Section 14
2016 Resource Coordination
Program Description
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**CDPHP® Resource Coordination Program Description**

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Introduction

It is the responsibility of the resource coordination department at Capital District Physicians’ Health Plan, Inc. (CDPHP®) to ensure the appropriate use of health care resources. This is accomplished through planning, directing, monitoring, and managing health care services to ensure appropriate, cost-effective care while contributing to the overall goal of patient wellness. The resource coordination program includes monitoring and evaluating utilization patterns to detect over- and under-utilization of services. These mechanisms contribute to improved 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 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 promote healthy lifestyles and improve health outcomes.
• 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 optimum utilization of health care services while protecting and acknowledging members’ rights and responsibilities, including the member’s right 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.

2016 Program Objectives:

• Provide a comprehensive care management program that will include high-risk health management services, inpatient care coordination and concurrent review, prior authorization, member appeal and complaint resolution, disease management services, and population health and wellness offerings.
• Extend 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®, ASAM Patient Placement Criteria, Hayes Medical Technology Directory, Health Technology Brief Service Technology Prognosis and Genetic Test Evaluation Program, Care Advance Enterprise Standard Clinical Package, 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 and wellness offerings.
• Establish targeted member outreach to impact child, adolescent, and women’s health HEDIS measures.
• Grow the embedded case management program to include specialty practices.
• Provide comprehensive population health and wellness offerings to employer groups based on group size, needs, and commitment.
• Evaluate and implement programs that enhance the ease and efficiency of medical practice and improve the quality of care our members receive.
• Use a standardized methodology to identify potential utilization outliers (both under- and over-utilization) and design interventions as needed.
• Enhance efficiencies in all resource coordination processes.
• Promote active engagement in healthy behaviors through Life Points®, a CDPHP member incentive program.
• Engage our participating acute care hospitals and skilled nursing facilities in reducing their inpatient readmission rate.
• Expand delegation responsibilities to investigate genetic testing authorization through eviCore.
• Audit for coding compliance and educate providers as appropriate.
• Enhance prior authorization program to ensure services are obtained by a qualified participating provider whenever possible.
• 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.

Revised December 2017
• Design and implement a multi-faceted approach to improving the health literacy of our members.
• Implement a HARP product.
• Continued focus on keeping utilization in network whenever possible based on medical appropriateness.
• Partner with local PPAs to support the DSRIP initiatives.

**Governance and Accountability**

CDPHP is a not-for-profit corporation. The board of directors is the governing authority and is responsible for managing the affairs and business of the corporation. The board of directors consists of 15 members. Eight of the 15 are participating physicians and corporate members of the corporation. The requirements for corporate membership in the corporation include an active participating physician agreement with the plan. The board also includes community business representatives, at least three of whom are CDPHP enrollees.

The president and CEO of CDPHP reports directly to the board of directors. The board of directors has assigned the utilization management committee the responsibility to develop, review, implement, and recommend enhancements to the resource coordination program. The committee reports through the quality management committee 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 committee (BHC); 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 senior vice president, medical affairs/chief medical officer. The senior 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 quality management committee as the responsible entity for the oversight and management of all quality-related activities, including delegated and collaborative activities and developing, implementing, and overseeing the quality improvement program. The quality management committee, chaired by the vice president/senior medical director, is comprised of fully credentialed physicians representing primary care and high-volume specialties. Committee members also include representatives from CDPHP, adjunct providers, and behavioral health staff. The BH medical director is available ad hoc.

The committee members are appointed by the vice president/senior medical director, subject to board approval, for a three-year term and may be re-appointed once. The vice president of health care quality, director of health care quality, accreditation and quality program manager, manager of informatics, director of provider services, and supervisor of member services represent CDPHP on the committee. Additional plan staff serve as ad hoc staff to the committee as needed.

**Responsibilities of the 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, QARR, and all clinical and service initiatives. Quality 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
  - Pharmacy and therapeutics/formulary management, including MTMP
  - Credentialing/recredentialing
  - High-tech radiology medical necessity program
  - Oversight of first-tier downstream entities (FDRs) and other delegates’ delegated activities.
  - CMS Quality Improvement Project (QIP) and Chronic Care Improvement Projects (CCIP)
  - Practitioner medical record and office site reviews
  - Preventive health 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
  - Recommend and monitor continuity and coordination of care initiatives

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○ Practitioner/provider profiling and incentive programs
○ Accreditation, certification, and regulatory compliance
○ Development of initiatives to address health equity based on identified health literacy, cultural, and linguistic needs of our membership
○ Submit regular reports of QM activities to the board of directors

Utilization Management Committee (UMC)
The CDPHP board of directors has assigned the UMC 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 and providers.
- Identify and ensure implementation of appropriate interventions to address opportunities for improvement identified through monitoring activity.
- Evaluate, select, and approve industry-standard medical necessity/medical appropriateness screening criteria.
- Monitor consistency of application of medical necessity criteria, including inter-rater evaluation process for physicians and non-physician reviewers, to develop and oversee implementation of interventions to address identified opportunities for improvement.
- Monitor timely resolution of UM, BH, and pharmacy determinations and service indicators.
- Evaluate for potential over- and under-utilization on a plan-wide, product-specific, and practitioner-site level, with recommendation of corrective action as appropriate.
- Evaluate results and develop and recommend interventions and corrective actions for plan-wide and practitioner-specific opportunities for improvement identified through ongoing monitoring of care, service, and utilization indicators.
- Evaluate requests for new technology and/or new uses for existing technology, including medical and behavioral health technologies, procedures, and/or devices.
- Recommend revisions to the member benefit package.
- Monitor progress toward achieving established performance goals.
- Monitor member and provider satisfaction with the resource coordination department and with related services and processes.
- Serve as a liaison between participating practitioners and CDPHP on all clinical and utilization-related issues.

