services, whether or elective or emergent, are followed concurrently by a behavioral health care coordinator to ensure the member is in the most appropriate setting given the changes to the clinical status. During the concurrent review process, the behavioral health care coordinator collaborates with facility personnel to develop and execute discharge plans. Discharge plans are designed to address all aspects of the member situation that may result in relapse and/or readmission. Discharge plans are shared with behavioral health case managers who may follow the member post-hospitalization. In addition to inpatient services, concurrent review is performed on additional ancillary services that require intensive case management intervention.

- **Retrospective review**—CDPHP conducts post-payment review of specified services to evaluate for medical necessity, benefit availability, quality of care, and appropriateness of coding. In addition, periodic targeted audits may be conducted.

- **Case management services**—The CDPHP behavioral health care program has established a systematic approach to identifying members who may benefit from case management services. The goals of case management are treatment plan adherence and the prevention of relapse. The behavioral health staff work directly within the medical case management department. This whole person approach empowers members to take responsibility for their care while directing them to the plan and community services that are available. Behavioral health case managers are embedded in multiple hospital crisis units and community clinics.

In addition to these services, the behavioral health team is working with all aspects of resource coordination and quality enhancement to integrate behavioral health into all facets of our programs.

**Pharmacy Services**

The CDPHP pharmacy professional services department administers the pharmaceutical benefit to ensure that medication needs of Plan members are met in an effective manner. This is accomplished by interfacing with our pharmacy benefits management company, our specialty pharmacy, the P&T committee, and other departments as well as the practitioner community.

The department manages the Plan’s formularies. Medical exception requests are processed in the department for drugs not covered on a formulary. The department also reviews requests for drugs requiring prior authorization or exceeding quantity limitations based on department policies that are reviewed at least annually or as necessary for new pharmaceutical technology or treatment guidelines.

As part of the pharmacy services program, authorization requests are reviewed for medical necessity. These requests are reviewed by or under the supervision of a pharmacist registered in New York State. In the event that medical necessity cannot be justified, the case will be referred to a medical director for review and determination. The medical director will review individual patient circumstances, capacity of the delivery system, availability to provide care in an alternate setting, available practice guidelines, applicable contract benefits, and supporting pharmacy policies and procedures to render a determination. The medical director may also contact a board-certified physician of the same or similar specialty in the event that clinical peer review of the case is necessary. The medical director or clinical peer reviewer may also speak with the requesting provider. Medical directors are the only staff authorized to deny a service for medical necessity.
Health care services deemed not medically necessary result in an adverse determination. Members and providers are notified of the adverse determination by telephone and in writing. Timeliness of notification is determined by the classification of the request. Denial notifications include the reason for the denial as well as the appeal process available to the member and provider.

Adverse determinations may be given reconsideration when the medical director was unable to discuss the case with the PCP and/or requesting physician prior to the determination. The medical director who made the original decision may review requests for reconsideration. If no new medical information is provided or the reconsideration review results in an adverse determination, the member may submit a verbal or written request for a first-level appeal.

The department staff serve as presenters and consultants to the P&T committee, providing recommendations on pharmaceutical product reviews, formulary closures, policies, and procedures. The department serves as a resource to research pharmaceutical issues and questions for this committee and other departments within the Plan.

The department monitors utilization, clinical appropriateness, and economic measures to ensure that the Plan's pharmaceutical benefit is adequately meeting the needs of its members. The pharmacy department is focused on seeking out opportunities to assist Plan members with obtaining the highest clinical standards of pharmaceuticals at the most reasonable cost to the Plan and its members. To accomplish pharmacy goals and the corporate strategic goals of the Plan, the department must focus on strong partnerships with network providers, the Plan's pharmacy benefits management company, pharmacy vendors, and internal departments.

The pharmacy services department maintains the clinical drug formularies for the Plan at the direction of the CDPHP P&T committee. Each formulary consists of covered and non-covered (excluded) drugs. Quantity limitations, prior authorizations, and/or step therapy may apply. All new drugs are excluded from the formularies and require prior authorization review until reviewed by the P&T committee. CDPHP reserves the right to develop payment guidelines for new-to-market drugs not yet reviewed by the P&T committee.

These guidelines will be developed by the CDPHP medical directors and pharmacists and will be based on (but not limited to) the approved U.S. Food and Drug Administration (FDA) indications for the new drug. The CDPHP P&T committee developed a well-defined medical exception review process to ensure that practitioners may request an excluded drug or a new drug not yet reviewed by the P&T committee for a specific patient when determined medically necessary.

