Samaritan Health Plans

Medical Management Plan

InterCommunity Health Network-CCO

Samaritan Advantage Health Plan (HMO)

Samaritan Choice Plans

Employer Group Plans

Prepared by: Medical Management Department

2020

References:

- *Centers for Medicare & Medicaid Services (CMS)*
- *Code of Federal Regulations (CFR)*
- *Oregon Health Authority*
- *National Committee for Quality Assurance (NCQA)*
- *MCG Health CareWebQI*
- *Samaritan Health Plans Medical Management Department approved policies*
- *Samaritan Advantage Health Plan HMO Approved Special Needs Plan Model of Care*
  SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

CONTENTS

INTRODUCTION

Samaritan Health Plans is an integrated nonprofit health care organization that includes InterCommunity Health Network Coordinated Care Organization (IHN-CCO), Samaritan Health Plans (SHP) and Third-Party Administrator (TPA) Services. IHN-CCO serves Oregon Health Plan members in Benton, Lincoln and Linn and parts of Marion and Polk counties. SHP serves Medicare through the Samaritan Advantage Health Plan, HMO and the Special Needs Plan (SNP) members in Benton, Lincoln and Linn counties. SHP also serves Samaritan Health Services employees through a self-funded Samaritan Choice plan (Choice). Samaritan Health Plans also offers large, small and association Employer Group (Commercial) Plans.

The Medical Management Plan describes the Medical Management program structure, scope and department objectives. The Plan provides a current overview of the individuals, programs, project components and activities in place to monitor and improve the delivery of health care services contained within the oversight of the Medical Management program. The Plan demonstrates and ensures the program meets compliance with all applicable SHP policies, and regulatory and accreditation requirements.

PROGRAM OVERVIEW

The primary focus of the Medical Management program is to ensure that appropriate, effective and high-quality care is provided to members. The program provides a systematic process to promote timely access of medically appropriate care across a network of providers, treatment facilities and services through complex care coordination, case management, preauthorization, referrals, concurrent reviews and population health management. The delivery of health care services is continually evaluated to identify opportunities for improvement. The scope of the Medical Management program includes all physical, oral and behavioral health care delivery and social and health-related services provided to members across the continuum of care.

OBJECTIVES

1) **Assure effective care delivery, utilization and care management services:**
   - Use data and reports to improve the utilization of care and services to our members in a way that is fiscally responsible and responsive to individual health care needs.
   - Improve handoffs and transitions.
   - Remove barriers to care, improve access and identify members for social service referrals, care coordination, complex care management and chronic disease management and navigation programs.
2) **Advance delivery of clinically-effective, evidence-based care:**
   - Engage community-wide collaboration with providers, traditional health workers and members to develop and implement clinical practice guidelines and programs that address the social determinants of health to meet individual health needs.
   - Bring providers together to integrate physical, oral and behavioral health and social services to promote whole-person care.
   - Engage local and national subject matter experts in the specific and relevant field of practice in developing guidelines.
3) **Develop infrastructure and systematic approach to manage health, risk and outcomes of care:**
   - Establish system-wide population health management processes across the continuum of care.

- Use population health assessment, risk stratification and identification of subpopulations, to deploy care management interventions.
- Advance evidence-based care through use of measures and metrices, i.e. Health Effectiveness Data Information Set (HEDIS).

All components of the program comply with Federal and State regulations and meet the nationally recognized population health management and utilization standards of the National Committee for Quality Assurance (NCQA).

ORGANIZATIONAL AUTHORITY

The governing bodies for Samaritan Health Plans have the ultimate oversight of the Medical Management Department. The Chief Executive Officer has the senior level executive responsibility and reports directly to the governing boards. The Chief Medical Officer directs the clinical components of the Medical Management Department. All activities are communicated through the executive staff or reported to the Quality Management Committee to report to the governing bodies.

LEADERSHIP AND STAFFING

See Attachment II for the Medical Management Organizational Chart.

Chief Medical Officer

Provides clinical leadership for system-wide quality program through active participation in development and oversight of the implementation of the quality program and all committee activities that support the quality program. Conducts peer review activities associated with the credentialing process and recommends practitioners to the Credentialing Committee and Quality Management Council (QMC) for review and approval. Ensures and provides oversight for the provider use of clinical practice guidelines within the scope of physician practice oversight. Provides clinical oversight for authorizations and conducts medical chart reviews as indicated. Conducts and/or observes interdisciplinary care team meetings on a non-scheduled basis to ensure that all medical, pharmacological and other service needs are being met for the Special Needs Plan population. Must be a board-certified Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO).

Medical Director

A board-certified physician with an active and unrestricted license who, under the direction of the Chief Medical Officer, provides clinical expertise needed to support SHP operations that ensure clinical guidelines and criteria are up-to-date and members receive medically appropriate evidence-based care at the appropriate level of care.

Behavioral Health Medical Director

A doctoral-level practitioner with an active and unrestricted license who, under the direction of the Chief Medical Officer, provides behavioral health expertise needed to support care management and utilization management programs that ensure members receive medically appropriate evidence-based care at the appropriate level.

Director of Behavioral Health

Reports to the CMO and is responsible for development of the Behavioral Health Network and Services. Provides behavioral health expertise and leadership within SHP and the community.

Director of Medical Management

Reports directly to the CMO and is responsible for the oversight of department operations, including population health management, care management and utilization review, pharmacy and quality programs. Provides expertise and leadership within SHP and the community.

Manager − Community Care Coordination

Reports to the director of Medical Management and is responsible for nonclinical care coordination and utilization management teams and has direct oversight of the care management vendor, AxisPoint Health, and the Special Needs Plan Model of Care (SNP MOC). Ensures SNP MOC, care coordination and intensive care coordination processes are developed, implemented and followed.

Manager – Medical Management

Reports to the director of Medical Management and is responsible for day-to-day operations of clinical utilization management activities, including care coordination, case management and behavioral health.

Manager – Technical Medical Management

Reports to the director of Medical Management and is responsible for implementation and maintenance of automated solutions that facilitate department operations and support regulatory reporting.

Authorization Specialist

Coordinates and monitors the authorization request process by utilizing systems, tools, policies and procedures and applying knowledge of coding and medical record research. Facilitates professional communication to ensure the authorization process is completed in a patient-centered manner with adherence to quality and timeline standards. Serves as a primary department contact for questions, concerns and inquiries related to the authorization request process.

Behavioral Health Care Manager

Required to possess a master's degree in Mental Health, Social Work, Clinical Psychology (or a closely related field) and maintains active licensure in the state of Oregon as one of the following: licensed clinical social worker (LCSW), licensed marriage and family therapist (LMFT), professional counselor (LPC), psychologist (PhD or PsyD), or current Oregon certification in alcohol and drug counseling (CADC II or III). The behavioral health care manager provides screening, knowledge of criteria and clinical judgment to assess patient needs and assure that medically appropriate treatment is provided in a quality, cost-effective manner within the benefit plan of the member. Participates in care coordination and transition planning for members receiving mental health services and collaborates with community partners to identify member needs, support service delivery, and close gaps in members' care. Supports community efforts in establishing the Youth and Family System of Care and initiatives aimed at improving access to services and quality of care.

Behavioral Health Specialist

Required to have a bachelor's degree in Behavioral Science or a closely related field as well as maintain or actively seek Oregon Certification in alcohol and drug counseling. Has experience in behavioral health care delivery systems, managed care, utilization management and behavioral health care coordination. Coordinates behavioral health care services and supports access to care. Provides support to the behavioral health care managers in screening and assessment of patient needs to assure medically appropriate treatment is provided in a quality, cost-effective manner within the benefit plan of the member as it relates to chemical dependency.

Business Analyst

Performs data analysis for Medical Management. Supports and may lead analysis in multiple areas within the department or health plan. Serves as the liaison between Medical Management and other departments within SHP to ensure project timeliness and accuracy. Researches, analyzes, audits, evaluates, prepares, monitors and maintains assigned projects.

Clinical Care Manager

A licensed registered nurse who facilitates care coordination and planning. Manages utilization by effectively communicating with all care providers, caregivers and vendors involved in the member's care.

Clinical Reviewer

Licensed or certified clinical staff to include: registered nurse (RN), licensed practical nurse (LPN), certified durable medical equipment specialist (CDME), assistive technology professional (ATP), licensed clinical social worker (LCSW), licensed professional counselor (LPC) or other appropriately licensed clinical specialist who reviews utilization management authorizations. Clinical reviewers will use the appropriate criteria applied as part of the review process. Criteria source examples may include (but are not limited to): Oregon Health Authority Guideline Notes, Medicare Coverage Determinations, and MCG Health (formerly known as Milliman Care Guidelines). Final determinations to limit or deny coverage are made by the appropriate Medical Director or delegate. Only licensed physicians with the appropriate clinical expertise and board certification can deny for medical necessity. It is the department's responsibility to review benefit limitations, medical necessity denials, including partial denials, with the Medical Director or his/her designee.

Clinical Services Health Outcomes and Accreditation Coordinator

Assures continuity and consistency in compliance with accreditation standards and regulatory compliance across Health Plan departments. Evaluates the impact of specific issues, defining areas for improvement and communicates to appropriate departments. Leads and conducts business process and gap analysis of department processes compared to standards and regulations.

Health Care Guide or Intensive Care Coordinator

Responsible for ensuring a collaborative and holistic approach to care coordination through integration of physical, behavioral and oral health. Health Care Guides and Intensive Care Coordinators (ICC) have advanced training in trauma informed care and are certified in mental health first aid. ICCs work with members, providers and community partners to promote member engagement and access to care. The ICC assists in identifying and resolving barriers to care and safeguards vulnerable populations through early identification and resolution of their needs.