A medical director who has a primary focus on utilization management chairs the committee and supervises/oversees all utilization activities. The committee membership is appointed by the vice president/senior medical director, subject to approval by the CDPHP board of directors, and consists of participating board-certified physicians representing primary care and the high-volume specialties. The committee meets at least six times per year and minutes are reported through the QMC to the board of directors. The senior vice president of medical affairs operations and the vice president of behavioral health serve 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, and revision of medical, behavioral health, pharmacy, utilization management, and reimbursement policies. Industry norms and clinical research are considered 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 billing 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.

The senior vice president of medical affairs operations chairs the committee. The committee is an interdepartmental team consisting of a medical director and representatives of finance, government programs, configuration team, internal operations, medical affairs, healthcare network strategy, pharmacy services, behavioral health, business development, special investigations unit, application management, and resource coordination. The committee meets on a bi-monthly basis and 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 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, quarterly and annually in accordance with CDPHP policies and procedures. The committee approves the written pre-delegation and delegation agreement documents, the quality management evaluations, programs, and work plans, and receives quarterly and annual reports containing results and action plans regarding delegated activities. The CDPHP board of directors and quality management committee 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.

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The CDPHP Joint Health Services Committee consists of all CDPHP delegates: pharmacy vendor (CVS/Caremark); Medicare complex care coordination vendor (Landmark Health, LLC); disease management of rare chronic condition vendor (Accordant); NYS DOH health homes; disease management vendor (Health Dialog); radiology medical necessity program (MedSolutions/eviCore); physician and hospital online directories vendor (Clarus Health Systems); Child Health Plus and Medicaid dental vendor (DentaQuest); and credentialing and recredentialing at specific sites. The new delegate in 2016 to case manage our HARP enrollees will be Community Care Behavioral Health (CCBH). The vice president of 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, 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.
- Review quarterly reports containing results of delegated activities with corrective action plans as indicated.
- Approve pre-delegation assessment and agreements.
- Conduct annual oversight of all delegates through annual reporting requirements.
- Ensure delegates’ adherence to CDPHP policies, procedures, and QI goals.
- Pursue plan of correction for areas not meeting standards and consider delegate termination where applicable.

Refer to the CDPHP Quality Management Program Description 2016 for details regarding the delegated functions for each UM delegate.

**Behavioral Health Committee**
The Capital District Physicians’ Health Plan, Inc. (CDPHP) board of directors formed the Behavioral Health Committee to provide advice and recommendations concerning utilization management and quality management related to behavioral health, as well as expert opinions on other select behavioral health issues. The CDPHP behavioral health medical director chairs the committee, which includes representatives from psychiatry, psychology, social work, pediatrics, and substance abuse/mental health clinics and/or facilities. Members of the CDPHP management team, including but not limited to the vice president of behavioral health services and behavioral health operations director, serve as non-voting staff on the committee. Committee minutes are reported to the UMC and QMC, and then to the board of directors. In addition, state requirements for the CDPHP Medicaid HARP product, effective July 1, 2016, include the involvement of stakeholders who include family members, peer specialists, providers, plans subcontractors, RPC, and other member serving agencies. Satisfaction of this requirement is met by the creation of the Quality Stakeholder Advisory Group, which will report to the Behavioral Health Committee. The Quality Stakeholder Advisory Group will include three (3) members from the current BH UM Committee; two (2) members from new community service organizations (peer specialists, SA, and MH); and three (3) members/family members from the Behavioral Health Committee will hold regular meetings three times per year.

Beginning in 2017, the Behavioral Health Committee and the Quality Stakeholder Advisory Group shall meet quarterly. Behavioral Health Committee members review and provide input on service or clinical quality indicators, preventive and clinical practice guidelines, and utilization management and case management processes. They review and recommend medical policies and procedures for benefit coverage by assessing technologies, medical interventions, and drugs in terms of effectiveness, safety, and outcomes. They provide expert opinions on behavioral health issues, encourage and promote communication between CDPHP and the behavioral health provider network, review and provide input into satisfaction surveys, share information relative to trends in the behavioral health care industry, and share ideas and recommendations on effecting better outcomes with specific populations.

**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 formulary in accordance with pharmacy and resource coordination 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

Senior Vice President, Medical Affairs, Chief Medical Officer
Responsible 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.

Vice President, Medical Affairs, Senior Medical Director
The vice president, medical affairs, senior medical director will work directly with the chief medical officer in the implementation of the plan’s medical management, quality improvement, resource coordination, and pharmacy management initiatives in accordance with regulatory, accreditation, corporate policies, and the strategic plan. The vice president, senior medical director will provide leadership to and serve as a resource to the physician community and the plan’s management. The vice president, senior medical director will coordinate the medical director resources to execute the CDPHP corporate initiatives and strategies.

