BlueCross BlueShield of North Carolina | HealthyBlue

Healthy Blue
Utilization Management (UM)
Program Description
2021

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Introduction and Background

Healthy Blue is a Medicaid plan offered by Blue Cross and Blue Shield of North Carolina ("Blue Cross NC"). Certain administrative services for Healthy Blue are provided by Amerigroup Partnership Plan, LLC. ("Amerigroup") pursuant to a strategic alliance with Blue Cross NC.

Amerigroup Partnership Plan LLC is a leader in serving low-income families and people with disabilities through state sponsored health care programs, with more than two decades of experience managing health care for the nation's most vulnerable people.

Amerigroup Partnership Plan, LLC (Amerigroup), under the Government Business Division (GBD) and together with its affiliate plans, administers Medicaid and other state-sponsored programs for more than 8 million members in 24 states across the country. Blue Cross and Blue Shield of North Carolina has established an alliance with Amerigroup Partnership Plan LLC ("The Company") to serve North Carolina Medicaid Members. Some members are dual eligible and have Medicaid coverage including those that qualify for Long Term Services and Supports (LTSS) Product (LTSS). Each market is dedicated to the unique clinical and administrative features of its contracted members.

The Company's Health Care Management (HCM) mission is to coordinate the physical and behavioral healthcare of eligible members, offering a continuum of targeted interventions, education, and enhancing access to care to ensure improved outcomes and quality of life for eligible members. The Company works collaboratively with healthcare providers and community resources to fulfill this mission and provide cost-effective quality-driven alternatives to care.

HCM also collaborates with several other programs within the company in promoting healthy lifestyles among the demographic continuum of the membership. The HCM areas collaborating with Utilization Management (UM) or UM Clinical Shared Services are: Behavioral Health (BH), Case Management (CM), Disease Management (DM), Maternal Child Services, and Clinical Quality Management. Each department maintains its own program description and evaluation. The UM program within the HCM Division is designed to assist licensed clinical professionals in making informed clinical decisions based on an assessment of individual member needs as well as an assessment of the availability of services within the local delivery system.

For LTSS services, the UM function is also coordinated with community-based contracted care coordinators.

The Medicaid UM functions are performed at the Medicaid plans and in partnership with Clinical Shared Services teams such as the GBD Medicaid Prior Authorization Team and Behavioral Health.

Purpose

The purpose of the UM Program is to assist the Plan/Region in ensuring that eligible members receive the most clinically appropriate care and services in the most efficient manner possible and to enhance consistency in reviewing cases by providing a framework for clinical decision making.

Scope

The scope of the UM Program includes activities related to inpatient and ambulatory care and collaborates with other programs within HCM in care coordination, discharge planning, and case management to meet the physical and behavioral healthcare needs of its members. It adopts an integrated medical management model based on the physical, behavioral, and social needs of eligible members. The UM program, in collaboration with other programs such as DM and CM, facilitates the delivery of the most appropriate medically necessary care, benefits, and services to eligible members in the most appropriate setting. The UM Program coordinates with the Company Pharmacy Services where Pharmacy Benefit Administration is managed.

A coordinated comprehensive approach ensures that members receive services at the appropriate level of care through the development of individualized, innovative programs and coordination of services with other HCM programs and community resources. The UM Program works proactively and collaboratively to ensure continuity and coordination of care exists between the medical and behavioral health care needs of our members. Lastly, the UM Program engages and supports effective member education to promote measurable positive health outcomes.

Goals

The goals of the UM program are: (1) to ensure adequacy of service availability and accessibility to eligible members; (2) to maximize appropriate medical and behavioral health care; and (3) to minimize/eliminate over- and/or under-utilization of medical and behavioral health services.

Objectives

The UM Program objectives are to:

- Ensure the delivery of quality, medically necessary and appropriate health care services including ambulatory care, inpatient care, and alternative care settings, both in-and out-of-network;
- Promote continuity and coordination of care among physical and behavioral healthcare practitioners;
- Promote the delivery of care and services in a culturally competent manner within the context of members' cultural beliefs, behaviors, practices, disabilities and language preferences;
- Maintain compliance with local, state, and federal requirements, as well as Accreditation Bodies (e.g. NCQA);
- Adopt objective and evidenced-based guidelines, protocols, and criteria that support appropriate clinical decision-making;
- Assure clinical quality practices and outcomes are attained.
- Analyze claims and UM data to identify over- and/or under-utilization;
- Enhance member satisfaction with the UM process by ensuring member's continuity of health care services when needed through timely determination of requests received;
- Enhance provider satisfaction by improving the Company and practitioner relationships through increased Medical Director involvement and peer-to-peer conversations;
- Define the program scope and process to determine benefit coverage and medical necessity.
- Protect personal health information of all members and abide by Health Insurance Portability and Accountability Act (HIPAA) regulations;

- Identify members with complex and exceptional needs that may be appropriate for CM, Maternal Child Services, DM, and Wellness Programs
- Establish and maintain education and training for health care professionals to foster expertise that is commensurate with the UM reviews they conduct.
- Evaluate and modify the UM program description annually which includes:
    - Identifying barriers to expected outcomes;
    - Establishing a work plan to accompany the UM Program description that includes:
        - A schedule of activities
        - Measurable objectives
        - Continuous monitoring of previously identified issues and effectiveness of UM services
    - Routine monitoring and evaluating of target metrics and benchmarks.
    - Perform analysis of the population being served and compare the results to available services, programs, educational materials, and network providers to determine if any gaps exist.

The UM Program provides relevant UM information to the Quality Management (QM) Program for quality improvement activities. This includes identifying quality of care concerns, disproportionate utilization trends, adverse access patterns, and lack of continuity and coordination of care processes.

HCM achieves its goals and objectives in this program by working collaboratively with a variety of other areas external to HCM such as Regulatory, Provider Contracting/Provider Relations, Clinical Informatics, Medical Finance and the National Customer Care Department (NCC), which includes Member Services.

The Company annually notifies its members, practitioners, providers, and employees who make UM decisions of its Affirmative Statement concerning UM decisions. UM decision-making is based only on appropriateness of care and service and existence of benefit coverage. The Company does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization, or create barriers to care and service. Additionally, the Company does not materially misinform or intimidate providers or members that will have the foreseeable effect of significantly discouraging request for covered services, continuation of covered services, or the filing or prosecution of OAH appeals is prohibited.

The Company provides communication services to members and providers to enable access to staff and to information related to UM processes and the authorization of care.

- Associates are available at least eight (8) hours per day during normal business hours for inbound collect or toll-free calls regarding UM issues
- The Company has an operational system to receive inbound communications after normal business hours and on holidays
- All associates must provide their first name/last initial, title, and organization name to the provider (or provider's representative in the health care provider's office/hospital) or to the member when initiating or returning calls regarding UM issues

- Members and providers are notified of designated toll-free numbers and the appropriate Company websites and are able to access these numbers and/or methods through the following avenues:
    - Provider Manuals
    - Member Handbooks and Newsletters
    - Member Identification Cards
    - Member and Provider Websites
- Staff are accessible to callers who have questions about the UM process
- The Company offers TDD/TTY services for members who need them
- For all members who request language services, the Company provides services free of charge through bilingual staff or interpreter to help members with their UM issues

UM Program Structure and Staff Responsibilities

Clinical Shared Services

The Staff VP of Total Population Health (UM Clinical Shared Services) provides oversight to the UM Program. He/she or designee co-chairs the company's Medical Operations Committee (MOC) with the Chief Medical Officer (or designee). MOC reviews and/or approves policies and procedures and utilization management policies, and operationalizes approved Medical Policies and Clinical UM Guidelines for use across the GBD to ensure consistency. Additionally, MOC reviews appropriate UM, DM, and CM Program documents dependent upon market and product. MOC membership includes Enterprise and Regional/Plan Medical Director and HCM clinical leadership.

MOC responsibilities include:

- Review and/or approval of documents related to disease management programs, utilization management, behavioral health, and case management policies and procedures;
- Review of UM Policies and Procedures that are in place to meet NCQA UM Standards;
- Review of Medical Policy and Technology Assessment Committee (MPTAC) approved medical necessity policies/criteria/Clinical UM Guidelines for operationalization;
- Review of DM specific clinical practice guidelines that have been approved by Quality Improvement Committee (QIC);
- Review Model of Care documents
- Review of Inter-rater Reliability Program Report
- HCM Regulatory Policy/Procedure Review and Approval; and
- Review of State specific medical necessity criteria

The MPTAC serves as the official medical/clinical policy-making body of the Company in development of clinical standards or review and adoption of nationally recognized standards, to support evidence-based coverage policies. MPTAC-approved Medical Policies and Clinical UM Guidelines are presented to the MOC for adoption to ensure consistency and a standardized process across the Medicaid Business Unit. MPTAC responsibilities include evaluation and recommendation of revisions to existing UM decision-making guidelines adoption of new criteria for standardized UM decision-making, and the assessment of new medical procedures and technologies and new applications of existing medical technologies for incorporation into Parent Company Medical Policy and Clinical Guidelines.

Our Medical Directors and Care Management team have access to input from practicing licensed, board-certified physicians through MPTAC, which is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. Behavioral Healthcare professionals are also represented in the MPTAC decision making process. Voting membership includes:

- External physicians in clinical practices and participating in networks;
- External physicians in academic practices and participating in networks;
- Internal medical directors.

Input from the medical community is solicited and utilized in developing and updating policies.

Plan/Region

Although the Chief Medical Officer is ultimately responsible for the UM Program, the responsibility for the oversight of the program rests with the Clinical Operations Chief Medical Officers. The Company Behavioral Health Medical Director and/or an appropriate designee who is a Doctoral-level Behavioral Healthcare practitioner (clinical PhD or PsyD) participates in the development and oversight of Behavioral Healthcare aspects of the UM Program. The HCM Regional Clinical Leader/Plan Clinical Leader is accountable for the implementation and daily operations of the UM Program. The Plan Lead for Behavioral Health is accountable for the implementation and operation of the behavioral health components of the program in conjunction with the Plan Behavioral Health Medical Director. The Pharmacy Management Program is managed in the Company office by the Pharmacy Department and provides guidance and Plan assistance through the Medical Director and/or Lead for HCM.

