POLICY AND PROCEDURE

DEPARTMENT: Population Health and Clinical Operations-Utilization Management	**DOCUMENT NAME:** Utilization Management Program Description
PAGE: 1 of 35	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:**
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PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** NC.UM.01

SCOPE:
Carolina Complete Health (Plan) Utilization Management, Quality, Compliance, Pharmacy and Member Service Departments.

PURPOSE:
To describe the Utilization Management Program.

POLICY:
The Population Health and Clinical Operations Department will maintain a Utilization Management Program Description that encompasses the functions of pre-authorization, care management, concurrent review, and disease management. The program description will be consistent with all regulatory and accrediting guidelines. The program description is reviewed and revised at least annually, and more frequently, as needed.

The Plan shall comply with Department policies as identified and required by the NC Department of Health and Human Services (DHHS), including the following, as may be amended from time to time: Medicaid Managed Care Enrollment Policy; DHHS Clinical Coverage Policies; Transition of Care Policy; Care Management Policy; Advanced Medical Home Program Policy; Care Management for High-Risk Pregnancy Policy; Care Management for At-Risk Children Policy; Management of Inborn Errors of Metabolism Policy; Uniform Credentialing and Re-credentialing Policy.

REFERENCES:
1. NCQA Health Plan Standards and Guidelines
2. CM.01 Care Management Program Description
3. CC.UM.01.01 Covered Benefits and Services
4. CC.UM.01.07 Concurrent Review
5. CC.UM.01.09 Discharge Planning
6. CC.UM.02.05 Interrater Reliability
7. NC.UM.05 Timeliness of UM Decisions
8. CC.UM.07 Adverse Benefit Determination
9. NC.UM.20 Transition of Care

DEFINITIONS: N/A

REVISION LOG	DATE

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in the P&P management software is considered equivalent to an actual signature on paper.

Vice President, Population Health Clinical Operations: Approval on File
Director, Utilization Management: Approval on File
Director, Population Health and Clinical Operations: Approval on File

Carolina Complete Health

Utilization Management
Program Description

2020 - 2021

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PURPOSE
The purpose of the Utilization Management (UM) Program Description is to define the structures and processes within the Population Health and Clinical Operations Department, including assignment of responsibility to appropriate individuals, in order to promote fair, impartial and consistent utilization decisions and coordination of care for the health plan members.

SCOPE
The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care types including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long term care and ancillary care services. The UM Program incorporates all care locations including, office, outpatient facility inpatient facility, home or other residence, telemedicine, and telepsychiatry.

GOALS
The goals of the UM Program are to optimize members' health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM Program aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

IMPLEMENTATION
The UM Program seeks to advocate the appropriate utilization of resources, using the following program components: twenty-four (24) hour nurse triage, prior authorization/precertification, second opinion, concurrent review, ambulatory review, and retrospective for both medical and behavioral health care services, care management, disease management, maternity management, preventive care management and discharge planning activities. Additional program components implemented to achieve the program's goals include tracking utilization of services to guard against over- and under-utilization of services and interactive relationships with practitioners to promote appropriate practice standards. Referrals to hospital discharge planners and dialogue with the Primary Care Provider (PCP)/Advanced Medical Home (AMH) regarding long-term or supportive needs are initiated promptly. The AMH/PCP is responsible for assuring appropriate utilization of services along the continuum of care.

CONFIDENTIALITY
Confidential information is defined as any data or information that can directly or indirectly identify a patient or physician. The Plan adheres to the following:

- Staff and consultants are required to sign a confidentiality statement.
- All members of the UM Committee are required to sign a confidentiality waiver.

- All employees and practitioners are allowed to access and disclose confidential information only as necessary to fulfill assigned duties and responsibilities.
- Medical information sent by mail or fax to the attention of the recipient is clearly marked “personal and confidential”.
- All medical information is secured in a locked location with access limited to essential personnel only.
- Medical information stored in the software system is protected under multiple levels of security by system configuration, which includes user access passwords.
- Confidential information is destroyed by a method that induces complete destruction when no longer needed.
- The Plan abides by all federal and state laws governing the issue of confidentiality.
- The Plan does not discriminate against members, providers, or employees in the provision of services or administration of the program.