Medical Directors
The medical directors will assist the vice president/senior medical director, medical affairs with ensuring compliance with the plan’s quality management, pharmacy, and resource coordination programs. The medical directors will participate in medical advisory committees, providing leadership to and serving as a liaison between the physician community and the plan’s management. One of the medical directors is designated as having primary responsibilities in resource coordination. This medical director chairs the UMC and is responsible for oversight of the resource coordination program.

Senior Vice President, Medical Affairs Operations
Responsible to the executive vice president, chief operating officer, in conjunction with the UMC 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 case management/disease management/wellness 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; and health promotion and wellness programs to encourage healthy lifestyles among members.

Director, Medicaid Innovation
Responsible to the senior vice president, medical affairs operations for the design/ modification, implementation, and monitoring of medical management initiatives that support achievement of the Triple Aim for the Medicaid line of business. This includes designing new programs and altering existing programs to meet the unique and complex needs of the Medicaid population. This position manages a defined set of virtual team members in collaboration with departmental heads and leads this team in establishing and attaining Medicaid-specific annual goals. In addition to coordinating internal resources, this position is responsible for the development and monitoring of value-based arrangements with community partners, as well as programs that optimize risk-based revenue.

Community Health Specialist
Responsible to the director, Medicaid innovation, for the identification of community health needs and implementation of programs that promote appropriate utilization of medical and behavioral health services, improvement of health outcomes, and enhanced HEDIS/QARR performance. The CHS provides expertise in conceptualizing and implementing effective outreach and engagement initiatives and works collaboratively across multiple departments and community partners to monitor and prioritize interventions aimed at Medicaid and HARP enrollees.

Director, Population Health and Wellness
Responsible to the senior vice president, medical affairs operations, for the development and execution of innovative population health and wellness programs that support our participating practitioners in achieving optimal health outcomes. CDPHP relies on the director to align efforts, which will distinguish the health plan as “best in class” in health promotion and wellness programs.

Manager, Population Health and Wellness
The manager, population health and wellness programs is responsible for the execution of day-to-day activities of the CDPHP population health and wellness programs, including the development, implementation, and evaluation of worksite wellness programs provided to employer groups, community health programs, and targeted member outreach efforts. The manager, population health and wellness works in a collaborative role with quality, care management, behavioral health, pharmacy, and sales and marketing departments.

Health Promotion Specialist
The health promotion specialist works closely with the department manager to identify the educational needs of members and to promote healthy lifestyles and behaviors. The health promotion specialist works in a consultative role with employer groups and brokers with support from marketing to meet their specific unique health and wellness needs. Additionally, the health promotion specialist develops and executes programs throughout the community and in partnership with
health care providers in our network. The development of preventive and wellness programs is considered pivotal to the health management framework. Monthly reporting and evaluation of the effectiveness of programs is an integral part of ensuring the success of the population health and wellness department.

**Population Health and Wellness Specialist**

The population health and wellness specialist works across the population health and wellness team to identify population health needs and develop and implement programs and activities in partnership with providers, employers, and community partners to promote healthier lifestyles and improve health outcomes. The population health and wellness specialist provides expertise in conceptualizing chronic disease prevention and management programs for specific provider practice patient populations.

Additionally, the population health and wellness specialist develops innovative strategies to engage members in the communities where they live, work, and gather to connect them to care and appropriate CDPHP resources. Regular reporting, data analysis, and evaluation of targeted member outreach efforts are integral to ensure the success of the population health and wellness department.

**Population Health Coordinator**

The population health coordinator is responsible for working with the population health and wellness team to identify CDPHP population health needs across all lines of business and coordinate the delivery and evaluation of population health and promotion programs, campaigns, and other targeted member outreach to promote healthier lifestyles and better health outcomes. Outreach includes member communication about gaps in health care needs and preventive health opportunities, member and provider education, communication campaigns, and medical management referrals. Regular reporting, data analysis, and evaluation of targeted member outreach efforts are integral to ensure the success of the population health and wellness department.

**Manager, Inpatient Programs**

Responsible to the senior vice president of medical affairs operations for the overall development, planning, monitoring, and evaluation of inpatient care management program for all lines of business. The manager shall ensure consistent and appropriate application of MCG and resource coordination policies for all utilization review activities. Responsible for the oversight of the on-site and telephonic care coordination at participating and non-participating facilities. Functions as liaison between CDPHP resource coordination staff and hospital utilization and case management staff. Focuses on industry standards and best practices in utilization management. Operations and program development are continuously evaluated for process improvement. The manager monitors inpatient care activities, reviews aggregate data and trend analysis for program development, and ensures processes are in place for identification of potential quality of care issues and potentially avoidable readmissions.

**Supervisor, Inpatient Programs**

The supervisor, inpatient programs, is responsible for oversight of the execution of day-to-day utilization review and care coordination of members’ health care needs during hospitalization. This comprehensive review process 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. The supervisor oversees the training and education of the inpatient care coordinators, monitoring their daily activity, enforcing policies and procedures, and ensuring appropriate application of MCG. The supervisor of inpatient programs works collaboratively with many departments within CDPHP to meet the needs of members during inpatient confinement and immediately following.

**Inpatient Care Coordinator**

The inpatient care coordinator is responsible for assessing the medical necessity of inpatient admissions and continued stay by adhering to MCG. Frequent collaboration with the inpatient supervisor and medical director is necessary to meet coordination needs for CDPHP members. The inpatient care coordinator is responsible for on-site and/or telephonic utilization at inpatient hospitals and acute and sub-acute rehabilitation facilities. All new admissions and concurrent review must meet medical necessity.