Review and approval of the UM Program is the responsibility of the Medical Director, the Plan Medical Advisory Committee (MAC) and the Plan Quality Management Committee (QMC). These committees also provide direction and feedback to Plan management responsible for the development and implementation of the UM Program.

VP of Clinical Shared/Specialty Services

The VP Clinical Shared/Specialty Services is responsible for end-to-end design and delivery of core Enterprise clinical programs which focus on improving member outcomes and supporting plans, regions, and providers. The many functions of the VP Clinical Shared/Specialty Services include responsibility for UM, CM and DM, as well as the delivery and governance/infrastructure for UM/CM/DM and Specialty Products.

The VP provides general medical oversight of the HCM program and helps identify health priorities and quality focus for the company as a whole, based on an analysis of data and trends. He or she serves as the principal medical policy advisor to the Executive Leadership of the company.

National Medical Directors

National Medical Directors provide leadership at the Enterprise level in the development and implementation of programs that support the efficient utilization of medical resources and the practice of quality (evidence-based) health care by providers. They work closely with Regional/Plan Medical and Clinical Leadership in the implementation of health care management programs that

assure the delivery of appropriate and timely medical services to our members. They also promote and/or lead the development and implementation of medical quality management programs at the level that assure members' health care needs are met and that they have appropriate health maintenance, disease management and preventive services. Additional functions of the National Medical Directors include the establishment and implementation of the company's medical management policies. They also work collaboratively with senior leadership of the company and of the Plan/Region to achieve overall company goals of growth, financial performance, quality care and service to the community. The Behavioral Health National Medical Director provides oversight for all of the BH UM Programs. National Medical Directors for Obstetrics and Neonatology provide leadership for the Maternal Child Services program at the Enterprise level and to the Plan/ Regional Medical Directors.

Staff VP Total Population Health (UM)

The Staff VP Total Population Health (UM) is responsible for UM clinical shared services. This includes oversight of medical policies and procedures, operationalization/governance related to medical necessity medical policy, standardized UM workflows, precertification rule oversight and change management process, annual Inter-Rater Reliability auditing, Outpatient Precert, Post Service Clinical Claims Review, along with clinical training and compliance. She/he leads strategic UM operational initiatives for HCM. The Staff VP or designee co-chairs the MOC which is responsible for review and approval of medical policy, clinical care guidelines and medical necessity criteria.

Staff VP Total Population Health (Clinical Solutions)

The Clinical Solutions Staff Vice President, Total Population Health is responsible for the strategic planning and oversight of HCM, UM, and CM programs for all CSBD, Medicare and/or GBD lines of business. This includes oversight of medical policies and procedures, operationalization/governance related to medical necessity and case management policy, implementation of standardized workflows, execution and delivery of large scale initiatives including new market expansions/implementations, best practices and process improvement/ change management processes.

Director Healthcare Management

Responsible for ensuring the integration of care, implementation of best practices and the delivery of quality, high touch customer, cost effective UM and CM services within assigned regional zones. This includes leading care delivery teams providing integrated solutions including behavioral health, wellness, pharmacy, quality and provider partnerships to achieve plan goals and manage medical loss ratios.

VP Behavioral Health Operations

The VP is a Doctoral-level Behavioral Healthcare practitioner who is involved in UM activities including implementation, supervision, oversight and evaluation of the UM Program. He/she provides general oversight of the Behavioral Health UM Program and facilitates the development of the strategic vision of the department.

Plan or Regional Medical Directors

Medical Directors oversee all medical care for members served by a particular Plan/Region. Each Medical Director provides medical leadership and serves as principal medical advisor to the

executive leadership. The Medical Director is responsible for supervision, oversight and evaluation of the UM Program, and identifies health priorities for the membership based on an analysis of data and trends. He or she oversees Medical and Behavioral Health programs at the Plan/Regional level and oversees UM decisions. Medical Directors, or appropriately licensed practitioners, review all requests not meeting medical necessity approval criteria. Only Medical Directors or appropriately licensed practitioners make any medical necessity adverse determinations. The Medical Director directs Plan/Regional-specific policies and program descriptions through the Plan/Regional committees. The Medical Directors also serve on the MOC, GBD Pharmacy Advisory Committee, and QIC committees.

The Medical Director (Chief Medical Officer (CMO) of the North Carolina Medicaid Managed Care Program) oversees and is responsible for all clinical activities, including but not limited to the proper provision of covered services to Members, developing clinical practice standards and clinical policies and procedures. Requirements:

- Must reside in North Carolina
- Physician, licensed to practice in NC and in good standing (Exception: Medical Director in the event that the CMO is not licensed to practice in NC)
- Minimum experience of five (5) years in a health clinical setting and two (2) years in managed care

Associates performing utilization review must have the qualifications, education and/or experience to successfully perform utilization reviews as consistent with state and federal regulations and state contracts. Utilization Management Managers, Behavioral Health Managers, and other positions as contractually required, must be located in and operate from within the State of North Carolina.

UM supervisors:

- Provide day-to-day supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Are available to UM staff on site or by telephone.

The appropriate HCM, BH, or Prior Authorization Team Clinical Leader may identify licensed health care professionals such as LPN/LVNs with sufficient experience and expertise for hiring consideration to collect data for precertification and concurrent review and to approve services for which there are explicit criteria. The HCM, BH, or Prior Authorization Team Clinical Leader is responsible for ensuring:

a) That the licensed individual is properly trained and supervised, and
b) That this individual has an identified RN resource to provide oversight and direction

Full-Time Utilization Management Staff conduct utilization management activities, including but not limited to prior authorization, concurrent review and retrospective review. They are required to be NC-licensed nurses and/or licensed behavioral health professionals in good standing.

Key aspects and interfaces of the UM Program

The UM Program includes the following key aspects and interfaces, and each is summarized in the subsequent sections:

- Criteria Selection and Approval/Adoption and Resulting Implementation
- Medical Necessity and Non-Medical Necessity Review Decisions
- Prospective, Concurrent, and Retrospective Review Decisions
- Second Medical Opinion
- UM Timeliness Reports
- Adverse Determinations and Appeals
- Inpatient and Outpatient Care Coordination
- Behavioral Health
- Inter-Rater Reliability (IRR) and Performance Monitoring
- New Technology Assessment
- Integration and Collaboration with other Operational Units
- National Customer Care Organization (NCC- Non-Clinical)
- Emergency Services
- Pharmacy Management
- Delegated UM Services
- Annual Program Evaluation

Criteria Selection and Implementation

The Company primarily utilizes current editions of MCG™ Guidelines along with Medical Policies and Clinical Utilization Management Guidelines and AIM guidelines to review the medical necessity and appropriateness of physical health services, unless superseded by state requirements or regulatory guidance. The Behavioral Health UM Program primarily utilizes MCG™ Guidelines, along with Medical Policies and Clinical Utilization Management Guidelines for behavioral health and substance abuse services unless superseded by state requirements or regulatory guidance. These guidelines are objective and evidence-based and are used to guide clinical decision-making.

The Medical Policies and Clinical Utilization Management Guidelines are developed by the MPTAC. Criteria for review of behavioral health issues are reviewed by the Behavioral Health UM Policies and Clinical Practice Guidelines Subcommittee which reports to the GBD MOC. In addition to policies developed and or approved through MPTAC, the Plan/Region's medical reviewers use criteria developed by AIM Specialty Health for review of selected diagnostic imaging requests.

All Federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) criteria and the particular needs of the child are considered for diagnostic and treatment services provided to Medicaid members under the age of 21, as required.

American Society of Addiction Medicine Criteria (ASAM) for Substance Abuse services is required and is used in evaluating the medical necessity of requests for substance abuse services for all populations except children ages zero through six. EPSDT criteria is used for evaluation requests for service to children.

The ASAM criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, adolescents, and children. When using the criteria to match a level of care to the member's current condition, all reviewers consider the severity of illness and co-morbidities, as well as episode-specific variables. Their goal is to view members in a holistic manner to ensure they receive necessary support services within a safe environment optimal for recovery.

These criteria and guidelines are objective and provide a rules-based system for screening proposed medical and behavioral health care based on patient-specific, best medical care processes and consistently match medical services to patient needs, based upon clinical appropriateness.

A specific subset of North Carolina Medicaid Fee-for-Service clinical coverage policies are utilized to review the medical necessity and appropriateness of specific physical and behavioral health services. It covers services based on nationally recognized, evidence-based guidelines and decision support methodologies to support UM and prior authorization for services not otherwise defined in mandated clinical coverage policies.

In addition to these standards, the Company uses clinical best practice guidelines from professional organizations and up-to-date clinical research. National guidelines produced by healthcare organizations such as individual medical and surgical societies, National Institutes of Health, and the Centers for Disease Control and Prevention, are reviewed and adopted.

Criteria and guidelines used by the Company are reviewed and approved annually by members of the MPTAC, and updated when appropriate. Input from the medical community is solicited and utilized in developing and updating policies. The MACs, as applicable, representing practitioners with knowledge of local delivery systems, also review and approve Medical Necessity criteria. Policies and procedures for application of medical necessity criteria are reviewed and approved annually by the MOC.

- The Company makes UM criteria available to practitioners upon request. If a medical necessity decision results in an adverse determination, practitioners are welcome to discuss the denial decision with a Company Medical Director. For additional information, to speak to a Medical Director, obtain UM criteria or for any inquiries, contact may be made via the Company's Prior Authorization Team at 1-800-454-3730.

Benefit coverage is determined according to applicable contract/governmental program benefits/handbook as applicable.

Medical Necessity and Non- Medical Necessity Review Decisions

Medical necessity reviews require that denial decisions be made only by an appropriate clinical professional as specified in all applicable accreditation and/or regulatory requirements, such as NCQA or CMS standards. As applicable, denials resulting from medical necessity review are within NCQA scope of review.

Decisions about the following require medical necessity review:

- Covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits.
- Preexisting conditions, when the member has creditable coverage and the organization has policy to deny preexisting care or services.