AUTHORITY

The Plan Board of Directors (BOD) has ultimate authority and accountability for the oversight of the quality of care and services provided to members. The BOD oversees development, implementation and evaluation of the Quality Improvement Program. The Plan BOD delegates the daily oversight and operating authority of UM activities to the Plan’s Quality Improvement Committee (QIC), which, in turn, delegates responsibility for the UM Program to the UM Subcommittee (MMC), including the review and appropriate approval of medical necessity criteria and protocols and utilization management policies and procedures. The MMC is responsible for reviewing all utilization management issues and related information and making recommendations to the Plan’s QIC or the BOD as necessary. The UM Program is reviewed and approved by the Plan’s BOD or the QIC on an annual basis.

The Chief Medical Director has operational responsibility for and provides support to the Plan’s UM Program. The Plan Chief Medical Director, Vice President of Population Health and Clinical Operations (VPPHCO), and/or any designee as assigned by the Plan President and CEO are the senior executives responsible for implementing the UM program. Included responsibilities are cost containment, quality improvement and review activities pertaining to utilization review, complex, controversial or experimental services, and successful operation of the QIC and MMC. A behavioral health practitioner is involved in the implementation, monitoring and directing of behavioral health aspects of the UM Program. Appropriate specialists are involved in the implementation, monitoring and directing of specialty health and service aspects of the UM Program. A pharmacist oversees the implementation, monitoring and directing of pharmacy services. In addition to the Chief Medical Director, the Plan may have one or more Medical Directors.

The Chief Medical Director's responsibilities include, but are not limited to, coordination and oversight of the following activities:

- Assists in the development/revision of UM policies and procedures as necessary to meet state and federal statutes and regulations and accrediting body requirements
- Monitors compliance with the UM Program.
- Provides clinical support to the UM staff in the performance of their UM responsibilities.
- Assures the medical necessity criteria used in the UM process are appropriate and reviewed by physicians and other practitioners according to policy.
- Assures the medical necessity criteria are applied in a consistent manner.
- Assures reviews of cases that do not meet medical necessity criteria are conducted by physicians or other healthcare professionals as appropriate, in a manner that meets all pertinent statutes and regulations and takes into consideration the individual needs of the involved members and assessment of the local delivery system.
- Reviews, approves, and signs (if required) denial letters for cases that do not meet medical necessity criteria after appropriate review has occurred in accordance with Plan policy.
- Assures the medical necessity appeal process is carried out in a manner that meets all applicable contractual requirements, as well as all federal and state statutes and regulations, is consistent with all applicable accreditation standards, and is done in a consistent and efficient manner.
- Provides a point of contact for practitioners calling with questions about the UM process.
- Communicates/consults with practitioners in the field as necessary to discuss UM issues.
- Coordinates and oversees the delegation of UM activity as appropriate and monitors each delegated arrangement assuring all applicable contractual requirements and accreditation standards are met.
- Assures there is appropriate integration of physical, behavioral, and social health services for all Plan members.
- Participates in and provides oversight to the UMC and all other physician committees or subcommittees.
- Recommends and helps to monitor corrective action as appropriate for practitioners with identified deficiencies related to UM.
- Serves as a liaison between UM and other Plan departments.
- Educates practitioners regarding UM issues, activities, reports, requirements, etc.
- Reports UM activities to the QIC as needed.

INTEGRATION WITH OTHER PROGRAMS

The UM, Pharmacy and Therapeutics (P&T), Quality Improvement (QI), Credentialing, and Fraud and Abuse Programs are closely linked in function and process.

The UM process utilizes quality indicators as a part of the review process and provides the results to the Plan's QI Department. As care managers perform the functions of utilization management, quality indicators (including those prescribed by the Plan as part of the patient safety plan) are identified. The required information is documented appropriately and forwarded to the QI Department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the Plan UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific care management decisions, discharge planning, precertification of non-covered benefits, etc. The information is forwarded to the QI Department in the format prescribed by Plan for review and resolution as needed. The Chief Medical Director or Medical Director determines if the information warrants additional review by the Plan Peer Review or Credentialing Committee. If committee review is not warranted, the information is documented in the practitioner's record and may be used for trending or reviewed at time of the practitioner's re-credentialing.