**Director, Care Management**

Responsible to the senior vice president of medical affairs operations 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. The director of care management oversees case management, disease management, health home delegation, and Medicaid long-term services and supports high-cost claims review, the medical affairs triage line, and new Medicare enrollee medical outreach.

**Care Management Administrator**

The care management administrator, case management, is responsible for the execution of day-to-day activities of the complex case management program and services listed under the director. This includes hiring and training case management staff; monitoring daily program activity; enforcing policies and procedures; collaborating with physicians, NYS DOH, and vendors; and generally ensuring that the needs of CDPHP members are met during the case management episode of care.

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Case Manager
The resource coordination case manager is responsible and accountable for coordinating the care of CDPHP members who meet case management criteria across the continuum of care; ensuring and facilitating the achievement of quality, clinical, and cost outcomes; and procuring and coordinating services and resources needed by the members and their families.

Social Worker Case Manager
The resource coordination social worker case manager is responsible and accountable 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.

Director, Utilization Review
Responsible to the senior vice president of medical affairs operations for oversight, administration, evaluation, and planning for referral services and ambulatory review and coding departments. Areas of responsibility include the prior authorization process to meet all regulatory requirements, as well as the ambulatory clinical audit process, retrospective claim reviews, and clinical code auditing.

Supervisor, Referral Services
The supervisor, referral services, is responsible for the oversight of day-to-day activities within the referral services department. This includes training staff and monitoring daily referral 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.

Utilization Review Nurse
The UR nurse is 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.

Utilization Review Specialist
The UR specialist supports the utilization review nurse by obtaining the necessary case information for a determination to be made. The UR specialist is trained on request entry and authorization procedures. This training enables a case to be set up and forwarded to the appropriate nurse queues.

Supervisor, Ambulatory Review and Coding
The supervisor is responsible for the oversight of day-to-day activities within the ambulatory review and coding department. This includes staff training and monitoring of queue work to ensure timely case review completion to avoid regulatory penalties, as well as identifying coding outliers for further investigation and auditing.

Ambulatory Review Specialist
The ambulatory review specialist is responsible for pre- and post-payment review of complex hospital and physician cases to evaluate the medical necessity, appropriateness, and quality of health care services. The ambulatory review specialist will conduct provider audits to analyze coding, payment and practice pattern activities, report findings and recommend areas for improvement.

Medical Policy Analyst
Responsible to the senior vice president of medical affairs operations for the overall development, monitoring, implementation, and evaluation of policies and procedures for resource coordination. Areas of responsibility include policy development of external resource coordination policies and procedures, including ensuring compliance with documentation standards, review dates, and regulatory requirements; research of evolving medical and behavioral health technologies and new applications to existing technologies; active participation on the policy committee; maintaining an annual review schedule for existing external resource coordination policies; and staying up to date with current medical trends, technology, and treatment modalities. The medical policy analyst 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
The senior vice president of clinical integration/chief pharmacy officer is responsible for managing all aspects of clinical and administrative pharmaceutical management and pharmaceutical benefit management (PBM), including contract negotiations and management. This position also 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 health plan’s business.

Director, Pharmaceutical Care Programs
The director of pharmaceutical care programs develops programs, policies, and benefit designs to address the pipeline of biotech and specialty drugs. The director 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, disease...
managing, and population health and wellness initiatives. 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.

**Manager, Formulary and Clinical Pharmacy Operations**

Responsible for assisting the vice president, pharmacy and health quality programs 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. The manager, formulary and clinical pharmacy operations will serve 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 NCQA.

**Manager, Medicare Pharmacy 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. The manager of Medicare pharmacy programs will serve 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 pharmacist and Medicare Stars pharmacist, 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.

**Academic Detail Representative**

The academic detail representative introduces, presents, and promotes 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.

**Managed Care Pharmacists**

The managed care pharmacist assists the vice president, pharmacy professional services 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. Managed care pharmacists also 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 Specialists**

The supervisor, pharmacy benefit specialists is 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.

**Medical Director, Behavioral Health**

Under the direction of the vice president of behavioral health services, the medical director for behavioral health directs all clinical aspects of the behavioral health department and assists with providing medical expertise to the plan as well as integration with other medical services.

**Vice President, Behavioral Health**

Responsible to the senior vice president, medical affairs operations for the administration of a comprehensive managed behavioral health care program. This includes budgetary responsibilities, 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 under and over utilization, and integration of behavioral health into all facets of medical management activities.

**Director, Behavioral Health**

Responsible to the vice president of behavioral health to provide administrative and clinical leadership to the behavioral health team, while driving the unit to meet business goals. Provide strategic operational oversight of the following: clinical administrative operations of the program, quality control, utilization management, customer service, and workflow. Monitor clinical performance of the unit through regular reviews of clinical documentation, regular clinical supervision meetings, and attendance at psychiatric reviews.

**Medicaid-Manager, Behavioral Health**

Under the direction of the director of behavioral health services, the behavioral health Medicaid-manager provides administrative and clinical leadership to CDPHP Medicaid HARP. Monitors clinical performance of the unit through regular
reviews of clinical documentation, regular clinical supervision meetings and interfaces with NYS regulatory agencies and CCBH, and delegates to provide case management for HARP.