- Care or services whose coverage depends on specific circumstances.
- Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits.
- Out-of-network services that are only covered in clinically appropriate situations.
- Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
- Experimental" or "investigational" requests covered by the organization.

Decisions about the following do not require medical necessity review:

- Services in the member's benefits plan that are limited by number, duration or frequency.
- Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
- Care that does not depend on any circumstances.
- Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other ADL-related activities.
- Experimental" or "investigational" requests that are always excluded and never deemed medically necessary under any circumstance. In these instances, the organization either:
    - Identifies the specific service or procedure excluded from the benefits plan, or
    - If benefits plan materials include broad statements about exclusions but do not specify excluded services or procedures, the materials state that members have the opportunity to request information on excluded services or procedures and the organization maintains internal policies or criteria for these services or procedures.

Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met in-network (e.g., a service or procedure not provided in-network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards).

If the certificate of coverage or summary of benefits specifies that the organization never covers an out-of-network service for any reason or if the request does not indicate the member has a specific clinical need for which out-of-network coverage may be warranted, the request does not require medical necessity review.

Appropriate practitioners review all medical necessity denials for requested health care services offered under the Company's medical benefits. No practitioner review is required for requests of medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits.
Practitioners are required to have:

- Education, training, or professional experience in medical or clinical practice
- A current clinical license to practice or an administrative license to review UM cases

The Company follows established procedures for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery

system. These procedures apply to precertification, concurrent, and retrospective reviews. UM clinicians collect and review relevant clinical information to determine if the level of service requested meets medical necessity criteria. Criteria can be accessed via criteria-specific software/web applications.

For EPSDT diagnostic and treatment services provided to Medicaid members under the age of 21, practitioners and UM reviewers consider Members' home environments, individual circumstances, and the local delivery system in determining medical necessity for EPSDT services requiring authorization. Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services in the same day, or location of service) in clinical coverage policies, UM policies, service definitions, or billing codes do not apply to Medicaid members less than twenty-one (21) years of age when those services are determined to be medically necessary per federal EPSDT criteria. If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved to correct or ameliorate a defect, physical or mental illness, it shall be provided.

For behavioral health, utilization screening tools such as the Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS), Early Childhood Services Intensity Instrument (ECSII), Children and Adolescents Needs and Strengths (CANS), and Supports Intensity Scale (SIS)-Adult and Children's versions are used as part of the medical necessity process.

Clinical information for making determinations of coverage may include, but not be limited to:

- Office and/or hospital records
- A history of the presenting problem
- Clinical exam(s)
- Results from diagnostic testing
- Treatment plans and progress notes
- Psychosocial history
- Consultations with the treating practitioner(s)
- Evaluations from other health care practitioners and providers
- Photographs (MRIs, X-rays, Ultrasounds, ECGs, EEGs, etc.)
- Laboratory results
- Operative and pathological reports and results
- Rehabilitation evaluations
- Criteria related to request
- Information regarding benefits for services and/or procedures
- Information regarding the local delivery system
- Member's characteristics and information
- Information from responsible family member(s)
- Member's safety issues

The Company does not employ utilization controls or other coverage limits to automatically place limits on the length-of-stay for members requiring hospitalization or surgery. Length-of-stay for a member's request for hospitalization or surgery is based on the needs of the member, rather than on arbitrary limits. Members who are hospitalized or receiving surgical services are managed by an assigned Utilization Manager. The clinical review for these services will specify authorization for coverage limits as determined by clinical guidelines and individual needs. Subsequently, the Utilization Manager, working with the hospital, PCP/attending physician, and other parties, will monitor and continually review the case to determine discharge readiness and to facilitate discharge planning. For members found to require extended benefits, as identified by the concurrent review of individual needs, severity of illness and services being rendered, the Utilization Manager has the authority to extend the hospital stay or other services as needed.

Pre-service (Prospective) Review Decisions

The Company's approach to precertification promotes appropriate care. Established procedures are followed for applying criteria based on individual member's medical necessity and community standards of care, minimizing administrative barriers for physicians and other providers while promoting appropriate care. Through an aggressive provider-servicing model, the Company educates network providers on covered benefits and services and continuously evaluates the services requiring precertification. Precertification is required on select services to ensure timeliness and appropriateness of care, including:

- Planned inpatient admissions,
- Certain outpatient surgeries, procedures and services/programs,
- Non-emergent, out-of-network services (with the exception of covered EPSDT, family planning and women's preventive health services).
- Home health,
- Certain durable medical equipment,
- Rehabilitation services,
- Certain medications (see Pharmacy Program Description), and
- Certain diagnostic procedures.

The provider is held accountable to precertification notification standards.

Precertification requirements shall NOT be applied to:

- Emergency services
- Family planning services
- Preventive services
- Basic prenatal care in-network
- Psychiatric diagnostic evaluation
- Sexually transmitted disease services
- HIV testing
- Children's screening services

Information on services that do not require a referral or prior authorization are included in the Member Handbook.

When a course of treatment will involve services over an extended period, the treating provider includes that information in the initial precertification request. If approved, the precertification may be extended for a longer period of time.

Precertification reviews are performed by Company clinicians, who are licensed professionals with training and experience in utilization management and appropriate for their managed product and membership. They verify eligibility and benefits in the claim payment system and apply the appropriate criteria to determine whether the service is medically necessary. For those situations where medical necessity is met, the clinician approves the services.

When medical necessity is questioned, or when clinical information needed to make a decision has been requested but not received, the case is referred within the appropriate time frames to the appropriate Medical Director for medical necessity review and determination.

The Medical Director makes the determination, and documents the results of the medical necessity review. The clinician then notifies the treating practitioner and the member of the decision as policy requires. Treating practitioners are notified about the availability of and how to contact a Plan/ Regional Medical Director (or appropriate practitioner reviewer) to discuss any UM denial decisions.

Precertification clinicians are responsible for the following activities during the precertification review process:

- Informing Case Managers of complicated admissions or patients requiring care coordination
- Entering information including documentation of relevant clinical information into the core operating system
- Providing reference numbers to appropriate providers
- Promoting continuity of care between PCPs and specialists
- Identifying potential quality-of-care, patient safety, or fraud issues
- Issuing an administrative denial for Failure to Pre-Certify or Notification of Emergent Admission when notification or precertification requirements were not completed timely

The Company's precertification associates in the Prior Authorization Teams conduct timely reviews to comply with industry, accreditation and contract-specified timeframes. Reports that track aging of open cases are reviewed daily to set priorities and focus on those that require immediate action. The Clinical Management Team in the Prior Authorization Team reviews system-generated logs to identify and resolve potential barriers to timely case closure. They also monitor trended data in weekly or monthly reports to identify trends that may indicate problems with current processes or workload distribution.

The Company's utilization management process will not be used to improperly influence, change or prevent a request for a prior approval. Nothing in this paragraph should be construed to prevent clinical or treatment discussions.

Concurrent Review Decisions

In performing concurrent review, clinicians assess member progress and needs during the episode of care and coordinate such needs prior to discharge to help facilitate a smooth transition for the member between levels of care or home, and to avoid delays in discharge due to unanticipated care

needs. MCG Guidelines® are used to determine that the admission and continued length-of-stay are medically necessary. Behavioral Health Medical Necessity Criteria and ASAM Criteria are used to determine that the admission and continued length-of-stay are medically necessary for behavioral health, unless superseded by state requirements or regulatory guidance. If a stay does not meet standard criteria, the case is individually reviewed by the appropriate Medical Director and a determination made. Upon notification of an admission, the appropriate Company Concurrent Review Associate attempts to obtain clinical information to review. Decisions are made in accordance with currently accepted medical or healthcare practices, taking into account special circumstances requiring deviation from the norm. The Concurrent Review Associate performs the following activities:

- Admission approval and continuing length-of-stay approvals using the nationally recognized MCG™ Guidelines Criteria, Behavioral Health Medical Necessity Criteria, or ASAM Criteria
- Obtains clinical information to substantiate continued inpatient care upon notification of the admission,
- Contacts the attending physician directly or has the appropriate Medical Director establish contact if the needed clinical information cannot be obtained through the on-site clinical review process or from the hospital UM peer reviewer,
- Provides continued length-of-stay authorization at each concurrent review interval, if case meets continued acute inpatient stay criteria,
- Contacts the attending physician and/or hospital UM Specialist for additional information if the admission or continued inpatient stay does not meet medical necessity criteria,
- Notifies the attending physician and/or hospital UM Specialist if the member's level of care placement does not meet the appropriate medical necessity criteria,
- Contacts the appropriate Medical Director within the appropriate time frames for medical necessity review and determination if the medical necessity criteria or level of care placement is not met, or when clinical information needed to make a decision has been requested but not received.
- Notifies the provider of the decision as policy requires,
- Performs discharge planning activities, including the coordination of care needs for psychosocial, economic and other variables related to discharge planning.
- Refers members with complex cases and ongoing needs for case management or BH programs per plan/regional guidelines
- Ensures required notices are sent to treating practitioners and members, and facilities if applicable, within required time frames,
- Upon discharge of the member, the Concurrent Review Clinician ensures the documentation is completed in the authorization database following the Company documentation guidelines,
- For behavioral health discharges, the Telephonic Concurrent Review Clinician also makes certain the member has a follow-up appointment within seven (7) days of discharge and documents the location, time, and practitioner in the discharge notes, and

- If at any time a potential quality issue is identified through the review process, an appropriate referral is made to the Plan/Region's Quality Management Department.

POST-SERVICE (RETROSPECTIVE) REVIEW Decisions

A post-service or retrospective review is a review of a service authorization request for care or services that have already been rendered by the practitioner. Established procedures are followed for retrospective review based on individual member medical necessity, inpatient/outpatient, elective/ urgent/emergent status, timeliness of the request/notification, precertification and contractual requirements.

- If the provider contacts the Company after outpatient care has been rendered and the procedure was emergent (emergency services), the practitioner is advised that no precertification is required for emergency services, and that he/she should submit the claim for payment.
- If the provider contacts the Company after outpatient care has been rendered and the procedure was not emergent, a failure to certify is issued and the request is denied (unless retro review is contractually required).