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. The Population Health and Clinical Operations Department works closely with the Compliance Officer and the Special Investigations Unit to resolve any potential issues that may be identified.

In addition, the Plan coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- EPSDT services/Health Check
- Services provided by local public health departments

MEDICAL MANAGEMENT COMMITTEE (MMC)

Daily oversight and operating authority of UM activities are delegated to the MMC, which reports to the Plan's QIC and ultimately to the Plan BOD. The MMC is responsible for the review and appropriate approval of medical necessity criteria and protocols and UM policies and procedures. The MMC coordinates annual review and revision of the UM Program Description, Work Plan, and the Annual UM Program Evaluation. These documents are presented annually to the BOD or QIC for review and approval. The MMC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate over- or under-utilization, which may impact health care services, coordination of care, and appropriate use of services and resources as well as member and practitioner experience with the UM process. Analysis of the above tracking and

monitoring processes, as well as status of corrective action plans, as applicable, are reported to the Plan's QIC.

In addition to the above, the MMC also provides ongoing evaluation of the appropriateness and effectiveness of practitioner quality incentive payments and assists in modifying and designing an appropriate quality incentive program.

MMC SCOPE

- Oversees the UM activities of Plan in regards to compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as the National Committee for Quality Assurance (NCQA).
- Develops and annually reviews/approves the UM Program Description, guidelines, policies and procedures, and the list of services requiring prior authorization.
- Monitors reports for timeliness of behavioral, non-behavioral and pharmacy UM decisions and notification.
- Reviews practitioner-specific UM reports to identify trends and/or utilization patterns and makes recommendations to the QIC for further review.
- Reviews reports specific to facility and/or geographic areas for trends and/or patterns.
- Examines appropriateness of care reports to identify trends and/or patterns of over- and under-utilization; refers identified practitioners to the QIC for performance improvement and/or corrective action.
- Examines results of annual member and practitioner satisfaction surveys to determine overall experience with the UM Program and identify areas for performance improvement.
- Provides a feedback mechanism to the QIC for communicating findings, recommendations, and a plan for implementing corrective actions related to UM issues.
- Identifies those opportunities whereby the UM data can be utilized in the development of quality improvement activities and submitted to the QIC for recommendations.
- Reports findings of UM studies and activities to the QIC.
- Liaisons with the QIC for ongoing review of quality indicators.

MMC MEMBERS

The Plan actively involves participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. The Plan's UM Program Description and policies define when such a conflict may exist and describe the remedy when conflicts occur. Participation in the Plan's MMC is one of the primary ways in which network practitioners participate in Plan utilization review activities.

Plan's MMC is comprised of the following members:

- Network practitioners representing the range within the network and across the service area
- Plan Chief Medical Director/Medical Director
- Plan VPPHCO
- Plan executive leadership, UM, and QI staff
- Other operational staff as requested, e.g. Network/Contracting, Member/Provider Services, Compliance/Regulatory, Pharmacy

The MMC is chaired by a Plan Medical Director and may be co-chaired by a network physician; this activity may be delegated to another physician member or the VPMM for a specific meeting as needed.

MEETING FREQUENCY AND DOCUMENTATION OF PROCEEDINGS

The MMC meets at least four (4) times per year and the VPMM maintains detailed records of all MMC meeting minutes, UM activities, care management program statistics, and recommendations for UM improvement activities made by the MMC. The MMC submits to the QIC meeting minutes and reports regarding UM studies and activities.

UTILIZATION MANAGEMENT PROCESS

The UM process encompasses the following program components: twenty-four (24) hour nurse triage, referrals, second opinions, prior authorization, pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination. All approved services must be medically necessary or in the case of long-term services and supports (LTSS), be supported by an assessment of needs of the designated program benefits. The clinical or service decision process begins when a request for authorization of service or determination of service need for member receiving LTSS is received at the Plan. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, scheduled inpatient services, or emergent/urgent inpatient services, including obstetrical deliveries. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

QUALIFICATIONS AND TRAINING

Appropriately licensed, qualified health professionals supervise the UM process and all medical necessity decisions. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of healthcare services offered under the Plan's benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current professional licensure. This licensure is specific to the state.