Clinical Intake Specialist
Responsible to the director, behavioral health and 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.

Behavioral Health Case Management
The BH case manager is responsible for coordinating recovery-oriented care of CDPHP members with mental health, substance use disorder, and co-morbid medical disorders who meet criteria for episodic or complex case management. The behavioral health case manager provides face-to-face or telephonic assessments, referrals, and benefit-related counseling to members. S/he works collaboratively with the member and all applicable internal and external resources to plan and monitor care options. S/he works with hospital clinical staff to offer treatment recommendations to address members’ needs and decrease probability for inpatient readmission. The case manager monitors member utilization of services (over and under), as well as outcomes in the inpatient facility setting and in the community.

Behavioral Health Care Coordinator
The behavioral health care coordinator is responsible for assessing the medical necessity of inpatient admissions and continued stay using MCG and ASAM Patient Placement Criteria, as well as assessing discharge planning needs for CDPHP members. The behavioral health care coordinator is 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, they are responsible for ensuring that the discharge plan is in place at the time of discharge.

Director, Credentialing and Appeals
Responsible to the vice president of health care quality for the overall management, administration, evaluation, and planning of the member and provider complaints, grievances, and appeals (CGA) department and the credentialing department. The director is responsible for ensuring 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. The director is also responsible to ensure delegation management and delegation oversight is completed within CDPHP requirements. The director will provide 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. The position also communicates with all appropriate parties regarding appeals and grievance issues, implications, and decisions and analyzes and identifies trends for all complaints, appeals, and grievances. This position communicates with appropriate parties such as state, federal, NCQA accreditation, and HEDIS as it relates to CGA, credentialing, and re-credentialing functions.

Clinical Appeals Specialist
Responsible for ensuring a member/provider appeal and grievance process that meets state, federal, accreditation, and other regulatory requirements. Using knowledge of clinical nursing and medical practice, the clinical appeals specialist will review medical necessity and render 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. The clinical appeals specialist is responsible for tracking, trending, and monitoring appeals and grievances and external reviews and making recommendations for change. The clinical appeals specialist is responsible for oversight of the external review process.

Senior Appeals Analyst
The senior appeals analyst is responsible for the timely and accurate research, investigation, documentation, and response to all non-clinical member/provider complaints, grievances, and appeals. The senior appeals analyst will be responsible for the primary research, investigation, and response to all government regulatory agencies or related external entity complaints. The senior appeals analyst will complete weekly quality review on randomly selected appeals, provide educational coaching, and track and trend errors to determine route cause. The senior appeals analyst will also be responsible for providing coverage and assist with logging and triaging complaints, appeals, and grievances as needed.

Member Complaints and Quality Committee Coordinator
The member complaints and quality committee coordinator will be 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.

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
• Disease management
• Population health and wellness
• 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 CDPHP resource coordination department staff using approved resource coordination policies, MCG, ASAM Patient Placement Criteria, Hayes Medical Technology Directory, Health Technology Brief Service and Genetic Test Evaluation Program, Care Advance Enterprise Standard Clinical Package, and the clinical experience of the professional nursing staff, licensed master social workers, 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 and/or ASAM 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 resource coordination department is 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. 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, disease management, 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 ASAM 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 MCG and/or ASAM Patient Placement Criteria to determine the need for continued inpatient care 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.

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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/or ASAM 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 work-related problems that influence the health of the member. It encompasses effective communication with the patient, family, behavioral health case manager, PCP, and specialty care provider (when appropriate) as a team.

Case management is available to all CDPHP members. Operating within HIPAA regulations, members are specifically identified for case management through multiple sources, which may include predictive modeling software, Clinical Care Advance rules engine (CDPHP care management system), the precertification process, inpatient continued stay review, physicians, and the disease management 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, in 2016 CDPHP is expanding this service to all lines of business, with case managers meeting with members in various community settings when the plan of care warrants this type of interaction.

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, disease management, or wellness 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.

Health Ally Case Management Program

CDPHP has a dedicated case management program tailored to meet the unique needs of its Medicare members. The Health Ally program is a team of clinical staff, including nurses and medical social workers. The program features an enhanced benefit design tailored to focus on avoidance of hospital readmissions for chronic members. All newly enrolled members receive a telephonic health risk assessment to identify health conditions and a comprehensive plan of care at the time of enrollment. Members are stratified and offered enrollment to an appropriate program tailored to meet the member’s individualized needs and preferences. Intensive home-based complex case management through Landmark Health, LLC is available to chronically ill members who have six or more chronic diseases.

Embedded Case Management Program

CDPHP provides embedded case management services on-site in multiple enhanced primary care practices to facilitate face-to-face case management services, which enhances member and provider engagement.

The goals of embedded case management include:

- Enhanced member engagement
- Reduction of avoidable ER visits
- Reduction of readmission rates for chronic conditions
- Reduction in gaps in care for chronic conditions
- Identification of members with dual medical and behavior health conditions
- Enhanced health literacy

Community Based Case Management Program

CDPHP provides embedded case management 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 is effective for building relationships of trust and increases the likelihood of ongoing engagement in case management.
The goals of community based case management include:
- Enhanced member engagement
- Reduction of avoidable ER visits
- Reduction of readmission rates for chronic conditions
- Increased use of preventive health care services
- Identification of members with dual medical and behavior health conditions
- Remove any barriers to accessing care
- Provide linkages to social work resources that can help address the social determinants of health

**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**

CDPHP continues to refine its approach to preventable inpatient readmissions. We currently evaluate our members’ risk of readmission while they are hospitalized at selected high-volume hospitals. For those considered high-risk, we make telephonic outreach on post-discharge days two, seven, 14, 21, and 28 to review discharge instructions, help secure timely follow-up (within seven days of discharge) with their physician, conduct medication reconciliation, and determine if additional resources are needed to help meet the medical needs of each member. For our most frail Medicare members, we also use Landmark Health, LLC to provide in-home case management services. Our care team will use community resources as well as benefits available under the member contract to meet the unique needs of each member.