Each type of review request has a different timeframe for completion of the review process. All timeframes begin with the request for review, and end with issuance of the determination. Unless Federal Medicaid (CMS) or the State mandates otherwise, the Company's standard timeframes are listed in the Tables below.

Table 1 Standard Timeframe for Completion of Authorization or payment of healthcare services requests, for non-BH UM & for BH UM Decision-Making and Notification

Type of Request	Decision and Electronic/Written Notification Standard Timeframe
Pre-service (Prospective)	
Urgent (expedited)	As expeditiously as the Member's health condition requires, but no later than 72 hours (3 calendar days) from receipt of request.
Non-urgent	As expeditiously as the Member's health condition requires, and no later than 14 calendar days from receipt of request.
Concurrent	
Urgent	As expeditiously as the Member's health condition requires, but no later than 72 hours (3 calendar days) from receipt of request
Post-Service/Retrospective	
N/A	Within 30 calendar days from receipt of request

NCQA does not require an initial oral notification of a determination for Urgent Pre-Service and Urgent Concurrent Reviews. The Plan/Region may provide initial oral notification of a denial decision within the required timeframe (see Table 1). The organization records the time and date of notification and the staff member who spoke with the practitioner or member.

- A voicemail is not an acceptable form of oral notification.

- A fax may be sent as the initial notification. For urgent concurrent denials, the fax should include a statement asking the hospital Utilization Review (UR) department staff to notify the attending/treating practitioner of the decision.

There are certain circumstances under which the above standard timelines can be extended. The member or the member's authorized representative must be notified of the need for an extension and the date by which a decision is to be made. For urgent care decisions, health care practitioners with knowledge of the member's medical condition (e.g. a treating practitioner) act as the member's authorized representative.

Members or their authorized representative may agree to extend the decision-making time frame for urgent, preservice and post-service requests.

Unless Federal Medicaid (CMS) or the State mandates otherwise, the Company's standard extension timeframes for requests lacking necessary information are detailed in Table 2.

Table 2 Extension Timeframe for Completion of Authorization Request Lacking Necessary Information, for non-BH UM & for BH UM

Type of Request	Frequency	Decision and Electronic/Written Notification Extension Timeframe
Lack of Necessary Information or Matters beyond control of the Plan/ Region		
Urgent Concurrent and Urgent Pre-service	Member voluntarily agrees to extend the decision-making time frame. The organization may extend the urgent concurrent and urgent preservice time frame once if the Member requests the extension, or due to lack of information and the extension is in the Member's interest, for up to 14 calendar days (CD). ▪ The timeframe may be extended by up to 14 CD, but the organization must notify the member and the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension. ▪ If the timeframe is extended beyond seventy-two (72) hours, the Member and practitioner shall be provided with a written	Up to 14 calendar days

	notice of the reason for the decision to extend the timeline and inform the Member of the right to file a grievance if he or she disagrees with that decision.	
Non-urgent Pre-service	Once* If the timeframe is extended beyond fourteen (14) days, the Member and practitioner shall be provided with a written notice of the reason for the decision to extend the timeline and inform the Member of the right to file a grievance if he or she disagrees with that decision.	Up to 14 calendar days
Post-Service/Retrospective	Once*	Up to 14 calendar days

* For non-urgent pre-service and post-service decisions, if the Plan/Region is unable to make a decision due to the lack of necessary clinical information, the Plan/Region may extend the decision timeframe under the following conditions:

- Within fourteen (14) calendar days of a pre-service request or a post-service request, the Plan/Region must ask the member or the member's authorized representative for the specific information necessary to make the decision within the decision time frame. The Plan/Region gives the member or the member's authorized representative at least forty-five (45) calendar days to provide the information.

- The extension period, within which a decision must be made by the Plan/Region, *begins*:
  - On the date when the organization receives the member's response (even if not all of the information is provided), ***or***
  - At the end of the time period given to the member to supply the information, if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

For non-urgent pre-service and post-service decisions, the Plan/Region may also extend the decision timeframe due to matters beyond its control (also applicable and as outlined by CMS) (example, member waiting for an evaluation by a specialist), once, for up to fourteen 14 calendar days. Within 14 calendar days of a preservice request or 30 calendar days of a post-service request, the organization notifies the member (or the member's authorized representative) of the need for an extension, and the expected date of the decision.

Second medical opinion

The Plan/Region allows second medical opinion upon request of a member or a participating health professional treating a member. The second medical opinion must be provided by an appropriately qualified health care professional at no cost to the member.

UM Timeliness Reports

The Plan/Regions must monitor and submit reports for timeliness of decision-making for all non-behavioral and behavioral health, and pharmacy UM determinations resulting from medical necessity review, whether they are approvals or denials. Reports for timeliness of notifications must also be submitted for all non-behavioral, behavioral, and pharmacy UM denials resulting from medical necessity review.

Rates of adherence are calculated for time frames for each category of request (i.e., urgent concurrent, urgent preservice, non-urgent preservice and post service) for each factor, and are tracked monthly.

Adverse Determinations and Appeals

In circumstances where medical necessity is in question, or when clinical information needed to make a decision has been requested but not received, the clinical staff refers the case within the appropriate time frames to the appropriate Medical Director for medical necessity review and determination. Physician consultants from appropriate medical, surgical, and behavioral health specialties are accessible and available for consultation as needed. If an adverse determination is made, the decision is communicated according to the timeframes displayed on Table 1. The Plans/Regions monitor the accuracy and consistency of review decisions through periodic audits and criteria application is also monitored via annual Inter-Rater Reliability audits.

Peer-to-peer conversations give attending/treating practitioners the opportunity to discuss impending or issued medical necessity adverse determinations with a peer clinical reviewer. Peer clinical reviewers are available to discuss determinations with attending/treating practitioners. Practitioners must be notified about the availability of and how to contact a Medical Director (or appropriate practitioner reviewer) to discuss Utilization Management (UM) medical necessity denial decisions in the following ways:

- In the denial notification, ***or***
- By telephone, which includes leaving a voicemail, if the organization documents who left the message, along with the date and time it was left***, or***
- In materials disseminated to treating practitioners, informing them of the opportunity to discuss a specific denial with a reviewer.

The following information is included in the denial file:

- The denial notification, if the treating practitioner was notified in the denial notification
- The time and date of the denial notification, if the treating practitioner was notified by telephone
- For NCQA reviews, evidence the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

The denial notice resulting from medical necessity review is sent to members and their treating practitioners and providers (according to policy, federal and state requirements). The denial notice must include the bulleted elements listed below, along with any additional elements necessary to meet applicable accreditation and/or regulatory requirements.

- The specific reasons for the denial in easily understandable language. The notification must also state how the reason for the denial pertains to the member's particular case, to ensure that members and practitioners understand why the decision was made, what would be needed to render an approval decision, and have enough information to make a decision about appealing the denial.
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. The criteria used and referenced must be specific to the member's condition or to the requested services. Providing the criterion or an excerpt specific to the denial reason with the denial notification is also acceptable.

    - If the denial is due to lack of clinical information and there is insufficient clinical information to reference a specific guideline or criterion (for a given condition, service request), the notification must state the inability to reference the specific criteria, and must describe the information needed to render a decision, in easily understandable language.

Requirements applicable to Medicaid:

- Notification that the member may obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request,
- A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal,
- An explanation of the appeal process, including:
    - A statement that members may be represented by anyone they choose, including an attorney
    - The availability of an applicable office of health insurance consumer assistance or ombudsman and the contact information
    - The time frame for the member to file an appeal
    - The time frame for the organization to make a decision on the appeal, including the different time frames for expedited appeals

- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials. If the same process applies to standard and expedited appeals, there must be a description included in the letter that makes it clear that the process applies to both.

Utilization reviews are conducted in a timely manner to minimize disruption in the provision of medical care. Standards for response to ensure timeliness of determinations are developed, approved, and monitored in accordance with State, Federal, and NCQA requirements. Corrective action is implemented by the appropriate clinical leadership if standards are not met.

In the event of an adverse determination, the member, a person acting on behalf of a member, or a member's physician or health care provider may appeal any adverse medical necessity and benefit decision.

A system is maintained to receive, track and respond to appeals. Documentation of the appeal review process and determination is maintained in the member's database record. This database includes supporting documentation from the original request, actions taken, and appeal history as

applicable. The documentation of the substance of appeal includes, but is not limited to, the reason for the request and additional clinical or other information provided with the request. All this information is considered during the appeal review, as appropriate. Any notifications to members, providers and facilities, as applicable, are recorded.

Unless Federal regulations or the State mandates another timeframe, Medicaid members are allowed sixty (60) calendar days from the date of notice of an adverse action to file an appeal. Requests for retrospective review for non-emergent services more than ninety (90) days from the date of service are not considered.

HCM associates initiate the appeal review process upon receipt of the appeal for a procedure, service and/or admission from the member/member representative. The Company sends an acknowledgement notice within five calendar days of receipt of the request, containing:

- Acknowledgment of the date of the appeal receipt;
- A unique appeal file or appeal identification number;
- A description of the appeal procedures and time frames;

In addition, there is an expedited appeals process to accommodate clinical urgency of the situation. Each type of appeal request has a different timeframe for completion of the appeal process. All timeframes begin with the request for an appeal, and end with issuance of the determination. Unless Federal Medicaid (CMS) or the State mandates otherwise, the Company's standard timeframes for appeals are listed on Table 4. Refer to state-specific appeals policy for state-specific timeframes as applicable.

Table 4 Appeals Standard Timeframes

Appeal Type	Filing An Appeal	Decision Notification
Pre-Service		
Expedited/Urgent	ASAP	As expeditiously as the Member's health condition requires, but no later than 72 hours of receipt of the expedited appeal request.
Standard	Within 60 Calendar Days from the date on the Notice of Adverse Determination	As expeditiously as the Member's health condition requires, and within 30 calendar days of receipt of the appeal request.
Retrospective/Post-Service		
Post-service	Within 60 Calendar Days from the date on the Notice of Adverse Determination	Within 30 calendar days of receipt of the appeal request.