Health Plans Clerk

Responsible for a variety of clerical duties including screening incoming authorizations and scanning and mail processing for Medical Management. Prepares documents for Authorization Specialists and Clinical Utilization Management staff review. Facilitates professional communication to ensure the authorization screening process is completed in a patient-centered manner with adherence to quality and timeline standards.

Operations Coordinator

Partners and collaborates with leadership and department staff to ensure that benefits and programs are administered in accordance with accreditation, regulatory and plan-specific guidelines. Partners with other functional areas to ensure compliance and ongoing monitoring reach the goals of the department and health plan. Develops reports for care management and utilization management teams, provides

results to management, identifies gaps in operational polices and processes and develops process improvement. Manages operational functions such as process improvement, gap analysis, operational discovery and implementation projects, and coordinates with external vendors, internal staff and committees when necessary to create, review and amend policies, procedures, processes, projects and programs.

Traditional Health Worker Liaison

Serves as primary resource and provides central coordination for traditional health worker services within IHN-CCO service area. This position will implement IHN-CCO's Traditional Health Worker Integration and Utilization Plan and will be responsible for data collection and submission to the State. The traditional health worker liaison will collaborate with the Oregon Health Authority Traditional Health Worker Commission and Office of Equity and Inclusion to implement best practices and meet regulatory requirements. The liaison will coordinate with providers and community stakeholders to increase member access to traditional health workers. This position collaborates with providers and community stakeholders to improve the integration, availability and continuous improvement of traditional health worker services.

OPERATIONS

POPULATION HEALTH MANAGEMENT

The Population Health Management (PHM) strategy provides a cohesive plan to address the care needs of populations. Goals are established for keeping members healthy, managing emerging risk, and managing members with multiple chronic conditions, with complex care needs, and for ensuring patient safety and the provision of seamless care across the continuum. Programs and services are offered to members that promote whole-person care that addresses the needs, preferences and values of individuals within the population. PHM includes program activities that are not direct member interventions but support the needs of the population, such as provider education and technology investments to improve care coordination and communications between providers and effective transitions of care.

PHM programs are centrally coordinated through Medical Management to reduce member confusion when multiple contacts are necessary for the care they receive. Medical Management coordinates with care providers, community agencies, and contracted and delegated entities to alleviate member burden, provide navigation and ensure a seamless member-centered approach to care and services.

The population assessment integrates multiple types and sources of data, including factors such as social determinants of health; those economic and social conditions impacting health and quality of life, to better understand members and their needs. The population assessment is cyclical and provides a systematic approach to identify subpopulations and individual member needs. Data is refreshed monthly, collected from disparate sources and integrated to provide a comprehensive view of the population. Criteria are used to: monitor, screen and risk stratify the population. Criteria also identifies and segments individual members into complex, high, rising and low risk groups or cohorts. Members with behavioral health risk factors are offered behavioral health management services. Members with multi-condition, polypharmacy or complex risk factors are offered complex case management services. Members with rising risk factors or a new chronic condition are offered condition management, care intervention and coordination services. Members with little or no risk are offered wellness and preventive health education programs.

The results of the population assessment are used to determine the needs of a population, the effectiveness of programs and services and to focus resources where they will have the greatest impact. This information is useful in improving care management services with the goal of improving member health and well-being.

The PHM program engages support and alignment of the care delivery system and provider network in achieving goals through patient-centered primary care homes, care integration, data sharing and value-based payment arrangements.

POPULATION HEALTH MANAGEMENT PROGRAMS AND SERVICES

Behavioral Health Services

Behavioral Health services are provided by an extensive network of behavioral health providers and facilities. This includes inpatient psychiatric and substance abuse units as well as free-standing psychiatric and substance abuse facilities. Outpatient care is provided by psychologists, psychiatrists, psychiatric nurse practitioners, social workers, licensed mental health counselors and traditional health workers. Treatment is also provided in community mental health clinics and substance abuse programs. In addition to standard inpatient and outpatient behavioral health services, SHP has contracted with providers to develop both telephonic and mobile crisis intervention. All providers meet state requirements for licensure as well as SHP credentialing standards.

The Behavioral Health Director provides oversight of the Behavioral Health program and is involved in implementing and evaluating Behavioral Health services. The Behavioral Health program is integrated within Medical Management. Triage and referral processes for behavioral health services are coordinated through qualified behavioral health care managers. Referrals to intensive levels of care are facilitated through contracted Community Mental Health Crisis response teams and qualified licensed practitioners. The program oversees services such as Assertive Community Treatment (ACT), Wraparound, intensive care coordination, and care management for adults, youth and children.

SHP assesses population needs to identify gaps in community behavioral health services. By partnering with local behavioral health providers and developing new programs these gaps can be addressed.

Care Management Program

The Care Management (CM) program offers support, navigation and care coordination. Care management is ideal for members experiencing immediate and ongoing medical conditions or injuries that may require complex, high-intensity utilization of health care and social services. The CM program is coordinated through a care management hub. The purpose of our care management hub is to provide screening, linkage and coordination for members identified through registries, requirements, and referrals. The hub is the point of central coordination for our care management programs; providing a centralized team to screen, triage and refer members for various internal and external resources and programs. Standardized documentation is utilized to inform opportunities to evaluate our programs and services. Members may be identified for services through referrals, diagnosis of specific conditions, risk stratification and/or quality improvement initiatives.

Members have access to health care professionals who are certified care managers, wellness coaches, licensed social workers, pharmacists and behavioral health specialists and peer supports. SHP offers a whole-person approach that goes beyond medical needs to behavioral, oral, pharmacy, health, wellness and socioeconomic needs as well.

Referrals

There are multiple sources of referrals: direct referrals and system-generated referrals. Direct referral sources may include the following: provider, member or caregiver, community practitioners and partners, and agencies or vendors, such as home health and customer service. System-generated referrals are based on data and reporting of established referral criteria and conditions. Referral criteria may include health risk assessments, pharmacy and medical utilization, high dollar claims, hospital admission, lab and other data sources and reporting (i.e., hospital ED use, discharges and claims data reporting). SHP care

managers also refer members and track referrals to social service agencies, specialists and other health care providers.

Screening / Assessment / Triage / Monitoring

Referrals received are screened for appropriateness of participation in the Care Management (CM) program. The CM enrollment process is conducted by clinical and non-clinical staff. Screening and assessment are completed for each referral to assist in determining member's needs and appropriate referral pathways. Individual referrals are triaged by the intradisciplinary care hub team based on immediacy of need. Members are informed that participation is voluntary and that they will not be charged for participation. Once the member has agreed to participate, clinical staff complete the initial member clinical screening. The clinical staff identify themselves to the member, stating name, title, role and responsibilities. The screening process facilitates the timely evaluation of clinical, functional, cognitive, social determinants of health, engagement level, demographics and support systems.

The Population Health Management program provides data and reports to identify member needs. Member data is screened, risk stratified and organized into cohorts to identify members for the appropriate care track and outreach. Care managers monitor and review member reports and event notifications to identify members of prioritized populations and members with special health care needs.

24/7 Nurse Advice Line

Specially trained registered nurses are available to answer member health questions 24/7. Using this free service, members may call with health questions to understand their symptoms, decide the best place to go for care, learn more about a diagnosis, explore treatment options and understand their medications.

Care Coordination

A service that involves deliberately organizing member care activities and sharing information among all participants concerned with a member's care to achieve safer and more effective care. This means that the member's needs and preferences are known ahead of time and communicated at the right time to the right people. This information is used to provide safe, appropriate and effective care to the member.

Complex Case Management

A process designed for members with chronic and/or complex medical/behavioral health conditions to promote independence, optimal health and continuity of care at the lowest cost appropriate to the member's needs. The Complex Case Management (CCM) program is voluntary and is provided at no cost to the member. A member must give verbal and/or written consent for enrollment in this program. The program is most successful with participation of the member's family, caregivers and/or other support systems. The CCM program is delegated and provided through AxisPoint Health and is available to any individual enrolled into IHN-CCO, Samaritan Choice Plans, Employer Group Plans and Samaritan Advantage Health Plans, including the Special Needs Plan.

Medical Management provides oversight of the population health model that AxisPoint Health uses to identify and manage members with complex and emerging health needs. A focus on high-risk members with complex needs remains a core component of the model as these members represent only a small percent of our membership but account for a majority of medical costs. Typically, complex members have multiple diagnoses and psychosocial needs that can significantly diminish their quality of life. Care managers focus on identifying and reaching out to at-risk members before they require more intensive medical services.
Population identification and referrals:

- Monthly algorithms based on claims and authorization data.
- Proprietary predictive analytics to segment population for outreach.

- Referrals made by nurse care managers, utilization management staff and providers.
- Member self-referral through Customer Service or website to outreach members.

Care managers use a telephonic guideline to initiate their calls, ensuring consistency in conveying basic elements of the program. The care manager describes the voluntary nature of the care management program. Members have the right to disenroll at any time and the right to not be contacted if they are not interested in the program. Members are also reminded that they may initiate services in the future if they wish to do so.