CDPHP has implemented a value-based contract with a participating provider for readmission avoidance. Members with at least one identified chronic condition are eligible for services. If in agreement, members receive one RN home visit within three days of discharge, a PCP scheduled follow-up visit within seven calendar days of discharge, and three follow-up RN phone calls. CDPHP continues to work with other participating providers for similar readmission avoidance services.

**Disease Management**

The CDPHP disease management program, Health Coach ConnectionSM, provides members with education and support to help them better manage their disease and overall health. Disease management is a benefit available to all CDPHP members.

Diseases included for outreach by a health coach are (although a member can call for any health question or concern):
- CAD
- Diabetes

The Health Coach Connection key components are:
- Available 24/7, 365 days/year—Health coaches are available whenever a member may need them.
- Health coaches are specially trained medical professionals: nurses, dietitians, pharmacists, or respiratory therapists.
- Focused on building self-reliance, not dependence—Health coaches educate and motivate participants to become more engaged in their health care.
- Powerful, yet easy-to-use, support tools—Members have access to many online health tools via the Health Information Center:
  - Health Assessment—A personal, private health assessment that members can take to evaluate their overall health and receive results in the form of a printable action plan identifying areas they may need to work on or discuss further with their provider.
  - Healthwise Knowledgebase—An online health encyclopedia and Healthy Conversations interactive program.
  - Health Crossroads—For members facing difficult decisions such as surgery or treatment for breast cancer.
  - Healthwise® modules—Brings our members no-cost online wellness programs that can help them eat healthy, lose weight, quit smoking, manage stress, and prevent back pain.
  - Tracking tools—Members can track their symptoms and/or medications.
  - Email a question—Members can email a health question to a health coach.
  - Decision support for preference-sensitive conditions
  - Tailored support programs for the Enhanced Primary Care practices specific to back pain and bariatric surgery
  - Written materials—Members are sent educational materials for reference to reinforce telephonic education and remind them of important tests they may need.
The Community Health Project

CDPHP recognizes the benefits of strategic community partnerships to enhance our ability to outreach and engage Medicaid members. The Community Health Project is a partnership with two community-based organizations, the Commission on Economic Opportunity and Catholic Charities Care Coordination Services, focused on connecting Medicaid members to appropriate preventive health care services.

Through a structured arrangement, these entities use community health workers to provide street level outreach to Medicaid members who have not used any health care services in the last 12 months, as well as members with HEDIS gaps in care for breast and cervical cancer screening and diabetes care. The goal of this project is to link members with a PCP, remove any barriers to accessing care, and ensure that targeted gaps in care are closed.

Wellness on Wheels

CDPHP continues a two-year partnership with Whitney Young Health to provide convenient access to preventive care at community locations known to the Medicaid population using Whitney Young’s state-of-the-art mobile health unit. A minimum of 12 events will be held per year in Albany and Rensselaer counties, staffed by medical personnel from Whitney Young. Appointment slots are used for CDPHP Medicaid members with gaps in care for well-child visits, immunizations, and complete physical exams for adults.

Population Health and Wellness Programs

CDPHP continues a commitment to providing population health and wellness programs for our members in the community and at worksites and through health care practices to promote healthier lifestyles and better health outcomes.

Community Outreach and Wellness Programs

CDPHP is committed to providing opportunities for its members to engage in wellness activities and increasing member awareness of available resources to support a healthy lifestyle, enhance quality of life, and mitigate risks for chronic diseases and other preventable health conditions. CDPHP continues to offer the free wellness class schedule, featuring an array of opportunities for members throughout our service area to engage in educational and activity-based classes to improve their health, quality of life, and to introduce them to existing wellness resources in their communities. Topics covered include fitness, healthy eating, child and family health, senior health, mental and emotional health, smoking cessation, and chronic disease management and prevention.

In addition, CDPHP continues to enhance its community presence through partnerships with providers, community-based organizations, and local businesses to connect with members facing multiple challenges that affect their ability to achieve and maintain a healthy lifestyle. Last year marked the beginning of the CDPHP Healthy Neighborhood initiative, aimed at improving health outcomes and reducing gaps in care in targeted communities by providing ongoing support and access to health and wellness resources. Two community events took place in 2015, where CDPHP partnered with community organizations to offer a variety of services, including health and social service information, free health screenings, and activities promoting healthy eating and exercise for adults and children. CDPHP is expanding Healthy Neighborhood into a second community in 2016 and plans to offer a total of four events. By co-sponsoring and/or participating in community events, continuing to collaborate on the Healthy Living Center project, partnering with providers to offer programming specific to their patient populations, and conducting targeted member outreach, CDPHP has expanded its community reach.