The Plan ensures that financial considerations do not influence decisions to provide medically appropriate care. UM employee compensation includes hourly fees and salaried positions. All staff completing UM reviews and decisions are required to sign an affirmative statement regarding compensation annually.

Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is prohibited. The Plan and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

- The percentage of the amount by which a claim is reduced for payment, the number of claims or the cost of services for which the person has denied authorization or payment, decisions that result in under-utilization; or
- Any other method that encourages the rendering of an adverse determination.

The Plan determines appropriate staffing based on Plan need and contract requirements, which may include, but is not limited to the following:

Chief Medical Officer (CMO)

The CMO is a Physician who resides in, and whose license to practice in NC is unrestricted; has a minimum of five (5) years' experience in a health clinical setting; and has a minimum of two (2) years' experience in managed care. As previously stated, the Chief Medical Director oversees the UM Program. The Chief Medical Officer /Chief Medical Director and Medical Director(s) are hereafter collectively referred to as 'Medical Director'.

The Medical Director is required to supervise all medical necessity decisions and conducts Level II medical necessity reviews. Persons authorized to make a clinical denial based on medical necessity include licensed MDs, DOs, doctoral-level clinical psychologists, certified addition-medicine specialists, chiropractors, physical therapists, dentists (DDSs), and pharmacists (RPhs) (as allowed by state contract).

Behavioral Health Practitioner

The Behavioral Health Practitioner resides in and is a fully licensed psychiatrist or psychologist, in the State of North Carolina; has a minimum of five (5) years' experience in a behavioral health clinical setting; and has a minimum of two (2) years' experience in managed care.

A behavioral health practitioner is involved in implementing, monitoring and directing the behavioral health care aspects of the Plan's UM program. A behavioral health practitioner may participate in UM rounds to assist in identifying behavioral health care needs and integrating behavioral and physical care. Behavioral health practitioners also participate on various Plan committees.

Vice President of Pharmacy Operations (as applicable)
The Vice President of Pharmacy Operations (VPPO) is a registered pharmacist with experience in UM activities. The VPPO is responsible for overseeing the day-to-day operational activities of the Plan's Pharmacy Program. The VPPO reports to the Plan Chief Medical Director. The VPPO, in collaboration with the Pharmacy Benefit Manager, assists with the development of the Pharmacy UM strategic vision in alignment with the corporate and Plan objectives, policies and procedures.

Plan Pharmacist/Pharmacy Director
The Plan Pharmacist is a currently licensed (without restrictions) pharmacist in the state and has a minimum of three (3) years of Medicaid pharmacy benefits management experience. Plan Pharmacists report directly to the Plan Medical Director, or Vice President of Pharmacy Operations. The Plan Pharmacist monitors and analyzes pharmacy utilization, and reports findings to the Plan MMC and/or QIC. The Plan Pharmacist is a member of the Plan's Pharmacy and Therapeutics (P&T) Committee.

Pharmacy Manager
(If Plan has one – otherwise responsibilities roll up to Pharmacy Director)
The Plan Pharmacy Manager is a licensed pharmacist in the state. The Plan Pharmacy Manager reports directly to the Plan Pharmacist/Pharmacy Director. The Pharmacy Manager is the point of contact for Plan physicians regarding concerns with the preferred drug list. Where applicable, the Pharmacy Manager reviews all pharmacy prior authorization requests that do not meet criteria and makes an appropriate determination in conjunction with the Plan Medical Director, if needed. As permitted by state law, the plan's Pharmacy Benefit Manager (PBM) is responsible for performing prior authorization. Plan Pharmacy Manager and the Plan Pharmacist monitor pharmacy utilization and report findings to Plan MMC and/or QIC.

Pharmacy Technicians
Pharmacy Technicians are individuals with experience working in a pharmacy and have a minimum of a high school diploma. Where applicable, Pharmacy Technicians review information submitted for pharmacy preauthorization and may have the authority to approve specific services for which there are explicit criteria. Pharmacy Technicians cannot make clinical determinations and must refer all clinical decisions to the Plan Pharmacist. Pharmacy technicians report to and are supervised by the Plan Pharmacist.