The CCM program continues to evolve with advances in member identification and engagement techniques. The core tenant of the program is to activate members and engage them in removing barriers to health and independence. Together, the care manager and member establish an individualized plan that identifies specific health related goals and ways to address barriers to success. Interaction with a member's primary care provider and relevant specialists is also an important component of the care manager's role. Once a member has been identified and agrees to participate in the complex case management program, the nurse care manager completes interventions such as the following:

- Completion of a telephonic assessment that includes core domains and medication review, pain assessment and depression screening.
- Members that have had a hospitalization are assessed for their understanding of their discharge instructions and follow-up care.
- Provider outreach for members in need of additional coordination or medical intervention.
- Collaboration with multi-disciplinary team members such as social workers for community or behavioral health needs.
- Member education including mailed materials or shared resources for information or support.

Member education focuses on different ways to improve one's quality of life in the face of a complex health condition. Education includes self-care strategies to help avoid complications associated with one's condition, promotion of self-awareness about changes in health, and symptoms requiring early intervention. Nurse care managers inform program participants about educational materials and tools that are available (i.e., web-based programs, links and booklets) and suggest lifestyle modifications.

To evaluate the program's effectiveness, SHP monitors process metrics such as engagement rates and clinical leading indicators such as admission and readmission rate on a quarterly basis.

For members with complex care needs who opt to not participate in the complex care program, various outreach activities occur to inform both members and practitioners about what is available.

As part of SHP's effort to improve quality and health outcomes, the Quality Department mails educational materials to our members. Member outreach takes place monthly, annually and as needed.

Primary prevention outreaches such as breast cancer prevention, cervical cancer screening and pediatric/adolescent immunization reminders go out to both members and providers. The members receive a letter reminding them if they are overdue to receive their screenings and/or immunization. The providers receive a report on the members who are due for these.

Secondary prevention includes outreach for diagnoses such as asthma, cardiac disease, chronic obstructive pulmonary disease (COPD), diabetes, hypertension, medication safety, pneumonia, flu prevention and general women's health. Communications are sent to both members and their providers.

Flexible / Health-Related Services

Flexible Services are cost-effective services offered to supplement covered benefits and community benefit initiatives. These community-level interventions focus on improving population health and health

care quality. Health-Related Services are services intended to improve care delivery and overall member health and well-being, however, are not covered under Oregon's Medicaid State Plan. Health-Related Services include Flexible Services. The goals of Health-Related Services are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities and improve overall community well-being. Health-Related Services are provided instead of, or as a supplement to, billable office visits and are often cost-effective alternatives to covered benefits. Health-Related Services lack traditional billing or encounter codes; they are not encounterable and cannot be reported for utilization purposes. Flexible and Health-Related Services are coordinated and administered through the Medical Management Department.

Intensive Care Coordination for Members with Complex and Special Health Needs

Intensive Care Coordination (ICC) is a process to coordinate multiple services and supports available to members who have complex medical, dental and/or behavioral health needs that may include multiple chronic conditions and/or severe and persistent behavioral health challenges. ICC facilitates communication between member, providers and community partners through interdisciplinary care teams. They address health disparities, assist in accessing appropriate preventative, remedial, and supportive care and services and manage transitions and gaps in care to improve outcomes.

IHN-CCO currently serves more than 57,000 Medicaid managed care enrollees. Many of these members are relatively healthy and only require access to primary care practitioners to obtain episodic and preventive health care. The Medicaid program also serves several population groups who have complex medical, behavioral, and long-term care needs. These populations have poorer health outcomes and drive high-cost services, including inpatient and long-term institutional care. Navigating the current health care system can be difficult for these members. Encouraging the appropriate utilization of services, through ICC and service integration, is essential for controlling future health care costs and improving health outcomes for this population.

Maternity Case Management

SHP offers a case management program specifically tailored to the needs of members identified as having a high-risk pregnancy. SHP case management and public health departments are working collaboratively with participating OB/GYN providers to identify high-risk pregnant members in the first trimester of pregnancy.

Medication Therapy Management

The Medication Therapy Management (MTM) Program offers a comprehensive approach to improve medication use, reduce the risk of adverse events and improve medication adherence. The program follows Medicare Part D requirements and the expansion of MTM to Medicaid and high-risk commercial members. The MTM program aims to identify an additional group of at-risk Medicare beneficiaries beyond the Centers for Medicare & Medicaid Services minimum requirements, taking a multidisciplinary approach to MTM, coordinating engagement with beneficiaries with outreach, and interventions by case management as appropriate. SHP's pharmacists collaborate with our primary care providers to promote MTM services to our members. The goal of the MTM program is to improve the safety and effectiveness of pharmacotherapy for members, leading to improved medical outcomes and efficiencies. Improvement will be achieved through pharmacist or pharmacist-directed interventions with members, physicians or provider pharmacies regarding the pharmacy co-therapeutic management of chronic conditions. A comprehensive medication review is offered at least annually to all targeted members enrolled in the plan's MTM program.

Long-Term Services and Supports

Medical Management staff collaborate with our Long-Term Services and Supports (LTSS) partner through our Memorandum of Understanding. Our mutual goal is to improve person-centered care, align care and service delivery and provide the right amount of care in the right place at the right time for members across the LTSS system. Health care guides and behavioral health care managers participate in delivering activities within the MOU which include:

Interdisciplinary care team meetings: IHN-CCO and LTSS have established interdisciplinary care teams, consisting of health care guides and behavioral health care managers, PCP, LTSS representatives, as well as other agencies/services providers working with the members. The interdisciplinary care teams will coordinate care and develop individualized care plans for high-needs members.

Coordination of transitional care practices: Medical Management and LTSS staff collaboratively coordinate transitions for members experiencing a transition in their care setting or change in condition. Care coordination practices integrate cross-system education, timely information sharing, and coordination to avoid cross-system duplication of effort. They also ensure effective deployment of interdisciplinary nursing and psycho-social resources when a member has a transition of care or change in condition.

Increase member engagement in the care conference process: The LTSS case manager and Health Care Guides collaborate on how best to obtain member input and identify areas of need or services to be included in the member individualized care plan. The interdisciplinary care team promotes self-management of chronic conditions and participation in health promotion and/or prevention activities.

Special Needs Plan Model of Care

The Special Needs Plan (SNP) Model of Care (MOC) provides a framework for quality improvement and a method to ensure the unique needs of our members enrolled in our SNP are identified and addressed. The Centers for Medicare and Medicaid Services sets guidelines for the MOC for Medicare Advantage plans and requires approval by the National Committee for Quality Assurance. SHP is also required to contract with the Oregon Health Authority to operate a Medicare Advantage Dual Special Needs Plan (D-SNP) for members dually eligible for Medicare and Medicaid. The goal is to ensure coordination of care and payment to effectively support the special health care needs of this vulnerable population. The MOC provides care coordination and case management services for all SNP members. Case Managers talk with members by phone and work on identifying problems, goals and opportunities as well as capturing potential gaps or barriers to care. Individualized care plans are created by and for the member to positively impact health outcomes. Interdisciplinary care teams consist of the member, providers, community partners and a case manager. They meet regularly to review member conditions and status, goals, progress, gaps in care and needs for additional resources. Care coordination is provided for those members needing additional support through transitions, such as discharge from hospitalization or moving from their own home into a community-based facility.

Transitions of Care

SHP care management team ensures member care is coordinated and continuous for members who are experiencing a transition of care from one setting to another, between health care practitioners or episodes of care through established care management processes. Care management leadership meets regularly with community partners, agencies, primary care providers and specialists. Collectively they discuss challenges and barriers. They also ensure effective communication and coordination among behavioral health, oral health, physical health, and specialty providers and agencies, including non-emergent medical transportation. SHP care managers work closely with Patient Centered Primary Care Home (PCPCH) care management teams to monitor cohorts of high risk, high needs members and receive alerts from Collective Plan, formerly PreManage, of members who enter the emergency department so that care

managers can intervene. As part of utilization management concurrent review, SHP care managers begin discharge planning at admission and ensure planning is continuous throughout the stay and a clear plan is in place prior to discharge. SHP care managers convene and participate in interdisciplinary care team (ICT) meetings and develop individualized care plans which are shared with the member, family, and/or natural supports and the ICT through secure email. We engage members, their family and natural supports to ensure needs and care plans are adapted and understood by all using the teach back method. SHP care managers coordinate with providers and community agency partners to manage care between settings, including hospitals, Oregon State Hospital, acute care nursing and rehabilitative facilities, hospice, home health and home. Care coordination practices integrate cross-system education, timely information sharing, and coordination to avoid cross-system duplication of effort. It also ensures effective deployment of interdisciplinary nursing and psycho-social resources when a member has a transition of care or change in condition.

Wellness Programs

SHP offers and implements workplace wellness and prevention programs to support member and employer group sponsored worksite wellness needs and to drive health plan strategies.

UTILIZATION MANAGEMENT

Utilization management (UM) is integrated within the Medical Management Care Management Program. The medical director and medical management director oversee the program operations. Utilization review is conducted according to department policies, procedures and clinical criteria. Medical necessity is determined, and the decision time frame and notifications must adhere to policies and plan documents. Prospective, concurrent and retrospective reviews are performed to provide a basis for decision-making. UM decisions are made by qualified, licensed health care professionals who have the knowledge and skills to assess clinical information, evaluate working diagnoses and proposed treatment plans. Medical Management is supported by board certified UM physician reviewers and behavioral health physicians and doctoral-level practitioners who hold a current license to practice without restrictions. These licensed physicians have knowledge of Medicare coverage criteria and other plan-specific criteria to oversee UM decisions, and ensure consistent, appropriate medical-necessity determinations. Inter-rater reliability reviews are conducted to ensure consistent application of the utilization criteria.