CDPHP partnered with local health and wellness professionals, facilities, and community organizations throughout our service area to promote existing wellness resources and offer programming as a value-added benefit to members through the free wellness class schedule. Program offerings continued to be organized, as in years past, into the following categories to meet the diverse needs and interests of CDPHP members:

- **Healthy Families**: Programming for families with children on topics including healthy eating, physical activity, weight management, stress management, recreation opportunities, asthma, Type 1 diabetes education and support, and perinatal health.
- **Senior Health**: Programming for seniors on topics including physical activity, nutrition, fall prevention, stress management, Alzheimer’s, and arthritis.
- **Health Education**: Programming specific to the prevention and maintenance of health conditions including diabetes, hypertension, smoking cessation, weight management, preventive screenings, immunizations, and cholesterol. The following community resources were also promoted within this category:
  - The Healthy Living Center, a collaborative project with the Albany Hannaford Supermarket and Pharmacy and the Capital District YMCA, to offer a variety of programs on topics including fitness, nutrition, senior health, and disease management. Programming is available to CDPHP and community members.
  - The Center for Excellence in Aging & Community Wellness, which offers the Living Healthy NY Community Workshops to support members in their efforts to improve chronic disease self-management.
- **Wellness**: Programming related to health topics including stress management, sleep hygiene, mental and emotional well-being, musculoskeletal health, behavior change support, financial health, and alternative therapies including meditation techniques.
• **Nutrition**: Programming related to healthy eating and food preparation, specialty diets (e.g., vegetarian, gluten-free), and topics like seasonal cooking and healthy, budget-friendly grocery shopping (e.g., store tours). The following community resources were also promoted within this category:
  - The Capital District Community Gardens Veggie Mobile program, which supports a unique mobile produce van that makes fresh, nutritious fruits and vegetables affordable and available to Capital District neighborhoods with limited access to healthier foods.
  - Local markets, including Price Chopper, the Honest Weight Food Co-op, Hannaford, and Whole Foods Market, promote healthy lifestyle choices and disease prevention by offering educational programs to CDPHP members.

• **Fitness**: Programming includes a wide variety of physical activity classes suitable for members of all fitness levels.

Members receive the free wellness class schedule in the quarterly member newsletters, as well as online at www.cdphp.com/events.

CDPHP continues to conduct member outreach through partnerships with local community-based service organizations that have been recognized as leaders for offering support to individuals and families in need of multiple services. This includes focusing on CDPHP members who face challenges in transient housing, language barriers to care, and health risks secondary to daily social stressors. CDPHP plans to continue expanding its presence in the community through these types of collaborations, with the goal of supporting improved outcomes in member engagement and health care.

**Targeted Member Outreach Initiatives**

**Mail Campaigns**
CDPHP runs targeted automated letter campaigns to members with gaps in care in a variety of preventive measures using Clinical Care Advance, the CDPHP care management system. Most of these campaigns run continuously and target members in all lines of business who have specific health conditions or who have specific gaps in care, with a goal to encourage them to receive timely preventive care. Campaigns include but are not limited to breast cancer screening, well-child visits, childhood immunizations, prenatal and postpartum care, childhood obesity, and smoking cessation. In 2016, CDPHP will begin a campaign targeting members who have been diagnosed as obese to increase their awareness of CDPHP resources available to help them manage their weight.

**Enhanced Primary Care (EPC) Practice Outreach**
As part of our population management strategy, CDPHP continues targeted outreach efforts at EPC practices, including those with large Medicaid member populations. Activities include:
- Partnering with EPC staff to identify opportunities for member engagement to increase preventive care rates and address important health care needs.
- Partnering with EPC practices to offer chronic disease-focused health education programs on-site
- Coordinating outreach with CDPHP embedded case managers for best member outcomes.
- Collaborating with other CDPHP departments to identify EPC resource needs and empower practices with relevant tools to address HEDIS measures while simultaneously managing patient care.

**Mom 2 Be Program**
The CDPHP Mom 2 Be program identifies pregnant women and provides them with important information about pre and postpartum care. Women are identified through select OB/GYN and family practitioner offices, health risk assessments, claims, and through self-referral. Once identified, members receive targeted educational mailings during the second and third trimesters that include information on CDPHP resources such as text4baby, community wellness classes, and breastfeeding and postpartum toolkits. Members who are identified as high risk also receive telephonic support from a case manager during pregnancy and up to two months postpartum. Members can access a wide variety of pre and postnatal health information on the Mom 2 Be Website, www.cdphp.com/pregnancy. A free maternity calendar is available to members who self-refer into the Mom 2 Be program through the website or via mail.

**Workplace Wellness Programs**
The Centers for Disease Control and Prevention recognize that well-designed and implemented worksite wellness programs can reduce costs to the employer and improve employee health and morale. With the average working adult spending 40 or more hours per week at work, CDPHP is committed to providing value-added health promotion and wellness support to members at their worksites. CDPHP continues to assist employer groups in the adoption and implementation of comprehensive, results-oriented worksite wellness initiatives.

CDPHP partners with employer groups of all sizes to assess organizational resources, employee and dependent interests, health risks, and the goals and values that are unique to that employer. Health promotion specialists work with groups to build and maintain a foundation for enhancing corporate wellness culture through offering support to employers around wellness committees, health policies, and premium differentials. A wide variety of wellness program topics and formats are offered, including awareness campaigns, employee challenges, one-hour and multi-session health education programs, and 30-minute skill-building workshops. Results are tracked and measured through a variety of available reports.
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 Under-Utilization

As a managed care organization, CDPHP uses several resources to monitor and identify potential over- and under-utilization 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 under-utilization 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 and 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 our behavioral health medical director.