Although there are allowable extensions for initial UM decisions, there are only two provisions for extending the appeal time frame to obtain additional information:

- The member voluntarily agrees to extend the appeal time frame; or
- Federal program regulations allow the Company to request additional information from the member.

If the member voluntarily agrees to extend the appeal time frame, the specific time frame that was agreed upon must be documented in the appeal file.

The organization may allow a 14 day extension if the member requests the extension or the organization demonstrates that more information is needed and the delay is in the member's interest.

For Medicaid, oral notification is appropriate for non-urgent preservice, post-service and expedited appeals, but the organization must notify members of any delay and resolve appeals as expeditiously as the member's health requires.

The organization may provide initial oral notification of a denial decision within 72 hours of an expedited appeal request, and must provide electronic or written notification of its decision no later than 3 calendar days after oral notification.

For expedited appeals, the organization may inform the hospital Utilization Review (UR) department staff of its decision, with the understanding that staff will inform the attending/treating practitioner.

If the appeal does not qualify for an extension, the Company must make the appeal decision within the allotted time frame based on the information received.

A Full and Fair Appeal Review includes the following components:

- A physician (or other appropriate clinical practitioner) must evaluate all medical necessity decisions for adverse appeal decisions.
- Must conduct a review of the appeal that does not give deference to the denial decision; fully investigate the content of the appeal, including all aspects of clinical care involved; and document the findings and actions.
- Must appoint a person not involved in the prior adverse decision to review the appeal; the appointed person must not be the individual who made the adverse determination; and must not be a subordinate of (i.e. directly supervised by) the individual. Exceptions:
    - The practitioner who made the initial adverse determination may review the case and overturn the initial decision.
    - When the initial denial was made by an automated system (e.g., claims), any reviewer is considered non-subordinate.
- Must provide same-or-similar-specialist review for appeals of medical necessity decisions. The reviewing specialist's training and experience must meet the following criteria:
    - Includes treating the condition
    - Includes treating complications that may result from the service or procedure
    - Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate

"Training and experience" refers to the practitioner's clinical training and experience.

NCQA accepts board certification in a specialty as a proxy for clinical training and experience. A specialist who maintains board certification in a general and specialty area

(e.g., internal medicine and pulmonology) is considered to have training and experience in both areas.

Experience with the condition, service or procedure that is limited to UM decision-making in cases similar to the appeal in question is not considered sufficient experience, nor do UM decision-making criteria supersede the requirement for same-or-similar specialist review.

If the organization's clinical criteria limits who can perform a service or procedure, or who can prescribe a pharmaceutical to specific practitioner types or specialties, then only those practitioner types or specialties may be considered same-or-similar specialist reviewers.

- Must allow the member access to and copies of all documents relevant to the member's appeal, free of charge and, upon request.
- Must give the member the opportunity to submit written comments, documents, records and other information relevant to the appeal.
- Must allow an authorized representative to act on behalf of the member.
- For expedited appeals, must allow a health care practitioner with knowledge of the member's condition (e.g., a treating practitioner) to act as the member's authorized representative.
- Notification to the member about further appeal rights.
- Must allow continued coverage pending the outcome of an appeal.

Written appeal decisions must include the bulleted elements listed below, along with any additional elements necessary to meet applicable accreditation and/or regulatory requirements. The appeal decision notification must be written in a manner that is culturally and linguistically appropriate for the member.

- The specific reasons for the appeal decision in easily understandable language. The notification must also state how the reason pertains to the member's particular case.
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. The criteria used and referenced must be specific to the member's condition or to the requested services.
- Notification that the member may obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
- Notification that the member is entitled to receive reasonable access to and copies of all documents upon request.
- A list of titles and qualifications, including specialties, of each individual that participated in the appeal review. The appeal notice must identify who made the determination, including:
    - For a benefit appeal: The reviewers' title
    - For a medical necessity appeal: The reviewers' title, qualifications (e.g. MD, DO, PhD) and specialty (e.g., pediatrician, general surgeon, clinical psychologist).

- NCQA does not require the inclusion of the participant names in the written notification to members.

- A description of the next level of appeal either within the organization or to an external organization, as applicable, along with any relevant written procedures.
- If the denial is completely overturned, the appeal notice must state the decision and the date.

Inpatient and Outpatient Care Coordination

The Company Plan/Regions have a demonstrated track record of building and maintaining strong relationships with State and other community-based agencies, with the understanding that these relationships are essential to coordination of care for Plan members. In addition to routine care coordination with these providers of care, the Company designates a specific clinician or Case Manager to ensure continuity of services for members who are in active Case Management and, applicable to Medicaid, members with Severely Emotionally Disturbed children, adults with Serious Mental Illness, Children with Special Healthcare Needs, and women with high-risk pregnancies.

The program follows the framework of standards of practice established for Case Managers:

- Target members who will most benefit from case/care management services utilizing accurate and proven stratification methods; provide complex case management (*Identification/Stratification)*
- Actively communicate and collaborate with the member (*Engage)*
- Assess the member's ongoing needs *(Assessment)*
- Intervene to best meet the member's needs *(Planning and Implementation)*
- Review and update the care plan based on ongoing re-assessment of member's needs *(Monitoring and Follow-Up)*
- Conduct evaluation of case management practice activities, treatment plan goals, and medical cost ratio goals - met or unmet (*Outcome Measurement*)

Case Managers receive potential cases from a variety of sources including the Chronic Illness Intensity Index (CI3) list, High-Risk OB Screener and internal and external referrals. Case Managers contact members, conduct assessments, collaborate with members/families to develop Care Plans including goals and interventions, and conduct regular follow-ups to assess progress and continuing need for services.

Case Managers are responsible for arranging and coordinating services for the member. Such activities are not limited and may include:

- Comprehensive assessments
- Development of care plans
- Health education
- Interpretation of benefits
- Community resource referrals
- Service coordination
- Assistance in developing a self-management plan
- Community-based services (e.g. home or hospital visits)
- Provider-based Intensive Case Management (Behavioral Health)
- Special needs program interventions

- Post Discharge Management
- Coordination with other benefit plan benefits, including Medicaid for our dual special needs plan members

Designated Company Case Managers, working with UM associates, contact service providers to arrange services and otherwise ensure service provision for the member from acute admission to discharge to community-based aftercare to meet the needs of the acute care member; as well as assist with community-based care services through outpatient and less restrictive levels of care service delivery for those members in active Case Management.

The Company and its Plans/Regions have broad experience implementing various case management programs to provide a coordinated, comprehensive approach to care management. The organization strives to ensure members receive cost-effective services at the appropriate level of care through individualized, integrated programs and coordination with community services. Case management seeks to:

- Maintain members in the least restrictive, medically appropriate environment
- Foster members' physical, behavioral, and social well-being and promote optimal health outcomes
- Develop collaborative relationships with PCPs and specialty providers by assisting in the care management of complex cases and at-risk members
- Identify high-risk members, coordinate necessary services, and develop ways to minimize inappropriate use of services while improving health outcomes.

The Plans/Regions currently provide care coordination and case management for a variety of products including Medicaid, Medicare, SCHIP, and ABD populations in multiple states. Because in-sourced behavioral health/substance abuse services are combined with physical health services, each Plan/Region's care coordination program holistically integrates the medical, behavioral health/substance abuse, maternal and child health, functional, and social needs of Plan members. The Complex Case Management Program is part of the CM program and affords both members and providers expert assistance in the coordination of complex health care. Please refer to the Case Management Program Description for further detail.

Moderate and mild acuity case management is managed centrally by Disease Management (DM), for Medicaid and Medicare populations, as applicable. For more detailed information, please see the Disease Management Program Description.

Post discharge management

Post Discharge Management (PDM) Case Management is part of the continuum of care provided to our members. PDM helps Case Managers focus interventions on behaviors that can help prevent readmissions.

Members are to be referred for PDM Case Management as early as possible. The first twenty-four (24) to seventy-two-(72) hours post-discharge is the highest risk period for readmissions. Delay in member engagement is a missed opportunity for case management intervention in transitioning from acute care to the home, often leading to avoidable readmissions within the first thirty (30) days after discharge.

The goal of PDM Case Management is to focus on those members at highest risk for a rapid readmission, thus promptly engaging them to close gaps in care, improve the quality of care, and allow for real-time oversight, and feedback on open cases through enhanced reporting. This is achieved through the use of organizational tools and documentation standards that assist in managing the transitions from inpatient setting to the home. The result is consistent reporting and program management.

Utilizing short term case management activities, the Post Discharge Management (PDM) model has demonstrated a reduction of readmissions. PDM fulfills the opportunities for coordination of discharge care and augments the existing Utilization Management and Case Management activities.

Process
Members appropriate for PDM are identified through the use of a proprietary algorithm of predictive models, likelihood to engage scores, and readmission risk scores and cases auto created for plan use. PDM cases may be identified via collaboration by the Concurrent Review clinician and the PDM Case Manager. Contact between the Post Discharge Management Case Manager and patient or caregiver is made either prior to discharge and/or within twenty-four (24) hours to begin the transition management program. The following discussion points are reviewed with the patient or caregiver during the thirty (30) days after discharge:

- Precipitating Factors- Example: Situations or conditions that led to an admission
- Medication management: New prescriptions ordered post-discharge and medication reconciliation
- Follow-up care and establishing a medical home- Example: Ensuring appointments are made and having discussions regarding the importance of coordination through the member's primary care physician
- Red flag management- Factors that trigger the member to contact their physician or modify behavior related to their condition or chronic disease
- Maintaining and encouraging the member to manage their patient centered record
- Disease specific education

The member is provided with the 24 hour Nurse Line phone number and the PDM extension as resources for condition changes post discharge. Calls to PDM provide the opportunity to mitigate emergency circumstances, provide steerage to the most appropriate level of care, and ultimately prevent an unnecessary re-hospitalization.