The Medical Management department at SHP utilizes the Cognizant software program, Facets, in conjunction with the Hyland software program, OnBase. SHP activities related to members and providers, including authorizations, claims, customer services, appeals, quality and case management, are documented in the Facets system. Clinical and supporting documentation submitted to SHP is electronically stored within the OnBase system for viewing.

Monitoring for over-utilization and under-utilization occurs through utilization and case management reports, and clinical performance measures, including Health Effectiveness Data Information Set. Race, ethnic, cultural and linguistic disparities are used to identify actions for improvement. All sources of member satisfaction surveys, complaints, appeals and grievances are reviewed to identify potential areas of concern. Practitioner medical, pharmacy and utilization profiles are also reviewed.

Education and Support

SHP provides a Health Insurance Portability and Accountability Act (HIPAA)-compliant internet-based portal, called Provider Connect. This is accessible via OneHealthPort and allows providers easy access to real-time authorization information and submission, eligibility and claims.

Provider education is accomplished through Provider Connect, special trainings, annual updates and seminars, or through news bulletins or clinical education provided by the chief medical officer, Network Strategy and Contracting, Medical Management and Quality departments.

Members may receive education about benefits and care management through welcome letters, periodic newsletters, quality initiatives or projects, or individual communication through the efforts of Medical Management staff.

Prior Authorization Requirements

Decisions regarding what services should require prior authorization are made to target services that are high risk (of complications or side effects), frequently overused (by providers) and high cost (to members and the health plan). Services that are low risk, low cost, and not overused by providers are generally not targeted to require prior authorization.

The availability of a nationally recognized evidence-based guideline (from organizations like MCG Health or the Center for Medicare and Medicaid Services) that can be used to review a service for medical necessity/medical appropriateness also contributes to decisions about what services may require prior authorization (we need criteria to review against).

For the IHN-CCO line of business, information contained within the Oregon Prioritized List including Guideline Notes published by the Oregon Health Authority also contributes to decisions about what services should require prior authorization.

Prior authorization lists are managed by the Plan Contract and Benefit Administration Department in coordination with Medical Management clinical services. These lists are updated annually with input from multiple health plan departments and require external regulatory review.

Prior Authorization List

The Prior Authorization List is plan-specific and includes services and procedures requiring review prior to the member receiving care or treatment. The list is published on the SHP website and included in member benefit materials. The Prior Authorization List is designed to eliminate barriers for members with chronic conditions and/or special health care needs. Medical Management policies, procedures and criteria outline utilization requirements prior to authorizing for most procedures, diagnostic treatments, provider specialties, and code sets or item-specific requirements. Authorization determinations are made using evidence-based, established local, state or nationally accepted criteria, adhering to regulatory and plan-specific requirements.

Authorization Specialist Review

The authorization specialist's role is to verify eligibility, benefits and provider status and data entry, and to process determination letters, requests, as well as track clinical records. With training and supervision, the authorization specialist may process certain authorizations following written Auto-Authorization guidelines. The authorization specialist will refer all requests that do not meet criteria for Auto-Authorization to clinical review and organizational determination.

Clinical Review

All authorization requests that do not meet the written Auto-Authorization guidelines or that require clinical criteria review will be reviewed by a licensed RN (clinical care manager), licensed LPN (clinical care guide), licensed clinical social worker (LCSW)/licensed professional counselor (LPC) or behavioral health care manager, certified durable medical equipment coordinator, or other appropriately licensed clinical specialist. Authorization requests requiring clinical review will have the appropriate criteria applied as part of the review process. Criteria source examples may include but are not limited to Oregon Health Authority Prioritized List of Health Services, Guideline Notes, Oregon Administrative Rules, Oregon Revised Statutes, National and Local Medicare Coverage Determinations, Medical Coverage Policies and MCG guidelines.

Service Types

- **Alcohol and Drug Residential:** Outpatient chemical dependency (CD) services or substance use disorder (SUD) services for our members include inpatient hospitalization for medical detoxification, intensive outpatient and outpatient substance use treatment. We currently contract with multiple substance use providers across several counties to meet the needs of our members seeking substance use treatment. Coordinating resources is a collaborative effort between the medical management department, providers, hospitals, community programs and resources.
- **Ambulance / medical transport:** Medically necessary transportation of a member to hospital, facility or medical service. Methods of transportation include land, water or air.
- **Dental services:** Diagnostic, treatment and all aspects of oral health delivery for members in a comprehensive, continuously accessible, coordinated and person-centered process. Services provided by a qualified dental professional in office or inpatient setting.
- **Diagnostic studies:** Examination to identify diagnosis. Services include all testing and imaging to determine a condition, disease or illness provided in an outpatient, facility or inpatient setting. This includes CT scans PET scans and other diagnostic tests, excluding MRI/MRA.
- **Durable medical equipment:** Durable medical equipment (DME), prosthetics, orthotic devices or supplies are authorized by certified DME coordinators and appropriately trained RNs within the department. Authorization requirements may be plan-specific.
- **Emergency services:** Services furnished in an emergency department and ancillary services routinely available to an emergency department that may be needed to stabilize a patient, do not require referrals or prior authorization. The definition of an emergency is based on a prudent layperson's judgment. An emergent condition requires stabilization and may require ongoing care coordination and case management.
- **Hospital inpatient / facility services:** Clinical care manager, clinical care Guide and/or Behavioral Health Care Manager team members telephonically coordinate care, review documentation for quality and care, and facilitate transitions for members at contracted and out-of-network facilities.
- **Inpatient Mental Health –** Mental health treatment provided at the Samaritan Health Services Mental Health Unit and through our network of contracted mental health facility providers. Members are triaged from the emergency room, home, community or from another facility for care. This setting offers the highest level of physical security and most intensive level of intervention. Concurrent review for inpatient mental health is provided by the Medical Management Department using MCG guidelines for medical necessity and length of stay review.
- **Mental health:** Includes outpatient services in the treatment of conditions of psychological and emotional well-being. Excludes hospital and residential services.
- **Magnetic resonance imaging:** Diagnostic services that use magnetic fields and radio waves to produce a detailed image of the body's soft tissue and bones. This service type also includes magnetic resonance angiogram to provide pictures of blood vessels inside the body.
- **Non-emergency medical transport (NEMT):** Transportation to and from medical appointments for members with no other means of transportation.
- **Outpatient services:** Certain outpatient services including: diagnostic, procedural, limited specialist visits, speech therapy, occupational and physical therapy, transplants, and other procedures or services requiring prior authorization are published in the member benefit guide.
- **Out of network services:** Nonparticipating or non-contracted providers will have their requests processed in the same manner as contracted providers. Service and treatment will be approved on a case-by-case basis and depend on the plan and/or individual case considerations. Behavioral health services may be provided by non-contracted providers when: service to a contracted provider is not available in an appropriate time frame, member resides outside the CCO region (i.e., in a Behavior Rehabilitation Services or Adult Residential Program), or specialty provider required for services is not available through the network.

- **Pain management:** Medical approach that draws on disciplines in science and alternative healing to study the prevention, diagnosis and treatment of pain. Pain management services must be provided in an outpatient setting by a qualified provider.
- **Primary care provider:** Services provided in outpatient setting by member primary care provider who is a credentialed and qualified billing provider.
- **Psychiatric day treatment:** Comprehensive, interdisciplinary, non-residential, community-based program consisting of psychiatric treatment, family treatment and therapeutic activities integrated with an accredited education program.
- **Residential rehabilitation:** Treatment received at Residential Substance Abuse Facility or Psychiatric Residential Treatment Center. This 24/7 setting is an alternative to more intensive inpatient treatment and authorized when the benefit allows to treat psychiatric illness and substance use disorder as clinically appropriate.
- **Skilled nursing facility (SNF):** Facility services provided in a medical rehab facility. This covers a continuum of medical and social services designed to support the needs of members recovering from conditions that affect their ability to perform everyday activities.
- **Specialty care:** Surgical or medical specialty care provided in an outpatient or inpatient setting by a qualified provider.
- **Therapy: Occupational, physical and speech:** Therapy services provided in an inpatient facility or outpatient setting by a qualified provider. Therapies for members recuperating from medical procedures, surgical conditions, or mental illness that encourage rehabilitation through the performance of activities required for daily life.

Review Types

- **Pre-service review:** Review of services / treatments prior to the service date is considered pre-service or prior authorization. Prior authorization requests account for the highest volume of requests reviewed in the department. These include planned inpatient hospitalizations or procedures, outpatient services, and home health items, services and/or equipment.
- **Concurrent review:** A review to determine extending a previously approved, ongoing course of treatment or services. Concurrent reviews are typically associated with inpatient care, skilled nursing facility, residential behavioral health care, intensive outpatient behavioral health care and ongoing ambulatory care.
- **Post-service review:** The process of reviewing services or treatment after the date of service occurs is considered post-service review. Post-service review of services that require prior authorization is limited by exception reason. If an exception is granted, the same criteria, plan benefits, and guidelines are applied to the request, or case as would be applied for pre-service requests.

Utilization Management Criteria

The plan's evidence of coverage or plan document, federal and state guidelines are used to determine benefits. Nationally recognized criteria, federal, state, internal practice guidelines, and company-developed clinical standards are used to determine clinical, and medical appropriateness of services.

The criteria are selected, developed, approved and overseen by the SHP leadership team. The organization gives practitioners with clinical expertise in the area being reviewed the opportunity to advise or comment on the development or adoption of criteria. The SHP leadership team working closely with Medical Management leadership to ensure clinical consistency and appropriateness of all criteria utilized by the Medical Management department.