The behavioral health staff uses approved resource coordination policies, MCG and NYS LOCADTR, and ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders when reviewing services for 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.

- Admission review—Elective inpatient and rehabilitation behavioral health services require prior approval. This service is conducted telephonically through the Behavioral Health Access Center. Emergency admissions require notification by the admitting facility within 24 hours of the admission.

- Concurrent review—Once a member is admitted, the admission is followed concurrently to ensure the member is in the most appropriate setting given the changes to the clinical status. In addition to concurrent review, 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. In addition to inpatient services, concurrent review is performed on other ancillary that require intensive case management intervention.

- Retrospective review—CDPHP conducts pre-and/or 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 empowers members to take responsibility for their care while directing them to the plan and community services that are available.

In addition to all of 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.

Revised December 2017
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. These requests are reviewed by or under the supervision of a pharmacist registered in New York state and passed on to a medical director when they do not meet the guidelines for approval. Only a plan medical director determines denials of coverage. The department manages the practitioner and member notifications of approval or denial with appeal/reconsideration rights for these requests.

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 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 Program

The plan's pharmacy department provides medication therapy management (MTM) for Medicare Part D enrollees, as well as enhanced MTM services for all other lines of business, including Commercial and Medicaid enrollees. The Medicare program is designed to ensure that covered Part D drugs prescribed to targeted beneficiaries are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events, including adverse drug interactions for targeted beneficiaries. Targeted beneficiaries are those who:

- Have two or more of the following chronic diseases: diabetes, CHF, COPD, hypertension depression, dyslipidemia, and osteoporosis
- Are taking seven or more Part D maintenance drugs
- Are likely to incur annual costs for covered Part D drugs that exceed $3,138

The enhanced MTM program will target members based on various factors including but not limited to disease states, prescription costs, hospital and ER visits, and transitions in care and physician practice.

The programs are developed in cooperation with licensed and practicing pharmacists and physicians and administered by licensed pharmacists. Program components include:

- Comprehensive medication reviews (CMR)
- Targeted medication reviews (TMR)
- Ongoing monitoring
- Prescriber specific interventions

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. 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 through external review or internally to the grievance committee and then the board of directors, based on the member's line of business.
- 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 time frames 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**

CDPHP has partnered with Independent Health (IH), a Buffalo-based non-for-profit health plan, to combine efforts in seeking innovative ways to improve our technologies and manage resources effectively. As a result, the process for reviewing emerging medical and behavioral health technologies is a collaborative effort shared by both health plans.

The CDPHP medical affairs division and IH Medical Management-Health Care Services are responsible for ensuring the systematic and timely review of evolving medical and behavioral health technologies provided to the CDPHP/IH 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 and IH technology assessment teams consist of medical directors (physicians), medical policy analysts (registered nurses), and additional appointees as directed for each respective team. The team is chaired by a medical director from both organizations and is performed on a rotating basis, depending on whose turn the responsibility for presentation of research lies with. The medical policy analyst from each organization share, on a rotating basis, responsibility 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/IH technology assessment teams. 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 both teams. Draft policies developed to address coverage or non-coverage of a technology are presented to and reviewed by each organization's individual 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 the senior vice president of medical affairs operations, 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 draft is presented to the Utilization Management Committee or the Pharmacy and Therapeutics Committee for review and approval.

Revised December 2017
CDPHP uses both industry-standard and internally developed clinically based medical necessity criteria. The industry-
standard criteria are MCG, ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Hayes Medical
Technology Directory, Health Technology Brief Service and Genetic Test Evaluation Program, Technology Prognosis, and CareAdvance
Enterprise Standard Clinical Package. Internally developed criteria are based on current industry standards. 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-
norbidities, 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).

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regular business hours (8:30 a.m. to 5 p.m., Monday through Friday, excluding holidays).

Consistency of applying medical necessity criteria is evaluated routinely. All staff involved in utilization determinations, including
but not limited to nurses, social workers, and plan medical directors are evaluated for inter-rater reliability to establish the
consistency with which they are applying criteria in decision-making.

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 utilization management services for the following:

- Disease management
- Pharmaceutical safety, benefit management, and member connection activities
- High-tech radiology medical necessity review program
- Dental service for Child Health Plus and Medicaid members
- Intensive in-home case management for Medicare Choice members
- Rare chronic disease management
- NYS DOH Health Homes

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, service, or credentialing
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 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 2016, Section IX. Delegation Oversight & Activities: L. DentaQuest, M. Health Dialog
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. 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 remitted 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, 11/13/09, 01/12/10, 03/08/11, 03/13/12, 3/12/13, 3/11/14, 9/9/14, 3/10/15, 3/8/16

The 2016 Resource Coordination Program Description has been reviewed, revised, and approved:

Signed: ___________________________________________________________ Date: ________
Richard Dal Col, MD, MPH
Vice President and Senior Medical Director

Signed: ___________________________________________________________ Date: ________
Tracy Lynn Langlais, RN
Senior Vice President, Medical Affairs Operations

Date Approved by Quality Management Committee Date: _______________________

Date Approved by Board of Directors Date: _______________________

Revised December 2017