**Medication Therapy Management Programs**

The CDPHP pharmacy care management program, referred to as the MedCheck services, provides medication review services for CDPHP members. The program aims to identify at-risk members, taking a multidisciplinary approach to medication review, coordinating engagement with members with outreach and interventions by chronic condition support and CDPHP case management as appropriate. The traditional medication therapy management (MTM) program has expanded to our Medicaid and commercial lines of business and is now referred to as the MedCheck program as above. CDPHP pharmacists collaborate with our Enhanced Primary Care providers to promote the MedCheck services to our members as well as to coordinate interventions to improve health outcomes.

The goal of the MedCheck program is to improve the safety and effectiveness of pharmacotherapy for CDPHP beneficiaries, leading to improved medical outcomes and efficiencies. Improvement will be achieved through pharmacist-directed interventions with members, physicians, and/or provider pharmacies regarding the co-therapeutic management of chronic disease states alongside other members of the care team. A concentrated effort to identify and resolve medication related problems at the time of a transition in care has been instituted for Medicare members as well as commercial members with a high risk of readmission as well as for HARP members with a recent medical discharge. Outreach to members results in a complete medication reconciliation and includes but is not limited to identification of the following: therapeutic duplication, omission in therapy, incorrect dose, drug-drug or drug-disease interactions, medication related adverse effects, issues with medication adherence/acquisition, etc.

Pharmacists are also involved with provider and EPC practice education and support. This is achieved by providing education related to chronic disease state management with an emphasis on clinical outcomes and cost effectiveness. Pharmacists assist with developing treatment plans via the MedCheck service as well as part of the EPC team via embedded pharmacists. CDPHP pharmacy care management identifies opportunities to assist with quality metrics that are related to medication use. These quality metrics include but are not limited to: asthma, diabetes, cardiovascular disease, osteoporosis, rheumatoid arthritis, therapies for depression, ADD/ADHD, schizophrenia, etc. Intervention to help with improving quality metrics include direct member outreach as well as provider directed member identification and recommendations.

In addition, beginning in 2019, CDPHP will partner with CVS Health and their MTM vendor SinfoniaRx to administer our Centers for Medicare and Medicaid Services (CMS) required Medication Therapy Management Program (MTMP). This program identifies Medicare members who have multiple chronic diseases, are on multiple medications and have high prescription drug costs. Participation in this program is voluntary and offered as a no cost added service. A comprehensive medication review (CMR) is offered at least annually to all targeted members enrolled in the Plan’s CMS MTMP. At the end of the CMR the member will receive a personal medication list as well as a medication action plan. In addition, targeted medication reviews are performed and follow up with prescribers is completed as necessary.
Medical Necessity Denials

As part of the resource coordination program, authorization requests are reviewed for medical necessity. In the event that medical necessity cannot be justified, the case will be referred to a medical director for review and determination. The medical director will review individual patient circumstances, capacity of the delivery system, availability to provide care in an alternate setting, available practice guidelines, applicable contract benefits, and supporting resource coordination policies and procedures to render a determination, regardless of the member's financial risk. The medical director may also contact a board-certified physician of the same or similar specialty in the event that clinical peer review of the case is necessary. The medical director or clinical peer reviewer may also speak with the requesting provider. Medical directors are the only staff authorized to deny a service for medical necessity.

Health care services deemed not medically necessary result in an adverse determination. Members, providers, and, when appropriate, facilities are notified of the adverse determination by telephone and in writing. Timeliness of notification is determined by the classification of the request. Denial notifications include the reason for the denial as well as the appeal process available to the member and provider.

Adverse determinations may be given reconsideration when the medical director was unable to discuss the case with the PCP and/or requesting physician prior to the determination. The medical director who made the original decision may review requests for reconsideration. If no new medical information is provided or the reconsideration review results in an adverse determination, the member may submit a verbal or written request for a first-level appeal.