Complete criteria sets are maintained electronically and are available for reference to authorized entities, providers and members upon request.

Evidence-Based Criteria

SHP performs utilization management using nationally recognized evidence-based guidelines from MCG Health Care guidelines from MCG provide evidence-based medicine's best practices and care plan tools across the continuum of treatment, providing clinical decision support and documentation which enables efficient transitions between care settings. Eight of the largest United States health plans and nearly 1,900 hospitals use MCG Health's evidence-based guidelines and software. MCG Health's informed care strategies affect over 208 million covered lives.

Criteria Examples

- American Society of Addiction Medicine: asam.org/resources/the-asam-criteria
- MCG CareWebQI 11.8 MCG Health: mcg.com/care-guidelines/overview
- For Samaritan's Medicare Advantage Health Plans, we use applicable content from:
    - Medicare National Coverage Determinations, Local Coverage Determinations and the Medicare Benefit Policy Manual.
    - CMS Medicare National Coverage Determinations: cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961
    - CMS Medicare Local Coverage Determinations: cms.gov/medicare-coverage-database/indexes/lcd-state-index
    - Medicare Benefit Policy Manual: cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673
- Our IHN-CCO plan follows coverage guidelines and funding limitations that govern the Oregon Health Plan (Oregon Medicaid) established by the Oregon Legislature, and the Oregon Health Authority in the Prioritized List of Health Services and Oregon Administrative Rules:
    - Oregon Medicaid Prioritized List (which includes above the line and below the line information as well as guideline notes developed by the state Health Evidence Review Commission): oregon.gov/OHA/HPA/CSI-HERC/Pages/Prioritized-List
    - Oregon Administrative Rules: secure.sos.state.or.us/oard/ruleSearch.action

On the rare occasion that no appropriate guideline exists from the sources above, SHP uses a small number of internally developed Samaritan Health Plan Medical Coverage Policies, providers.samhealthplans.org/medical-coverage-policies.

It should be noted that the conclusion a service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by SHP) for a member. The member's benefit plan determines coverage. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps, or other limits.

Clinical reviewers consider the individual characteristics of the member, i.e., age, comorbidity, complications, progress of treatment, psychosocial situation, care supports and home environment when applying criteria.

Request Types

Requests for services, or items, and decision notification time frames are consistent with applicable state and federal laws, regulations and accreditation standards. Detailed explanations and timelines are outlined in decision support tools, and department policies and procedures.

- **Expedited**: When a service request is expedited, a provider is documenting that the member's health condition cannot wait the standard authorization timeframe to receive a response (see timelines below).

- **Standard**: Each line of business has a regulatory timeframe to process a standard request. When a request is incomplete or requires a more extensive review, additional time may be necessary to process the request. It is the responsibility of the plan to reach out a minimum of three times to request additional documentation and then refer to the plan medical director for follow-up (see timelines below).
- **Retroactive**: A post-service or retroactive request may be reviewed up to one year past the date of service. Retroactive requests are processed within 14 days of receipt for all lines of business except Commercial Plans which are processed within two business days.

Notification Process

Members may receive written notification of the authorization determination by mail. Each plan requirement is documented in Medical Management policies and procedures. In addition, phone calls, faxes, letters, and e-mails are documented, and maintained per regulatory requirements.

Prior authorization request processing timeline requirements:		
Line of business	Expedited timeframe	Standard timeframe
Samaritan Advantage	72 hours	14 days
IHN-CCO	72 hours	14 days
Choice	72 hours	14 days
Samaritan Health Plans Inc. Commercial Lines of Business	72 hours	2 business days

Denials / Appeals

A denial is a decision to **limit** or **deny** authorization of a requested service or item that is published as requiring authorization from Medical Management. This is defined by Centers for Medicaid and Medicare as an **adverse organizational determination**.

Whenever issuance of a denial is warranted, the member will receive notice in writing, which is copied to the provider. The written notification of a denial of coverage is based upon medical appropriateness or benefit limitation will include, but is not limited to:

- Reason for the adverse determination in terms specific to the member's condition.
- Description of the member's treatment interventions requested.
- Specific criteria deemed to be appropriate to apply to the specific request indicating (when appropriate and applicable) the portion of the criteria that was not met.
- Description of the member's appeal rights and how to initiate an appeal.

The chief medical officer or medical director is available to discuss with the provider the decision and rational for the adverse determination. This is called a "peer-to-peer" consultation and will not result in the decision being overturned; rather the intention is to provide an opportunity to discuss the details of a specific case and to better understanding why the request may have not met the required criteria.

Any request that is denied can be appealed by a member or their authorized representative. All lines of business have individual appeal processes including internal and external review. An impartial provider, who was not involved in the initial denial makes the redetermination of medical necessity.

QUALITY AND PERFORMANCE IMPROVEMENT

EVALUATION

The Medical Management Plan will be reviewed and approved annually by the Quality Management Council. The Medical Management Plan, clinical review criteria, departmental policies and practice guidelines will be reviewed no less than biannually, with necessary changes submitted to the Quality Management Council, or the SHP policy change process, as appropriate. Any necessary updates and changes will be made throughout the calendar year to reflect the current process.

Regulatory and Accreditation Compliance

SHP are governed by federal and state governmental statutes and corresponding regulations. Medical Management policies and procedures are tracked, reviewed and updated regularly to adhere to changing standards, and regulations. Ongoing audits are conducted to ensure regulatory compliance.

Federal Government Regulations

Samaritan Advantage Health Plans (SAHP) are our Medicare health plans. The regulations and guidelines governing these plans are available through the Centers for Medicare & Medicaid Services website at cms.hhs.gov and Code of Federal Regulations website at gpoaccess.gov/cfr/index.

Oregon State Government Regulations

IHN-CCO is governed by the Oregon Health Authority through the Oregon Administrative Rules arcweb.sos.state.or.us and Oregon Revised Statutes. Rules and statutes provide guidance for administration of Medicaid benefits. The benefits are included in the Oregon Health Authority Prioritized List, which can be found within the Oregon.gov website.

National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) sets national standards and guidelines for health plan accreditation, and other specific programs, including the Special Needs Plans (SNP). Medical Management has implemented NCQA Population Health Management Standards. ncqa.org.

Policies and Procedures

The organization reviews policies and procedures against current clinical and medical evidence, and updates as appropriate. Medical Management policies and procedures require consideration of community standards, available services, and capacity in the delivery system, and provider network to meet specific health care needs.

Confidentiality

Medical Management staff follow all Samaritan Health System (SHS) and Samaritan Health Plans (SHP) HIPAA policies as they relate to procedures, access, safeguards and security of protected health information. SHP ensures through the process of coordinating care each member's privacy is protected in accordance with the privacy requirements in ORS 414.679, and 45 CFR parts 160 and 164, subparts A and E, to the extent they are applicable. The policies are reviewed with all staff upon hire and annually.

Financial Incentives

Samaritan Health Plans does not use financial or other incentives to encourage over or underutilization. Decision making is based only on member eligibility, and the appropriateness of care and service.

Samaritan Health Plans physicians and staff make decisions about which care, and services are provided based on the member's clinical needs, the appropriateness of care and service and the member's coverage. SHP does not make decisions regarding hiring, promoting or terminating its physicians or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. SHP does not specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage or care. No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care or services. To maintain and improve the health of our members, all physicians and health care professionals should be especially diligent in identifying any potential underutilization of care or services.

New Technologies, Experimental, Investigational Services

New technology and the application of existing technology will be evaluated by the medical management clinicians to determine safety and effectiveness. Information will be gathered from the various published or peer reviewed scientific literature, national consensus guidelines, Food and Drug Administration or other regulatory bodies and internal and external expert consultative sources to evaluate the efficacy for the use of the service, treatment or procedure. The Quality Management Council recommends the inclusion or exclusion of new technologies as covered benefits to the health plan and tracks inquiries for medical technology assessment. The Quality Management Council provides answers to important questions about indications for use, safety, effectiveness and relevance of new and emerging technologies for the health care delivery system. The technology assessment process is expedited when clinical circumstances merit urgent evaluation of a new and emerging technology.

The Medical Management and Quality department leadership will review the results of the program evaluation and determine appropriate interventions to address opportunities for improvement, if applicable. The team will consider both qualitative and quantitative data to identify trends and unfavorable patterns or variance as opportunities for improvement.

OVERSIGHT AND MONITORING

The Medical Management Department maintains an external and internal monitoring and oversight process that ensures adherence to regulations, standards, and policies and procedures. High risk areas are identified, documented, and shared with the Medical Management leadership team. When any issues are identified, program staff complete an incident report, which is submitted to the Compliance Department through the Gorman OMT Monitoring Software System. Subsequent corrective action plans (CAP) are constructed and submitted to Compliance for approval. Once the CAP is approved, it is implemented, tracked and evaluated for effectiveness.

Oversight of Contracted and Delegated Entities

Behavioral Health Services are coordinated through SHP and provided through Community Mental Health programs, systems of care and contracted providers. Monitoring may include but is not limited to wraparound services, Assertive Community Treatment (ACT), Early Assessment Support Alliance (EASA), Supported Housing, supported education, contracted Patient Centered Primary Care Homes, Intensive Treatment Services, and agencies that provide behavioral health services. Medical Management meets quarterly and as needed with Community Mental Health Program leadership to review services, staffing levels and program results.