Board-Certified Clinical Consultants
In some cases, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may utilize a board-certified consultant from the appropriate specialty for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside the Plan may be contacted, when necessary to avoid a conflict of interest. The Plan defines conflict of interest to include situations in which the

practitioner who would normally advise on a UM decision made the original request for authorization or determination or is in, or affiliated with the same practice group as the practitioner who made the original request or determination.

Service Consultants
UM staff calls upon service experts outside the Plan to assist in making authorization determinations for specialty services in certain cases. In these instances, a licensed/certified service consultant specializing in the area of service in question is contacted. Specialty service consultants may include but are not limited to Occupational Therapist, Physical Therapist, Speech Therapist, Physician Assistant, Certified Nurse Practitioner, etc.

Vice President of Population Health and Clinical Operations (VPPHCO)
The VPPHCO is a registered nurse with experience in UM activities. The VPPHCO is responsible for overseeing the day-to-day operational activities of the Plan's UM Program. The VPPHCO reports to the Plan President and CEO or Chief Operating Officer (COO). The VPPHCO, in collaboration with the Chief Medical Director, assists with the development of the UM strategic vision in alignment with the corporate and Plan objectives, policies and procedures.

Utilization Management Director/ Manager
The UM Director/Manager is a registered nurse or appropriately licensed behavioral health professional. The UM Director/Manager directs and coordinates the activities of the department including supervision of the referral specialist staff, prior authorization, concurrent review nurses and denial/appeals staff as applicable. The UM Director/Manager reports to the VPPHCO or Director of Population Health and Clinical Operations. The UM Director/Manager works in conjunction with the VPPHCO or Director of Population Health and Clinical Operations and Care Management Director/Manager to execute the strategic vision in conjunction with corporate and Plan objectives, policies and procedures and state contractual responsibilities.

Director of Population Health and Care Management
The Director resides in North Carolina and is a NC licensed clinician (i.e. LCSW, RN, MD, DO) and has more than five (5) years of demonstrated care management/population health experience in a large healthcare corporation serving Medicaid members. This individual is responsible for providing oversight and leadership of all prevention/population health, care management and care coordination programs, including local care management plan, AMH model and care management delivered by LHD's. The Director of Population Health and Care Management reports to the Vice President of Population Health.

Care Managers
Care Managers are nurses or appropriately licensed behavioral health professionals with clinical and preferably UM and/or CM experience. There are

several levels or types of CMs within the organization and as such may be referenced with alternate titles such as: Prior Authorization Nurse, Concurrent Review Nurse, Discharge Planning Nurse, Hospital Case Manager, Complex Care Manager, Catastrophic Care Manager, Disease Care Manager, Care Manager I, and Care Manager II, etc.; *hereinafter collectively referred to as Care Managers.*

Care Managers who coordinate discharge planning and apply approved UM medical necessity criteria for concurrent review and requests for discharge services report to and are supervised by the Director/Manager of UM. Care Managers who are responsible for the daily coordination of care management and similar specialty programs and apply approved UM criteria to new or continued service requests report to the Director/Manager of Care Management. Care Managers are prohibited from making adverse medical necessity determinations. When request for authorization of services does not meet the standard UM criteria, the case is referred to the Medical Director for a medical necessity review.

Program (Social Service) Specialists
Program Specialists (also known as Social Service Specialists) are individuals with background in social services or other applicable health related field, who may or may not be licensed. Program Specialists work with Care Managers and other members of the Population Health and Clinical Operations team to coordinate psychosocial and community resources for members. They assist members with utilization of medical resources related to care management, disease management and discharge planning. Program Specialists are authorized to approve specific services for which there are explicit criteria, develop service plans (as applicable for members in LTSS or other service oriented benefit programs) and coordinate care plans. They are required to refer all potential adverse determinations to the designated Plan Medical Director. Program Specialists report to the Director/Manager of Care Management.