Behavioral Health
The scope of the BH UM Program includes activities related to behavioral health inpatient, transitional and outpatient care. The BH UM Program collaborates with other programs to ensure effective care coordination, discharge planning, and case management to meet the behavioral and physical healthcare needs of its members. The BH UM Program engages and supports effective member education to promote measurable positive health outcomes. It adopts an integrated medical management model based on the behavioral, physical, and social needs of eligible members. The BH UM program, in collaboration with other programs such as Disease Management, as applicable to Medicaid, and Case/Care Management, facilitates the delivery of the most appropriate medically necessary care and services to eligible members in the most appropriate setting.

The Behavioral Health National Medical Director provides oversight for all of the BH UM Programs. The BH National Medical Director is responsible for the development and implementation of programs that support the efficient utilization of medical resources and the practice of quality (evidence-based) health care by providers. He or she works closely with Behavioral Health and Physical Health Clinical Leadership in the implementation and quality of clinical programs that assure the delivery of appropriate and timely behavioral health services to our members. The BH National Medical Director is also responsible for the establishment and implementation of the Company's behavioral health management policies.

The BH UM Program is compliant with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Application to Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations (MCOs), the Children's Health Insurance Program (CHIP) and Alternative Benefit Plans (ABP)" proposed rule published in the Federal Register on April 10, 2015. The BH UM Program satisfies the mandates of the Federal Mental Health Parity Law, 21st Century Care Act and the Affordable Care Act including, but not limited to:

- Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits;
- Ensuring compliance with MHPAEA for any benefits offered by the Plan to members beyond those specified in the Medicaid State plans;
- Making the criteria for medical necessity determinations for mental health or substance use disorder benefits available to any current or potential member, or contracting provider upon request;
- Providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members and;
- Providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits.

The Behavioral Health Call Center performs a variety of services that assist the Utilization Management Team in managing care. Precertification requests are typically initiated at the BH Call Center where associates receive requests for services from members and providers. All requests that require a medical necessity review are pended and forwarded to licensed clinical staff for review.

The Company maintains toll-free emergency and crisis behavioral health services staff by trained personnel twenty-four hours a day, seven days a week, three hundred sixty five days a year. When a member or member representative calls to request Behavioral Health services (mental health or substance abuse) during business hours, the call is screened by a Utilization Management Representative (UMR) to determine if the request is for routine outpatient care, or if there are indications that the member is experiencing a level of distress and/or impairment that warrants an assessment by a clinical staff member. The Behavioral Health Telephonic Intake policy further outlines the procedures involved in this process.

The Company does not perform a centralized triage and referral function for Behavioral Health. Members may directly access behavioral health services and are not required to contact the Company to determine the appropriate setting of care or a referral.

The Company Medicaid Behavioral Health has NCQA Accreditation and conducts these activities for the health plan. Information on this activity/topic can be found in the Medicaid Behavioral Health Evaluation.

Maternal-child services

The Maternal Child Services Program is led by an Enterprise team providing vision, guidance and consultation to the Case Management and Utilization Management teams. It is staffed by a Staff Vice President, Maternal Child Services who oversees the strategic planning and coordination of the company's National Maternal Child Services Program. In collaboration with the Plan/Regional senior leadership and management team, he/she identifies priorities for program development and oversees the implementation of new program initiatives and advocates both internally and externally for the needs of pregnant women and their newborns. A limited program is available for those members who are dually eligible and have Medicaid services through the Company.
The Medical Director - Obstetrics (OB) reports to the Staff VP Maternal Child Services and is responsible for providing subject matter expert guidance to the Company. For the area of specialty, he/she develops medical policy and guidelines for companywide implementation. He/she also chairs the company's advisory committee and, in collaboration with Plan Medical Directors, provides oversight and direction for the specialty area's utilization management. In addition, he/she provides consultation and support for Plan obstetrical associates and medical staff. The Medical Director also participates in Plan OB rounds.

Medical Director - Neonatology (NICU) reports to the Staff VP Maternal Child Services and is responsible for providing subject matter expert guidance to the Company. For the area of specialty, he/she develops medical policy and guidelines for companywide implementation. He/she also chairs the company's advisory committee and, in collaboration with Plan Medical Directors, provides oversight and direction for the specialty area's utilization management. In addition, he/she provides consultation and support for Plan/Regional associates and medical staff. The Medical Director also participates in Plan NICU rounds.

There are four Enterprise Directors of Clinical Programs, Maternal Child Services. One Director of Clinical Programs is responsible for data analytics and quality, including: analyzing utilization, cost, quality and operational reports for Maternal Child Services as well as development of new clinical programs. The Director is also responsible for the development and maintenance of reports and the system used to track requests to ensure effective administration. She/he also serves as the Maternal Child Services Quality SME in support of quality strategies related to pregnant women and newborns.

The second Director of Clinical Programs is responsible for management and oversight of new market/market expansion, system migrations and new program initiatives. The Director is responsible for vendor relationships and management of several programs including My Advocate®, Healthy Rewards as related to Maternal Child Services and member/provider collateral fulfillment. The Director is also responsible for but not limited to budget submission and oversight, new hire setup, department purchasing and travel/event planning.

The third and fourth Directors of Clinical Programs are responsible for strategic and operational oversight of the Program. The Directors also assist with day to day management including education of members and associates, and reporting of program outcomes. New program initiatives are

identified for development, program implementations at each Plan/Region are monitored, and endeavors are made to improve the overall cost of care and quality of services provided to pregnant women and their newborns. These Directors share oversight of the Program, however one Director maintains oversight of the core maternity programs and provides leadership and guidance for the Maternal Child Diabetes Educator and Behavioral Health OB CM programs. The second Director maintains oversight of the NICU Program.

There are two Care Management Ops Directors. The Care Management Operations Director, Maternal Child Services develops and implements member and provider programs and manages and evaluates core services such as, but not limited to, Maternal Child Services program (member materials and incentives), Prior Preterm Pregnancy Program (17P), My Advocate®, pregnant member incentives, and You and Your Baby in the NICU. In addition, she/he tracks progress and develops action plans to achieve program financial, clinical and operational goals and assure a high degree of collaboration with members of the Company and Plan/Regional HCM teams as well as other key programs.

The Strategy and Program Development Director, Maternal Child Health is responsible for program and product development, RFP response content generation, cost of care ideation, and member and provider messaging. The Director also works with the department's operational reporting team and data analytics to format reporting tools essential to communicating program evaluations.

Manager Community Transformation serves as a lead for the Practice Consultant team. They serve as trainer and mentor to all newly hired Practice Consultants, share best practices and offer subject matter expertise for the OB QIP program. They work with leads at the designated plans where the Practice Consultant resides to ensure collaboration and integration of efforts dedicated to improving member outcomes and the provider experience.

The Practice Consultant for Maternal Child Services works closely with providers and groups in select, targeted markets that participate in the OB QIP program. The Practice consultant educates providers on the multiple components of the Maternal Child programs, shares Provider Profiles, and OBQIP scores, addresses issues and concerns, and serves as a partner with the providers to improve the overall member and provider experience. Additionally, the Practice Consultant partners closely with Plan/Regional based Provider Relations representatives and the HP Quality program.

The *Taking Care of Baby and Me*® program (Arkansas, Florida, Georgia, Iowa, Maryland, Missouri, Nebraska, New Jersey, Tennessee, Texas, Texas Dell Children's Health Plan, Washington and West Virginia) also known as the *New Baby, New Life*℠ program in California, Indiana, Kentucky, Louisiana, Minnesota, Nevada, New York, North Carolina, South Carolina, Virginia, Western New York & Wisconsin, provides quality, culturally-competent case management services to pregnant members during the prenatal and postpartum periods and to their infants. This program is applicable to Medicaid, and program staff encourages pregnant women to take action to optimize the outcome of their pregnancy, to prepare for the delivery and homecoming of their infant, and to participate in their infant's care should a NICU stay be required. Coordination between the *Taking Care of Baby and Me*® /*New Baby, New Life*℠ case management team and the UM team is essential. The *Taking Care of Baby and Me*®/*New Baby, New Life*℠ program includes Neonatal Intensive Care Unit (NICU) Case Management whereby NICU Utilization Review nurses and Case Managers coordinate the care of preterm infants beginning at delivery. This program ensures that high-risk infants receive quality and cost effective NICU care, identification of barriers to discharge, and a

successful transition to the home environment through a well-defined plan of care. NICU Post Traumatic Stress Disorder (PTSD) program presently active in the District of Columbia, Florida, Georgia, Indiana, Louisiana, Maryland, Minnesota, New Jersey, Nevada, Virginia and West Virginia seeks to improve outcomes for families of babies who are in the NICU by screening and facilitating referral to treatment for PTSD in parents. North Carolina will also be included in the PTSD program. For Arkansas, newborns will go to fee for service at birth and therefore there will not be a NICU program.

For details, please see the Maternal Child Services Program Description.

Inter-rater Reliability and clinical Performance Monitoring

Performance Monitoring is a formalized function within HCM. The monitoring activities help identify opportunities for improvement that can lead to delivery of higher quality services, and/or more efficiency of operations, thus cost savings. Another purpose is to monitor for standardization of core processes among all Plans/Regions and the Prior Authorization Teams. Monitoring for standardization helps better identify gaps in processes that inhibit efficiency and effectiveness of the HCM programs. HCM monitors process implementation; however, the goal is to expand the performance monitoring to support the cost effectiveness of selected HCM operations.

Inter-rater Reliability

The Inter-Rater Reliability (IRR) program is designed to assess the consistency and adherence to Company policy and process as related to utilization management practice within the corporation. The consistency with which health care professionals involved in UM apply criteria in decision-making is evaluated at least annually. Appropriate mechanisms, such as use of hypothetical UM test cases, or use of a sample of UM determination files using an NCQA-approved auditing method, are utilized to evaluate the consistency of application of criteria.

Physician and non-physician reviewers are assessed in applying medical necessity criteria to ensure consistency and accuracy in the application of the criteria. Licensed clinical UM staff, including behavioral health, who apply medical necessity criteria participate in the inter-rater reliability process.