Medical Management in cooperation with the Quality Department monitor behavioral health subcontractor's performance of delegated activities to ensure timely access and quality of care for members. This oversight will occur through yearly audits and Behavioral Health Program evaluations. The Behavioral Health Quality Committee (BHQC) was established by Samaritan Health Plans to advise the Quality Management Council and participating providers on community needs and priorities for

services in the areas of addiction and mental health, and to assist in planning and evaluating the service delivery system. The BHQC evaluates the care coordination, utilization, and the quality of behavioral health services and the integration of behavioral health services within the larger health care delivery system.

Complex case management services provided through AxisPoint Health (APH) are evaluated annually and as necessary through audits of individual records and activity and outcome reports. In addition, monthly and quarterly meetings are held with APH to review operations and member activity and to address issues as they arise. Medical Management in cooperation with APH developed a joint operating and oversight manual to guide daily operations and the provision of care management services.

At least annually, Medical Management will evaluate the Complex Case Management Program. The purpose of the evaluation is to determine the effectiveness of the program, identify areas of improvement, and outline interventions for the following year. The evaluation process includes, but is not limited to the following:

- **Number of Initial HRA eligible enrollees with Initial HRA performed.** All enrollees must have an Initial HRA within 90 days after the effective date of enrollment.
- **Population stratification.** All enrollees must be stratified by risk range (i.e. low, medium, high).
- **Individualized Care Plan (ICP) development.** Number of ICPs developed for enrollees per risk category. ICP development should start from high risk category members, then medium risk and finally low risk.
- **Interdisciplinary care team (ICT) interventions.** Portion of enrollees with whom their ICP has been shared, as well as the portion of enrollees who have had their ICP shared with their PCP.
- **Number of Reassessment HRA eligible enrollees compliant with Reassessment HRA performed.** All Reassessment eligible enrollees must be assessed within 365 days after the previous HRA was performed. Also tracked are the number of "first time" assessments occurring within 365 days of initial enrollment on individuals who were continuously enrolled up to 365 days from enrollment date, without having received an initial HRA.

Utilization Review services provided by Medical Management contracted Utilization Review (UR) providers are monitored for the quality and appropriateness of decisions and adherence to SHP policies and procedures. Vendors are also required to submit inter-rater reliability reports. Billing invoices are reviewed and reconciled at the end of the period.

QUALITY AND PERFORMANCE IMPROVEMENT

Medical Management takes a systematic and data-driven approach to evaluating, maintaining and improving the quality and safety of services delivered to our members. The department is focused on training and continuous improvement and uses the Agency for Healthcare Research and Quality (AHRQ) PDSA model of improvement.

Inter-Rater Reliability

The purpose of Inter-Rater Reliability (IRR) testing is to monitor and evaluate consistency of internal utilization review decision-making according to established standards. These standards address specifications for conducting effective and efficient Utilization Management services. The results are evaluated for opportunities to improve and to ensure consistency in decision making. IRR testing is completed annually by all clinical and medical reviewers making determinations including medical directors, nurses, physicians and behavioral health professionals.

Case study examples are compiled of typical authorizations that are encountered within the department that require clinical and/or medical review. The testing, for these cases, uses the criteria utilized for the

specific plan represented. This includes MCG Health evidence-based software, CMS standards, Medicare Benefit Policy Manual, Medical Coverage Guidelines (National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), SHP approved clinical policies, American Society of Addiction Medicine (ASAM) and Oregon Administrative Rules including Guideline Notes and the Prioritized List. Documented determinations of the case studies are compared for percentage of agreement of the reviewers. An overall percentage of 85% or higher is the acceptable standard.

The annual IRR review will be completed annually each calendar year. The current annual IRR percentage rate for Medical Management clinical reviewers is 94%.

Quality Data Collection and Analysis

Population based performance measures will be established, extracted, analyzed and reviewed related to the quality improvement projects as a collaborative between Medical Management and Quality Management.

Report Examples

- Emergency, hospital, home health & outpatient authorization data.
- Care Management dashboards and production reports.
- UM production and authorizations reports.
- Utilization reports and metrics.
- Stop Loss reports.
- HEDIS measures.
- Year-end trending by facility type, services and cost.

Performance Improvement Projects

- Care Management member tracking and referral for complex care coordination and checklist for handoffs and care transitions.
- Implementation of care management vendor AxisPoint Health for IHN and Choice plans.
- Implementation of CareAdvance platform for Utilization and Care Management.
- IHN Transformation and Quality Strategy Projects:
    - 01 Care Coordination Trainings.
    - 02 PHM Cohort Development.
    - 03 Second Opinions.
    - 07 Special Needs Population Assessment.
    - 13 Support Services for SMI Population Post Discharge.
    - 14 Meeting Special Health Needs by Convening Interdisciplinary Care Team Meetings.
    - 16 Aligning Services for SMI Population.

Oregon Health Authority CCO Measures

The Oregon Health Authority uses outcome and quality measures to demonstrate performance among coordinated Care Organizations (CCOs) to improve the quality of care, eliminate health disparities and reduce costs. Medical Management is giving priority focus to the following measures for 2020:

- Assessments for children in DHS custody.
- Oral assessments for adults with diabetes.
- Dental assessment: members receiving dental assessments ages 1-5 years and 6-14 years.
- Disparity measure: emergency department utilization among members with mental illness.
- Screening for clinical depression and follow up plan.
- Screening brief intervention and referral to treatment (SBIRT).

Key Performance Indicators

SHP monitors Medical Management performance through the key performance indicators (KPIs) by comparing performance to target. If measure is not meeting target, an action plan is initiated.

Attachment I

Terms and Definitions

Addictions and Mental Health (AMH)	A division within the Oregon Health Authority (OHA) whose mission is to assist Oregonians to achieve physical, mental and social well-being by providing access to health, mental health and addiction services and supports to meet the needs of adults and children to live, be educated, work and participate in their communities.
Administrative Denial Review	A denial of services/items that is based on reasons other than the lack of medical necessity. For example, administrative denials are made for services/items provided that require authorization, but the practitioner or facility provider did not attempt to obtain authorization.
Adverse Benefit Determination	Defined as any of the following: a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical appropriateness, OR b. The reduction, suspension, or termination of a previously authorized service, OR c. The denial, in whole or in part, of payment for a service, OR d. The failure to provide authorization in a timely manner, as defined by Centers for Medicare and Medicaid Services (CMS)
American Society of Addiction Medicine (ASAM)	Patient Placement Criteria for the treatment of Substance-related disorders ASAM PPC-2R.
Appeal	The right of the member or member's authorized health care representative to request reconsideration or redetermination of an authorization that resulted in denial.
Assertive Community Treatment (ACT)	An evidence-based practice designed to provide comprehensive treatment and support services to individuals with serious and persistent mental illness. ACT is intended to serve individuals who have severe functional impairments and who have not responded to traditional psychiatric outpatient treatment. ACT services are provided by a single multi-disciplinary team, which typically includes a psychiatrist, a nurse, and at least two case managers and are designed to meet the needs of each individual and to help keep the individual in the community and out of a structured service setting, such as residential or hospital care. ACT is characterized by the following: a. Low client to staff ratios; b. Providing services in the community rather than in the office; c. Shared caseloads among team members; d. Twenty-four-hour staff availability; e. Direct provision of all services by the team (rather than referring individuals to other agencies); and f. Time-unlimited services.
Authorization Request	The request for approval of a health care product or service such as a specific medical treatment, surgical procedure or diagnostic test.
Auto-Approval	Approval of a health care product or service based on established criteria determined appropriate by the Medical Director.
Auto-Authorization List	A predetermined list of health care products and services that may be automatically approved by the Authorization Specialist.

Behavioral Health Quality Committee (BHQC)	An advisory council to Samaritan Health Plans' Quality Management Committee. BHQC is made up of representatives from Linn, Benton and Lincoln County Mental Health, representatives from the major mental health providers, representatives from the Patient Centered Primary Care Home (PCPCH), and representatives from IHN-CCO.
Care Coordination	A service that involves deliberately organizing member care activities and sharing information among all participants concerned with a member's care to achieve safer and more effective care. This means that member's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the member.
Care Setting	The provider or place from which the member received health care. In any setting, a designated practitioner has ongoing responsibility for the member's medical care. Settings include: a. Home - the designated practitioner for the member in the home setting is the PCT and others as warranted b. Home Health Care - skilled services provided in the home/residence on an intermittent or part-time basis following discharge from a higher level of care. c. Acute care - services provided to members admitted to an inpatient status in a hospital d. Skilled Nursing care - services provided in a skilled nursing facility e. Rehab facility - services provided in an inpatient rehabilitation facility
Case Management	A collaborative process of assessment, planning, monitoring, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality, cost-effective outcomes.
Child and Family Team (CFT)	A group of people, chosen with the family and connected to them through natural, community, and formal support relationships, who develop and implement the family's plan, address unmet needs, and work toward the family's vision and team mission.
Civil Commitment process	Initiated when a Notice of Mental Illness (NMI) is filed with the court.
Community Benefit Initiatives	Health Related Services provided on a community-based level, such as activities or programs to improve the general community health, e.g., farmers' market in the "food dessert" or classes on healthy meal preparation.
Community Health Assessment	Systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community.
Complex Case Management (CCM)	A process designed for members with chronic and/or complex medical/behavioral health conditions to promote independence, optimal health, continuity of care and at the lowest cost appropriate to the member's needs. The CCM program is voluntary and is provided at no cost to the member. A member must give verbal and/or written consent for enrollment in this program. The program is most successful with participation of the member's family, caregivers and/or other support systems.
Concurrent Review	Part of a utilization management program in which health care is reviewed as it is provided. Clinical Reviewers monitor appropriateness of the care, care setting, and the progress of discharge plans. The ongoing review is directed toward alignment with clinical standards, effectiveness of care and coordination of the care team to ensure effective and timely care at the lowest cost.
Continued Access to Care	Providing access for members without delay to specific services.
Culturally and Linguistically Appropriate	The provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. The acronym “CLAS” has the same meaning. For more information relating to CLAS standards, see the following URLs: https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf and https://www.thinkculturalhealth.hhs.gov/