Appeals Process

The appeals process provides the member or the member's designee, physician, ancillary service provider, or facility an opportunity to have a medical necessity or benefit denial reviewed in compliance with the following process:

- A verbal or written request for review of an adverse utilization review (UR) determination is submitted to CDPHP.
- The appeal will be reviewed by a medical director other than the one who rendered the initial adverse determination.
- An appeal that results in a final adverse UR determination may then be further appealed internally or through NYS external review.
- At each level of appeal, the member will be advised of the appeal outcome in writing. The notice will include the detailed reasons for the decision, the clinical rationale, and the procedure for requesting the next level of review.
- If the appeal involves an imminent and serious threat to the health of the member, or the member is a current patient at a facility, the review will be completed in accordance with the timeframes specified in the New York State Managed Care Law and the Employee Retirement Income and Security Act (ERISA) for expedited appeals.
- A provider appeals process that allows the right for a provider to appeal a medical necessity denial of a concurrent or retrospective adverse determination on their own behalf or to appeal on behalf of a member with the appropriate designation form.

Detailed policies are in effect to define the appeals process for specific member products.

Technology Assessment and Medical Policy Development

The CDPHP medical affairs division is responsible for ensuring the systematic and timely review of evolving medical and behavioral health technologies provided to the CDPHP membership. This includes evaluation of new medical and behavioral health technologies, as well as new applications for existing technologies, using all of the following criteria to reach decisions regarding eligibility for coverage:

- Approval received from the FDA or other appropriate regulatory agency where required
- Improves health outcomes at least as well as existing technologies
- Is not cosmetic and is required for reasons other than convenience
- Provides greater value than currently available therapies
- Safety and effectiveness has been proven in scientific studies

The CDPHP technology assessment team consists of medical directors (physicians), a medical policy analyst (registered nurse), and additional appointees as directed. The team is chaired by an appointed medical director. The medical policy analyst is responsible for researching and compiling up-to-date information from computerized searches from various sources of evidence, such as evidence-based peer-reviewed literature, government agencies, and professional societies and associations, for review and consideration by the CDPHP technology assessment team. Board-certified consultants in medicine and behavioral health are used during the review process when additional expertise is needed regarding a newly emerging medical technology. Determining the effectiveness of technology based on scientific evidence from published clinical research, and the need for development of a new policy is based on consensus from the CDPHP technology assessment team. Draft policies developed to address coverage or non-coverage of a technology are presented to the CDPHP policy committee for approval.

Policies are developed to define benefit availability for existing as well as new technologies or changes in medical care. The CDPHP policy committee is a multidisciplinary team, chaired by a CDPHP medical director, with responsibility for the development, review, and revision of all CDPHP resource coordination, pharmacy, and payment policies. It is supported by
provider consultants in medicine and behavioral health and workgroups as needed to lend clinical expertise to the review activities. Addition of new policies, deletion of those outdated, and revision of current policies is based on input from members, providers, and staff, in addition to current trends in medical treatment and review of peer-reviewed literature. All draft policies are forwarded for review to the policy committee. After approval by the policy committee, the formal resource coordination and pharmacy draft is presented to the utilization management committee or the pharmacy and therapeutics committee for review and approval. Revisions are made to the resource coordination and pharmacy policies as recommended by the utilization management and/or pharmacy and therapeutics committee. Minutes from these respective committees are reported to the quality management committee and board of directors for final approval. All resource coordination, pharmacy, and payment policies are reviewed at least annually.

All policies are reviewed and/or revised on an annual basis and then communicated both internally and externally. Participating providers are notified through bi-monthly publication through our secure physician interface at www.cdphp.com and with individual policy mailings upon provider request. Copies are also available to CDPHP members at www.cdphp.com.

**Clinical Criteria**

CDPHP uses industry-standard clinically based medical necessity criteria, and develops internal criteria based on current industry standards. The information sources used to determine benefit coverage and medical necessity include industry-standard criteria such as MCG®, LOCADTR 3; Hayes: Medical Technology Directory, Health Technology Brief Service, Genetic Test Evaluation Program, and Technology Prognosis; Care Advance Enterprise Standard Clinical Package; or internally developed CDPHP Resource Coordination policies. When the resource coordination department receives a request for authorization, eligibility and benefit packages are verified. Clinical nursing staff review the request, required clinical information and medical reports, the member's individual needs, and the services available through the local delivery system, and the appropriate medical necessity criteria are applied. The member's age, co-morbidities, complications, treatment progress, psychosocial situation, and home environment are considered when applying criteria to an individual case. When clinical criteria are clearly met, the nurse issues the authorization and completes the appropriate notifications and documentation within the required timeframes. If the request does not meet the applicable criteria, questionably meets criteria, or the nurse is unable to determine if criteria are met based on the individual case specifics, the request is referred to a medical director for evaluation and decision. The medical director may seek further evaluation by a specialty clinical peer reviewer if additional clinical expertise is required. Medical director decisions are returned to clinical nursing staff for documentation and notification within defined turnaround times.