Plan/Region/Company Department results, as well as aggregate Company results, are reported to each Plan/Region/Company Department as well as the Chief Medical Officer/designated National Medical Directors and Quality Improvement Committee and/or Medical Operations Committee as required. Opportunities for improvement are identified and addressed by action plans.

Performance improvement and enhancement (pie)

The Performance Improvement and Enhancement (PIE) Team is responsible for conducting monthly associate-level clinical audits, outcomes reporting and process improvement management activities. The program ensures compliance with Company policies and procedures and National Committee for Quality Assurance (NCQA) guidelines. This Clinical Auditing Program plays an integral role in performance improvement by continuously evaluating associate-level performance within the Utilization Management (UM) areas. The independent program objectively monitors and evaluates the appropriateness, documentation and quality of the services provided to our members and is designed to ensure the consistent application of UM, and NCQA guidelines and processes.

For UM, the case review includes evaluation of several components within the following areas: timeliness, clinical review documentation, application of clinical criteria/guidelines for decision making, and appropriate case completion. The scope of the reviews include Medical Directors, Licensed clinical UM staff, including Physical Health, Behavioral Health, and Prior Authorization Teams.

The PIE Reporting Team directly supports the work of the Clinical Audit Program by developing and issuing detailed monthly audit result reports to the Directors, Managers, UM teams, Quality Committees, Clinical and Senior Leadership. These reports summarize the monthly clinical audit results, identify areas for improvement and create enterprise trend comparisons.

The PIE Process Improvement Team works with the Plans/Regions to ensure the team receives information from the Clinical Audit Program. This team is responsible for completing monthly data analysis, identifying trends, and assisting in the development of action plans to improve performance with the plan leads. They also teach and educate on navigating reports and extracting data for associate performance management. They work directly with the Plans/Regions to assist them in improving their scores through focused audits, providing or arranging educational sessions, and clarifying workflows for the teams.

NEW TECHNOLOGY ASSESSMENT

The Medical Policy, Formation, and Investigational Criteria Medical Policies address the evaluation of new and emerging medical technologies and treatment modalities that may enhance patient care, and the new application of existing technology. This process encompasses and supports each Plan/Region and all products for which the Plans/Regions assume medical cost risks. Through the Office of Medical Policy & Technology Assessment, the Medical Policy and Technology Assessment Committee (MPTAC) is responsible for review/evaluation of new and emerging technologies, and the new application of existing technology, and for making recommendations based on its reviews, for medical and behavioral health services. Technologies include devices, biologics and specialty pharmaceuticals.

MPTAC ensures that appropriate practitioners with professional knowledge or clinical expertise in the area being reviewed are included in the development and review process. Behavioral Healthcare professionals are also represented in the MPTAC decision making process.

The Medical Policy and Technology Assessment Committee is responsible for final review and determination whether the new technology/treatment is eligible for reimbursement. To be approved as a new covered service, the evaluated technology/treatment must meet established criteria that include:

- Final approval from appropriate government regulatory body
- Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility or drug (all services) on health outcomes
- Proven materially to improve the net health outcome
- Is as beneficial as any established alternative

- Shows improvement outside the investigational settings

In addition, MPTAC considers recommendations of national physician specialty societies, nationally recognized professional healthcare organizations and public health agencies, and may also consider other relevant factors, including information from the practicing community.

Utilization Management System Controls

The Company has UM system controls in place to protect the altering of data outside of prescribed protocols. The Company's policies and procedures describe controls specific to utilization management and appeal notification dates that:

- Define the date of receipt of requests and the date of written notification that are consistent with NCQA requirements.
- The process for recording dates.
- Identify staff authorized to modify dates and circumstances when modification is appropriate.
- Specific how the system tracks modified dates.
- Describe system controls that are in place to protect data from unauthorized modification.
- Describe how the Company audits the above described processes and procedures.

Integration and Collaboration with Other programs and Functional Areas

There are many business units such as Health Promotion, National Customer Care Department, Provider Relations and Communication that have an impact and provide direct support to HCM programs and services. They include, but may not be limited to: ITS Department, Healthcare Delivery Systems Business Solutions, Clinical Informatics, Medical Finance Operations, Claims, Credentialing, Marketing, Regulatory Compliance and Government Programs.

Clinical Quality Management

UM activities are reported at least quarterly to the Plan/Regional Medical Advisory Committees and/or the Plan/Regional Quality Management Committees (QMC). This reporting activity allows Clinical Quality Management the opportunity to provide feedback regarding UM processes. Where actual results are at variance compared to expected results, Clinical Quality Management adds ideas that may help identify the root cause of variance and offers suggestions to improve performance. UM forwards issues of potential breaches in quality of care to Clinical Quality Management. Within Clinical Quality Management, these issues are tracked and investigated to make certain that breaches in quality of care are directed to the appropriate Medical Director for review, and further assessment by the appropriate Plan/Regional committee if needed.

Complaints and grievances are also addressed by Clinical Quality Management allowing identification of any member or network issues pertaining to UM to be investigated. Trending and discussion of these complaints and grievances by Clinical Quality Management allow UM opportunities for improving service delivery and care.

The Quality Management Program monitors and measures the outcomes of clinical care and services by analyzing clinical and service performance indicators and health care outcomes; and identifies and acts on opportunities for improvement. Utilization management data is included in quality indicators that are tracked and trended to ensure measures are reported, outcomes are analyzed, and goals are attained.

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a jointly managed Medicaid program with the Company and is in compliance with State and Federal requirements. The Quality Management Program monitors the effectiveness and regulatory compliance of this program and acts on opportunities for improvement. The Plan/Region coordinates targeted outreach attempts to members for EPSDT services while the Company oversees a general mailing program of member birthday card EPSDT service reminders and overdue services postcards. Primary Care Physicians (PCPs) also receive notification of EPSDT services due.

The Quality Management Program promotes and facilitates improved continuity and coordination of care in clinical care, and between medical and behavioral healthcare. Continuity and coordination of care are key quality initiatives in the QM Program. The scope of continuity and coordination of care activities includes but is not limited to assessment for timely care post facility discharge, appropriate transition of members from one level of care to another, and medical record documentation that reflects presence of consultant's notes, as appropriate.

Clinical Quality Management facilitates member and provider surveys. Annually, a member CAHPS Survey and provider experience survey are conducted by an external vendor. Aggregate and individual results are shared with the Plan/Regions with market-specific rates and a corrective action plan is developed to address identified issues or areas of dissatisfaction.

Under and Over-Utilization

The Company is committed to assuring access to health care and services for all participating members. The Company facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under-and over-utilization.

Over-utilization and under-utilization of services are monitored using reports made available from the plan/region to the Health Care Management (HCM), Quality Management (QM) and Health Promotion (HP) programs by the Plan Performance Management Analysts/Plan Finance Analysts.

The results of the reviews are reported to the Medical Advisory Committee (MAC) and the Quality Management Committee (QMC), and are used to help implement strategies to achieve utilization targets consistent with clinical and quality indicators and identify fraud and abuse.

Aggregated data or non-identifiable utilization reports are produced by the Performance Manager or designee at a minimum, quarterly, to review physician/member utilization of services.

The plan reports are reviewed looking for patterns of over-utilization and/or under-utilization of services with specific attention given to any of the following as determined appropriate by the plan management:

1. Acute/Chronic Care:

    - Re-admissions,
    - Pharmaceuticals,
    - Specialty referrals,
    - Emergency Room (ER) utilization,

- Home Health and Durable Medical Equipment (DME) utilization relative to diagnostic entity,
- Behavioral Health, and
- Inpatient Utilization

2. Preventive Care:
   - Well-child/adult Primary Care Provider visits,
   - Age-appropriate immunizations,
   - Mammograms, and
   - Blood lead testing

Representatives from HCM and QM collaborate with the plan/regional Medical Director to review intervention strategies targeted at enhancing appropriate utilization practices, and provide member intervention for cases of member over-utilization and under-utilization through case/care management and/or health education and outreach.

Providers identified as having significant aberrant patterns of utilization, i.e. outliers are reviewed by the Medical Director and Provider Relations representatives to determine actual utilization of services.

- A provider and plan/region action plan is developed by Provider Relations in collaboration with the appropriate Medical Director and discussed with the provider as appropriate.

Utilization patterns of identified members/providers are monitored and trended and a review of the provider's performance is performed by the plan/region Medical Director or designee after a six-month period or earlier as indicated.

Examples of strategies that have been implemented for the Medicaid program are:

The Pharmacy Restriction "Lock-In" process which may limit members to a single pharmacy to obtain their medications. The need for restriction is determined as a result of medication claims review and is implemented only in those plans that have a state approved or mandated program. Members identified with uncoordinated care, excessive utilization or suspected patterns of fraud and abuse may also be referred to the pharmacy department from a specific Plan/Region or providers.

National Customer Care organization (NCC-Non Clinical and Prior Authorization Team-Clinical)

The National Customer Care Non-Clinical and Clinical Associates (Prior Authorization Team nurses) perform a variety of UM services that assist Plans/Regions in managing care. Precertification requests are typically initiated in the Prior Authorization Teams. Clinical associates receive requests for services from members and providers and apply medical necessity criteria to the clinical information presented. All requests that meet medical necessity are approved by the Prior Authorization Teams. Requests not meeting criteria are forwarded for further review by a secondary OPC reviewer (Licensed Utilization Review Lead) and finally the appropriate Medical Director if the case does not meet medical necessity. The Medical Director makes the final determination regarding medical necessity. Any adverse determination regarding medical necessity is always made by the Medical Director.

Prior Authorization Team Clinical Leadership is responsible for:

- Planning, development and implementation activities in support of the UM Program within the Prior Authorization Team UM Department operations.
- Interfacing with Company and Plan/Regional medical leadership to develop operational strategy and institute actions, workflows, key performance metrics, and procedures to achieve efficient and effective clinical processes between the NCC and Prior Authorization Team sites, home office business units, and Plan/Regional operations.
- Supporting quality and risk management initiatives for the Prior Authorization Team UM Department relating to clinical outcomes.
- Coordinating projects, improvement efforts, and policy on a regular basis with the Director of Clinical Operations regarding daily operations.