Custody	The prehearing physical retaining of a person taken into custody pursuant to ORS Chapter 426 by a peace officer, health care facility, state hospital, hospital or nonhospital facility.
Delegated Vendor	Any First-Tier, Downstream or Related Entity, Sub-Contractor; any party that has entered into a written arrangement with Samaritan Health Plans (SHP) to provide administrative or healthcare services for a SHP member.
Duplicate Request	Defined as meeting any one of the following descriptions: a. A request that is submitted by the same provider, for the same member, with the same International Classification of Diseases (ICD) diagnosis coding and Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) and is submitted within the appropriate appeal timeframe for that line of business on a previously denied request, OR b. A request that includes additional clinical documentation but is resubmitted by the same provider, for the same member, with the same ICD coding and CPT/HCPCS coding within the appropriate appeal timeframe for the line of business, OR c. Any authorization request that includes wording within the request such as "reconsideration" or "re-review" or any other additional wording that would indicate the submitting provider office is requesting an additional review of an authorization request that has been previously reviewed with a recorded outcome determination.
Durable Medical Equipment (DME)	Items and supplies, both rented or owned, that provide therapeutic benefits to a member in need because of certain medical conditions and/or illness. DME must be able to withstand repeated use in the member's home.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.
Emergency Services	Health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the member’s condition is not likely to materially deteriorate from or during a member’s discharge from a facility or transfer to another facility.
Emergent Services	Services provided for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a. Serious jeopardy to the health of an individual, or in the case of a pregnant woman or her unborn child; b. Serious impairment to bodily functions; or c. Serious dysfunction of any bodily organ or part.
Expedited mail	Any documents or written notifications that are required to be delivered to the post office the day of creation. Expedited mail may include, but is not limited to, any letter (denial or approved) that will be out of processing timeframe if it is mailed out the next day. The timeframes for expedited requests are: a. Samaritan Advantage Health Plan (SAHP) - 72 hours from the time of request b. InterCommunity Health Network Coordinated Care Organizations (IHN-CCO) - 72 hours from the time of request c. Samaritan Choice Plans (SCP) - 72 hours from the time of request d. Commercial Plans - 72 hours from the time of request

Expedited (Urgent) Request	A request for a health care product or service where application of the time frame for making routine or non-life-threatening care determinations: a. Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state; or b. In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is subject of the request.
Facility	A state mental hospital, community hospital, residential facility, detoxification center, day treatment facility or such other facility as the Oregon Health Authority determines suitable that provides diagnosis and evaluation, medical care, detoxification, social services or rehabilitation services.
Family	Parent or parents, legal guardian, siblings, grandparents, spouse and other primary relations whether by blood, adoption, legal or social relationship.
Family Partner	A formal member of the CFT whose role is to support the family and help them engage and actively participate on the team and make informed decisions that drive the Wraparound process.
Flexible Services	A type of Health-Related Service which are cost-effective services offered to an individual member to supplement covered services.
Formal Supports	Services and supports provided by individuals who are paid to provide care or paid to support under a structure of requirements for which there is oversight by state or federal agencies, national professional associations or the public arena.
Health-Related Services	Services intended to improve care delivery and overall member and community health and well-being, however are not covered under Oregon's Medicaid State Plan. Health-Related Services include Flexible Services and Community Benefit Initiatives. The goals of Health-Related Services are to promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities and improve overall community well-being. Health-Related Services are provided as a supplement to billable office visits and are often cost-effective alternatives to covered benefits. Health-Related Services lack traditional billing or encounter codes are not encounterable and cannot be reported for utilization purposes.
Hospital Admission	Formal acceptance by a hospital or other health care facility of a patient who is to be provided with room, board and medical service in an area of the hospital or facility where patients generally reside at least overnight.
Individualized Care Plan (ICP)	A document created with the member and their family and or supports by the care manager, using a trauma-informed, culturally and linguistically appropriate approach. The ICP is developed after a comprehensive assessment and screening of the member's clinical, functional, and socioeconomic needs and includes the specific and member-centered objectives, interventions, timeframe for accomplishing, and ongoing evaluation.
Informal Supports	Supports provided by individuals or organizations through citizenship and work on a volunteer basis under a structure of certain qualifications, training and oversight.
Intensive Care Coordination (ICC)	A process to coordinate multiple services and supports available to members who have complex medical, dental and/or behavioral health needs that may include multiple chronic conditions and/or severe and persistent behavioral health challenges. Intensive care coordination facilitates communication between member, providers and community partners through interdisciplinary care teams to address health disparities, assist in accessing appropriate preventative, remedial and supportive care and services and manage transitions and gaps in care to improve outcomes.
Intensive Case Management	A collaborative, person-centered process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, dental, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality, cost-effective outcomes. ICM and ICC may be used interchangeably.
Intensive Treatment Services (ITS)	The range of services delivered within a facility and comprised of Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTS), Subacute and other services as determined by OHA, that provide active psychiatric treatment for children with severe emotional disorders and their families.

Interdisciplinary Care Team (ICT)	A team of internal and external health professionals and social supports working together to coordinate the member's care. ICT members may consist of health care guides and behavioral health care managers, primary care provider (PCP), Long Term Services & Supports (LTSS) representatives as well as other agencies/services providers working with the member. The interdisciplinary care team coordinates care and develops a plan of care for high-needs members.
Inter-rater Reliability (IRR)	An assessment used to measure the level of consistency among medical management staff and adherence to appropriate criteria or standards.
Invalid Request	An authorization request that is missing required data elements.
Medical Appropriateness /Medically Necessary	Defined as accepted health care services and supplies provided by health care entities appropriate to the evaluation and treatment of disease, condition, illness or injury and consistent with the applicable standard of care.
Medical Coverage Policy	Clinical criteria used for decision-making when primary criteria does not exist.
Medically Fragile Children (MFC)	Children that have a health impairment that requires long-term, intensive, specialized services on a daily basis, who have been found for MFC services by the Department of Human Services (DHS).
Medicare Coverage Guidelines	The National Coverage Determinations (NCD's) and Local Coverage Determinations (LCD's) available to clinical reviewers via cms.gov/Medicare/Coverage/CoverageGenInfo/index
Natural Supports	Individual or organizations in the family's or youth's own community, social, cultural, or spiritual networks, such as friends, extended family members, ministers, neighbors and so forth.
Notice of Mental Illness (NMI)	Process that begins the Civil Commitment of an individual who is a person with mental illness and is in need of treatment, care or custody.
Notification	A fax or electronic notice that a member has been admitted, discharged or transferred to a hospital.
OneHealthPort	A secure portal that opens the door to valuable business and clinical solutions with a single sign on to local health care sites and online services for health care professionals.
Part C Reporting	Includes Grievances, Organization Determinations & Reconsiderations and Special Needs Plan data. Grievances and reconsiderations are managed by the Appeals and Grievances Team.
Peer-to-Peer	A discussion between the SHP MD designated as the primary reviewer of a specific denied authorization request in question and the requesting provider regarding a specific authorization request that resulted in a final outcome of denied or partially denied.
Plan of Care	A strategy developed by the Interdisciplinary Care Team (ICT) based on data gathered through the member assessment. The plan of care determines the needs of the member and establishes protocols to meet the unique needs of the member through a coordinated approach in a seamless continuum.