All industry standard and internally developed clinical criteria are reviewed, revised, and approved at least annually by the UMC. The UMC membership consists of participating board-certified physicians representing primary care and major specialties.

Practitioners/providers are notified of the availability of clinical criteria through the Provider Office Administrative Manual, provider newsletter, and individual determination letters. Practitioners/providers and members may also obtain a copy of the specific medical necessity criteria used to make individual decisions upon request. Physicians may discuss individual medical necessity determinations with a CDPHP medical director by calling the resource coordination department during regular business hours (8:30 a.m. to 5 p.m., Monday through Friday, excluding holidays).

Consistency of applying medical necessity criteria is evaluated at least annually. All staff involved in utilization determinations, including but not limited to nurses, social workers, pharmacists, and Plan medical directors are evaluated for inter-rater reliability to establish the consistency with which they are applying criteria in decision-making. The organization acts on opportunities to improve consistency, if applicable.

**Delegation**

CDPHP entrusts others to deliver specified activities to its members and thus has entered into mutual agreements to perform precise activities. CDPHP has entered into contracted agreements relative to resource coordination services for the following:

- Pharmaceutical safety, benefit management, and member connection activities
- Dental service for Child Health Plus, Essential Plan, and Medicaid members
- Intensive in-home case management for Medicare Choices members

Separate documents clearly delineate both the delegate's and the Plan's responsibility for the delegated activities. These documents describe the methodology used to evaluate and assess the delegated activities on a regular basis in accordance with the CDPHP delegation policies and procedures.

Strict adherence to accreditation and regulatory standards demonstrates our commitment to the highest standards of member care and service. CDPHP performs thorough assessment of external entities before delegating clinical or service activities to determine the ability of each entity to perform the activities. In addition, CDPHP maintains responsibility for ensuring that each delegated function is performed appropriately. CDPHP conducts monitoring and annual evaluation of delegates to ensure adherence to CDPHP policies, procedures, QI goals, and utilization activities. Delegates also report to the Joint Health Services Committee on a quarterly and annual basis. Failure to meet CDPHP standards will result in termination of a delegated activity.
CDPHP has entered into mutual agreements with its customers to perform specific activities as outlined in the CDPHP Quality Management Program Description 2019, Section IX. Delegation Oversight & Activities: J. CVS Caremark, M. Landmark Health, LLC and O. Delta Dental.

### Resource Coordination Incentives

CDPHP does not compensate medical directors or other individuals conducting utilization review for denials of coverage or service. UM decision-making is based only on appropriateness of care and service and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

### Confidentiality

CDPHP resource coordination program activities are privileged and confidential and are conducted in a manner that ensures the confidentiality of member and provider information. Staff and committee members are required to handle data responsibly and carefully and take the necessary steps to protect the privacy of the involved individuals in compliance with HIPAA regulations. Member and provider identifiers will be coded in any presentations, reports, and/or committee minutes. All Plan employees are subject to a confidentiality agreement as a term of employment with CDPHP. Any breach in confidentiality will result in disciplinary action as described in the employee manual. In addition, committee members are required to sign a confidentiality statement upon appointment to the UMC and on an annual basis thereafter.

### Resource Coordination Program Evaluation

The resource coordination program is formally reviewed and revised on an annual basis. The evaluation includes the assessment of the overall effectiveness of the program and the progress toward achieving established goals and objectives. (Reference the Quality Management Program Evaluation 2019, Section III., Resource Coordination Program Evaluation). The revised program description is presented to the UMC for review and approval and then forwarded to the QMC and board of directors for final approval.

In addition to the annual evaluation, all components of the program, including compliance with external accreditation and regulatory requirements, are monitored and reported to the UMC throughout the year to ensure that the program continues to be effective.

New: 11/15/94
Revised: 11/21/95, 12/17/96, 04/21/98, 12/15/98, 01/04/00, 01/30/01, 01/02/01, 12/30/01, 11/01/02, 02/17/04, 02/15/05, 03/21/06, 04/17/07, 03/18/08, 1/13/09, 01/12/10, 03/08/11, 03/13/12, 3/12/13, 3/11/14, 9/9/14, 3/10/15, 3/8/16, 3/14/17, 3/13/18, 3/12/19