The Prior Authorization Team UM Managers are responsible for:

- Maintaining daily operational management of the functions of the Prior Authorization UM team, including steerage to participating providers and precertification of services.
- Collaborating with the Plans/Regions to ensure process compliance with performance standards and supporting quality initiatives across the Prior Authorization Team UM department and Plans/Regions.
- Assuring that staff are properly trained and apply the appropriate medical necessity criteria in the authorization of services.

The Clinical Prior Authorization Team UM Manager works collaboratively with the Company and UM leadership at the Plan/Regions to assure that clinical services are performed in a manner consistent with high quality care.

Emergency services

The Company will cover and pay for "Emergency Medical Condition" services defined as a medical condition (or behavioral health condition, when covered by benefits) manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:

- Placing the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

"Emergency Services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act, and are needed to evaluate or stabilize an emergency medical condition that is found to exist under the prudent layperson standard.

- The Company will not refuse to cover services due to a lack of notification to the Company.
- The Company will not deny payment if the member obtained emergency services based on instructions of a practitioner or other representative of the Company
- The Company will not limit what constitutes an emergency medical condition solely on the basis of lists of diagnoses or symptoms.

- The Company will cover and pay for emergency services regardless of whether the entity furnishing the services is a participating provider. (All coverage and payment for services are contingent on member benefits and eligibility at the time services are rendered.)
- The attending emergency physician or the treating provider is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding.
- The Company will compensate the provider for all screenings, evaluations and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the member's condition is an Emergency Medical Condition.
- The Company will pay for all Emergency Services and Care in accordance with the contract or State-specific non-par methodology. If the provider determines that an Emergency Medical Condition does not exist, the Company is not required to pay for services rendered subsequent to the provider's determination.

Provider Relations and Communications

The UM staff interfaces with Provider Relations staff as necessary in order to achieve UM goals and objectives. The following are some areas where partnering occurs:

- Network development, contracting and recruitment opportunities
- Provider communication and education

Pharmacy Management

The goal of the pharmacy program is to ensure cost effective physician prescribing, optimal use of cost-effective products in support of controlling overall medical resource consumption and costs and to improve quality of care and outcomes within the scope of contractual requirements. This is accomplished through effective utilization management and unit cost management programs. The pharmacy benefit is designed to cover medically necessary prescription and over-the-counter (OTC) products for self-administration. The Company administers the pharmacy benefit for each Plan/Region, and the clinical drug programs and activities. The Pharmacy department also maintains Clinical and Operational Policies as a guide for the effective administration and management of the pharmacy benefit.

The Pharmacy Program falls under the Pharmacy & Therapeutics Process Charter and By-Laws. See the Pharmacy Program Description for complete details.

Delegated UM Services

Individual Plans/Regions may enter into agreements with other utilization management agents to perform utilization management on behalf of the Plan/Region. The Company grants delegates the authority to act on its behalf, but the agent remains accountable for compliance with the Company, accreditation and regulatory standards. These delegated agreements are entered into only after due-diligence is done by the Legal Department, the contracting team and the Delegation/Vendor Oversight and Management Committee preliminary and predelegation evaluations, and there is an established agreement between both the Company and the delegate which describes the delegated activities and the responsibilities of the organization and the delegated entity, and the delegated activities.

If the delegate subdelegates an activity, the delegation agreement must specify responsibility for oversight of the subdelegate, i.e. the delegation agreement must specify that the delegate or the Company is responsible for subdelegate oversight. If the delegate oversees the subdelegate, it must report to the Company regarding the subdelegate's performance. NCQA confirms that oversight of the subdelegate is performed according to its standards. The Company is responsible for oversight of all activities performed by the delegate and subdelegate on its behalf.

The delegation agreement also includes at least semiannual reporting requirements of the delegated entity to the organization, provisions to protect PHI (Protected Health Information) describes the process by which the organization evaluates the delegated entity's performance, and describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.

Annually, a desktop or onsite audit is completed, and includes an assessment of the delegate's policies and processes and performance as they relate to those activities or services that are delegated, the appropriate NCQA standards, and federal and applicable state regulatory laws and regulations.. UM denials and appeals files (as applicable) are reviewed during the annual audit. Delegates are contractually required to ensure the consistent application of review criteria that are used for authorization decisions. Written policies/procedures, evidence of evaluation of the consistency with which health care professionals involved in UM apply criteria in decision-making, and action on opportunities for improvement are also reviewed during the annual audit.

The Delegation/Vendor Oversight and Management Committee (DVOMC) has final approval of all delegated Utilization Management functions through internal auditor activities, Plan/Regional monitoring activities and financial reporting activities, among others. Joint administrative oversight meetings are held on a quarterly basis at a minimum between the delegate, Plan/Region and the Company account manager. Information on clinical performance and member experience data (as applicable) are provided to the delegates, as requested.

Additionally, oversight is performed through review of reports and collaborative efforts such as collection of data from vision vendors to improve HEDIS rates, and the delegates' UM programs are annually reviewed. The Company maintains oversight and remains accountable for all delegated activities.

Evaluation of the UM Program

Each Plan/Region conducts an annual evaluation of their UM Program, including clinical and service outcomes for medical and for behavioral health, in comparison to program objectives and activities.

- For the UM Program Evaluation, the leadership annually includes the review and evaluation of the program structure
- The program scope, processes, information sources used to determine benefit coverage and medical necessity
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program.
- Members' and practitioners' experience data

Results are submitted to the Plan Medical Advisory Committee, Medical Operations Committee, or Quality Management Committee as applicable, and to the applicable Quality Management Committees for review and approval annually. Results and recommendations will become the basis for the year's activities, and unrealized goals/objectives may be carried over to the subsequent year. The leadership also updates the UM Program based on the annual evaluation results.

Confidentiality and ethics

Confidentiality and Records Management

All associates have a responsibility to keep member information confidential in accordance with applicable federal and state laws. The Privacy Policies and Procedures set forth guidelines that all associates must follow when collecting, accessing or disclosing member information and set forth rights individuals have pursuant to federal and state law. These policies and procedures provide specific guidance on the following topics:

- Collection, use, and disclosure of Protected Health Information (PHI)
- Individual rights
- Personal representatives, authorized representatives, informal representatives
- Administrative requirements

At all times during the Utilization and Case Management process, associates maintain the confidentiality of member information in accordance with Medicaid Policies and Procedures and applicable laws and regulations.

Associates receive mandatory training on confidentiality via the annual Company Standards of Ethical Business Conduct training. All associates completing the annual compliance training must also complete a confidentiality statement and an acknowledgement of training attestation. Electronic Certificates of Completion are awarded and stored with the documented electronic record of each associate's completion of the course. Managers are responsible for ensuring that associates complete the annual training and complete the confidentiality statements.

The Company Record Management Program provides a consistent and effective approach to managing company records from creation to destruction. Associates are responsible for compliance with the Records Management Policy, the Records Management Procedure and the Records Retention Schedule.

Patient-specific medical information obtained with regard to the precertification process, utilization review, and case management is only released upon the advice of Legal Counsel under the Company, and in accordance with Federal and State laws and regulations. Insurance regulation indicates that the Company may not disclose or publish medical records, personal information, and other confidential information about a patient/member in the performance of utilization review without the prior written consent of the patient, guardian or as required by the law. If such authorization is submitted by anyone other than the individual who is the subject of the personal or confidential information requested, such authorization must be dated and must contain the signature of the individual who is the subject of the personal or confidential information requested. The signature must have been obtained one year or less prior to the date the disclosure is sought; otherwise the authorization is invalid**.**

The Company's confidentiality policy includes:

- Individual medical records or any confidential information about a patient may not be disclosed outside of treatment, payment or health care operations (TPO) without prior written consent of the patient, guardian or as otherwise required by law.
- Information obtained is used solely for the purpose of authorizing the medical necessity and appropriateness of care and services, ensuring or improving the quality of care and services provided by the Company, and ensuring the continuity of care through discharge planning and case management. This information is shared only with those agencies, providers, and staff who have both the authority to receive and a "need to know" for this information. Summary information that meets the definition of "De-identified Information" per 45 C.F.R. 164.514 is not considered confidential because it does not provide sufficient information to allow identification of individual patients. The retention of records relating to business operations in states where the Company conducts operations is in accordance with state-specific contractual requirements and/or state/federal regulations governing health maintenance organizations. When this information is no longer needed and has met the legal requirement for maintenance, it will be destroyed by a method that induces complete destruction so that it is no longer readable, discernible or decipherable.
- Utilization staff, on a need to know basis only, will access information regarding a patient, his/her medical care, and his/her medical records.
- Essential personnel shall maintain all medical records and patient specific information in a secure area with limited access.

In accordance with Federal and State law, all activities set forth in this plan including minutes, reports, and worksheets belonging to the Company are considered confidential. Such materials are to be held in the strictest confidence and carefully safeguarded against unauthorized disclosure. HCM staff will sign confidentiality statements at the time of employment.

Ethical Framework for Business Practice

Our Company is committed to integrity, respect, and trust in the workplace. The Company's core values support the commitment to conducting business with integrity and the highest ethical standards.

The cornerstone of the Ethics and Compliance Program is the document, "Standards of Ethical Business Conduct," which provides guidance to assist all associates in upholding the highest ethical standards while conducting business. All associates complete mandatory training on these standards upon hire and annually thereafter.

The UM Program Policy will be posted on Healthy Blue's Provider and Member website, or in other forms as requested by the provider or Member, at no cost. A reference to the web address for the UM Program Policy will be included in the Provider Manual and Member Handbook.

Approval of UM Program

The Company will submit our UM Program Policy to the Department for review 90 calendar after Contract Award. The UM Program Policy will be revised based on changes requested by the

Department and any changes to the UM Program Policy will be submitted to the Department no less than 60 calendar days before such changes go into effect

CEO, (Plan Legal Name)	DATE
CHIEF MEDICAL OFFICER, (Plan Legal Name)	DATE
BEHAVIORAL HEALTH MEDICAL DIRECTOR, (as applicable)	DATE
QUALITY MANAGEMENT COMMITTEE, Chairperson	DATE