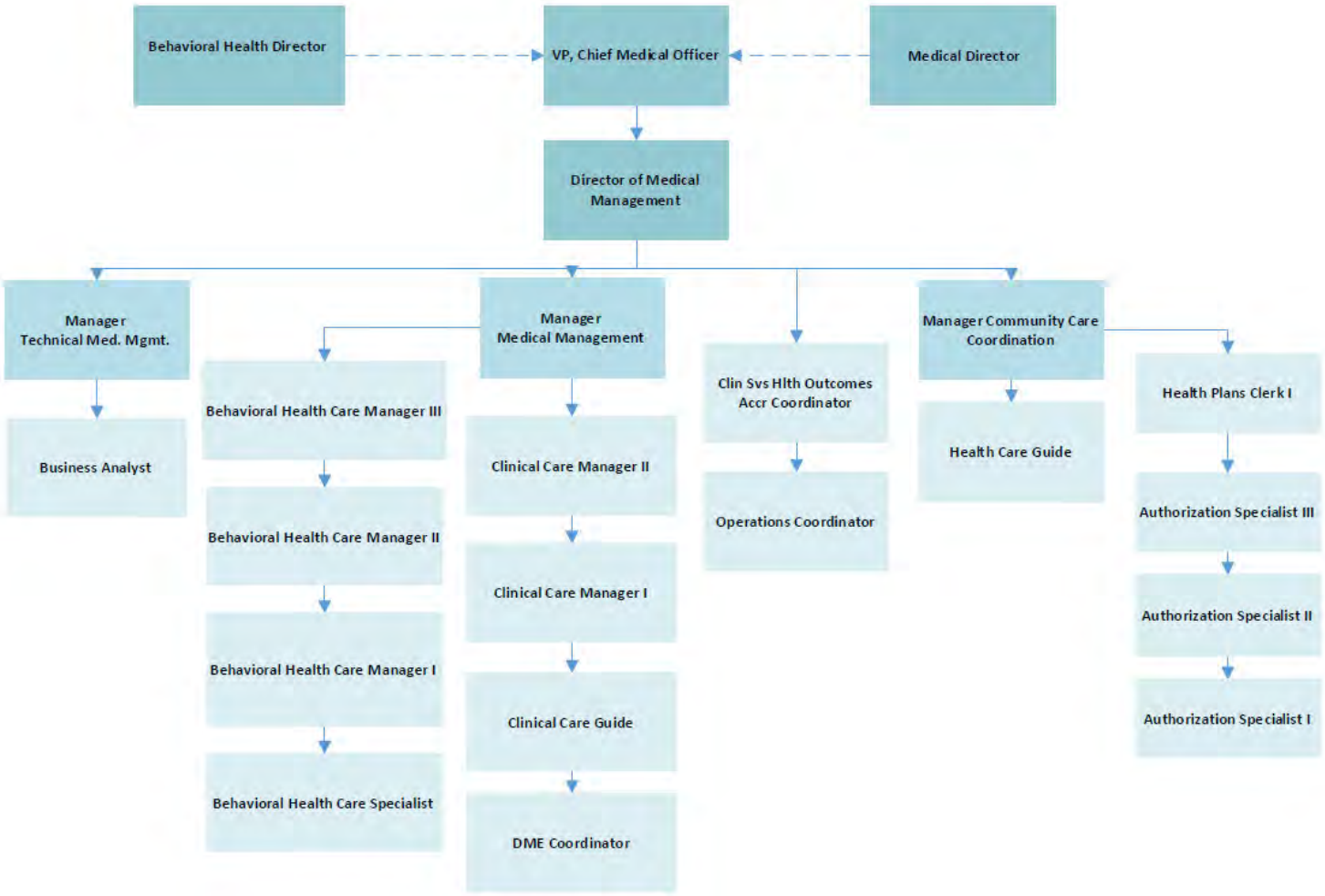
Population Assessment	Systematic assessment of a population integrating data from multiple sources and using criteria to identify characteristics and needs. Characteristics that can be used to define a population or subpopulations may include but are not limited to: a. Federal or state program eligibility (e.g., Medicare or Medicaid, dual eligible). b. Multiple chronic conditions. c. Severe injuries. d. At-risk ethnic, language or racial group. e. Intellectual and developmental disabilities. f. Serious mental illness. g. Housing status. h. Employment status. i. Socioeconomic status. j. Food insecurity. k. Geographic region. l. Age. m. Groups with common comorbidities.
Prehearing period of detention	A period of time calculated from the initiation of custody during which a person may be detained.
Primary Care Provider (PCP)	The practitioner designated by the member and involved treatment team as the person/unit responsible for coordination of medical treatment and services warranted by varying health care needs and conditions.
Prior Authorization	A pre-service request for health plan review and determination of medical necessity and appropriateness of health care services under the applicable benefit plan. Each line of business has a list of services that require authorization prior to the service being completed which is updated annually and posted to the health plan website. Contracted providers agree to be familiar with services that require prior authorization. Services that require prior authorization may include, but are not limited to, surgical services, diagnostic testing, items of DME, etc. Prior authorization is not required for emergent services as defined by the prudent layperson rule.
Prioritized Populations	Individuals who: a. Are older adults, individuals who are hard of hearing, deaf, blind or have other disabilities. b. Have complex or high health care needs, or multiple or chronic conditions, or serious persistent mental illness (SPMI), or are receiving Medicaid-funded long-term care services and supports (LTSS). c. Are children ages 0-5 showing early signs of social/emotional or behavioral problems or have a serious emotional disorder (SED) diagnosis. d. Are in medication assisted treatment for substance use disorder (SUD). e. Are women who have been diagnosed with a high-risk pregnancy. f. Are IV drug users, have SUD in need of withdrawal management. g. Have HIV/AIDS or have tuberculosis. h. Are veterans and their families, and i. Are at risk of first episode psychosis and individuals within the intellectual and developmental disability (IDD) populations.
(Psychiatric) Hospital Hold	The taking of a person into custody by order of a physician pursuant to ORS 426.
Quality	The standards of work measured against similar work including the degree of excellence.
Received Date	The date the request is received by the health plan. This date is counted as Day 1.
Reopening /Reopen	A remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.
Retroactive "Retro" (Post-service) Request	A request for authorization of a health care product or service that has been received.

Risk Stratification	The process of integrating data from multiple sources and using criteria to stratify member risk. Criteria is used to assign members to tiers and subsets with the goal of determining member eligibility for programs or specific services.
Second Opinion	A visit with another qualified provider other than the one previously seen in order to obtain more information, hear a differing point of view, or confirm or make a diagnosis and/or recommendation for treatment.
Segmentation	The process of dividing the population into meaningful subsets using the population assessment and other data sources and criteria.
Self-management Plan	Activities that help members manage a condition and are based on instructions or materials provided to them or to their caregivers.
Serious and Persistent Mental Illness (SPMI)	The current Diagnostic and Statistical Manual of Mental Disorders diagnostic criteria for at least one of the following conditions as a primary diagnosis for an adult age 18 or older: a. Schizophrenia and other psychotic disorders. b. Major depressive disorder. c. Bipolar disorder. d. Anxiety disorders limited to obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). e. Schizotypal personality disorder. f. Borderline personality disorder. SPMI may also be referred to as severe and persistent mental illness.
Services	Activities and treatments described in the wraparound plan and service plan that are intended to assist the individual's transition to recovery from a mental health condition.
SHP Medical Coverage Policies	A series of policies developed by SHP based on local, regional and national practice standards; literature researched and consensus of appropriate SHP team members. Recommended policies must be approved by the Quality Improvement Committee (QIC) to be considered an SHP developed and approved policy.
Special Health Care Needs	Individuals who have high health care needs, multiple chronic conditions, mental illness or substance use disorders and either: a. Have functional disabilities. b. Live with health or social conditions that place them at risk of developing functional disabilities.
Standard Mail	All non-urgent or concurrent service authorizations requests which are processed within 14 calendar days.
Standard Request	A request in advance for authorization of a health care product or service for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.
Successful Outreach	Any verbal contact with an engaged member.
Supports	Individuals who have high health care needs, multiple chronic conditions, mental illness or substance use disorders and either: a. Have functional disabilities. b. Live with health or social conditions that place them at risk of developing functional disabilities.
System of Care Wraparound Initiative (SOCWI)	An initial grant received from the Oregon Health Authority to support the development of a System of Care service delivery model for children with special health care needs.
Timely Notification	Communication to the member within the timeframe determined by line of business, either telephonic, written or fax.
Transitions of Care	Planned or unplanned transition from one care setting to another or between health care practitioners, or episodes of care or changes in health status.

Transition of Care Data	The data supplied to IHN-CCO for purposes of ensuring continued access to care. The data includes data received from OHA documenting clinical services, data received from other CCO's and data received from previous providers.
Transition of Care Period	The period of time after a member becomes effective with IHN-CCO as defined in this policy during which IHN-CCO must provide continued access to are.
Transition of Care Reporting Package	The reporting package developed by IHN-CCO for the purposes of managing and monitoring transition of care requirements.
Trauma Informed	A program, organization, or system, that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures and practices; and seeks to actively resist re-traumatization.
Treatment Plan	A documented plan that describes the member's condition and procedures that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the health care professional. This therapeutic strategy shall be designed in collaboration with the member, the member's family, or the member's representative.
Triage	A clinical process to prioritize service type, need and urgency based on assessed risk, need, disability and dysfunction or a clinical process to assess and identify the needs of the member and the appropriate response required.
Unsuccessful Outreach	Any attempt to contact a member and the member is unable to reach.
Urgent Care Services	Health services that are medically appropriate and immediately required to prevent serious deterioration of a member's health that are a result of unforeseen illness or injury.
Utilization Management	Process for responding to requests for prior authorization, concurrent review, and post-service review for medical appropriateness using specific clinical criteria and assisting care managers, physicians and other providers in planning and managing care with efficiency and high-quality standards.
Valid New Request	An authorization request where all of the required data elements are present.
Warm Handoff	The process of transferring a patient from one provider to another prior to discharge from an acute care psychiatric hospital that involves face-to-face meetings with the patient, either in person or through the use of telehealth, and that coordinates the transfer of responsibility for the patient's ongoing care and continuing treatment and services. A warm handoff shall be offered to individuals with SPMI, defined in OAR 309-032-0860(22), as part of the discharge planning process.
Withdrawn Request	An authorization request that has been retracted at the provider's request.
Wraparound	A definable, team-based planning process involving a member 0-17 years of age (or members who continue receiving services from 18-25 years of age) and the member's family that results in a unique set of community services and supports individualized for that member and family to achieve a set of positive outcomes based on youth and family voice and choice.
Written Notice	A determination letter sent to the member and/or the provider.
Youth	The statewide-accepted term to describe children, adolescents, teenagers and young adults.
Youth Partner	A formal member of the CFT whose role is to support the youth and help them engage and actively participate on the team and make informed decisions that drive the Wraparound process.

Attachment II

Medical Management Organizational Chart



Samaritan Health Plans
Medical Management Department
January 2020