Program Coordinators
Program Coordinators are highly trained clinical or non-clinical staff with significant experience as a health service professional. This experience may be from a variety of settings of care: lab, hospital, clinic, or other community based entity. This staff assists the care team with administrative duties such as member or provider follow-up calls, data collection for screening assessments, obtaining test results, coordinating home health services, and obtaining transportation. They may attend marketing and outreach meetings and coordinate services with community-based organizations. They work in collaboration with the interdisciplinary care team and refer all clinical decisions to the Care Manager.

Referral Specialists
Referral Specialists are individuals with significant administrative experience in the health care setting. Experience with diagnosis and CPT coding is preferred. Referral Specialists work with providers to collect demographic and other data

necessary for preauthorization and may have the authority to approve services for which there are explicit criteria or algorithms. Referral Specialists cannot make clinical determinations, referring all clinical decisions to a Care Manager. Referral Specialists report to and are supervised by the UM Director/Manager or qualified designee.

MEDICAL NECESSITY REVIEW

Covered services are those medically necessary health care services provided to members as outlined in the Plan's contract with the State and/or CMS. We provide all services in alignment with State standards, which includes transplants. Each case is treated individually, given the individual circumstances and in accordance with State defined scope of services: Standards for organ transplants that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to Members. Section 1903(i) of the Social Security Act. Medical necessity means the covered services prescribed are based on generally accepted medical practices in light of conditions at the time of treatment. Medically necessary services are those that are:

- Appropriate and consistent with the diagnosis of the treating practitioner and the omission of which could adversely affect the member's medical or behavioral health (BH) condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the member, the practitioner, or the facility providing the care;
- Not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage and appropriate; and
- There must be no other effective and more conservative or substantially less costly treatment, service and setting available.

As part of the UM program, the Plan maintains a referral and prior authorization process with the Member-selected or Plan- assigned AMH/PCP. The Plan conducts prior authorization reviews using current clinical documentation, considers the individual clinical condition and health needs of the Member. The Plan may require a referral for any medical services not provided by the AMH/PCP except where specifically provided in the Department-Plan contract and in federal and state statute and regulations.

Medical necessity determinations are made by appropriate professionals and include decisions about covered benefits defined by the Plan, including inpatient and outpatient services, as listed in the summary of benefits and care or services that could be considered either covered or non-covered, depending on the circumstances.

Covered benefits details are included in the CC.UM.01.01 – *Covered Benefits and Services* policy.

Two levels of UM medical necessity review are available for all authorization requests:

Level I Review
Conducted on covered medical benefits by a Utilization Manager who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. A Level I review is conducted utilizing McKesson's InterQual criteria, the American Society of Addiction Medicine's (ASAM) criteria, or applicable state or company developed clinical policy, while taking into consideration the individual needs and complications at the time of the request, in addition to the local delivery system available for care. Other factors that must be considered when applying criteria to a given individual situation includes the member's age, co-morbidities, complications, progress of treatment, psychosocial situation and home environment, when applicable. At no time does a Level I review result in a reduction, denial, or termination of service. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by an individual who has appropriate expertise in addressing the Member's medical, behavioral health, or long-term services and supports needs during a Level II Review. 42 C.F.R. § 438.210(b)(3).

Level II Review
Conducted on a case-by-case basis by an appropriate practitioner with a current license to practice without restriction, or other healthcare professional as appropriate. For instance, if the request is for behavioral health service, a qualified behavioral health practitioner will conduct the Level II Review, or be consulted during the review. If the request is for dental services, a qualified dental practitioner will conduct the Level II Review. Automatic referral for Level II Review includes requests for services or procedures that require benefit determination, services that do not have existing medical necessity criteria, or are potentially experimental or new in practice. A Level II Review is also indicated when the request does not meet the existing medical necessity criteria following a Level 1 Review. All Level II reviews are conducted with consideration given to continuity of care, individual needs at the time of the request, and the local delivery system available for care. A board-certified consultant may be used or consulted in making a medical necessity determination.

CLINICAL CRITERIA

The goal in utilization management is to help guide best practice medicine in the most efficient and economical manner while addressing patient-specific needs. To that end, the clinical decision criteria utilized aligns the interests of the health plan, the practitioner, and the member. The UM criteria are nationally recognized, evidence-based standards of care and include input from recognized medical experts. The guidelines and decision support methodologies are used to

support UM and prior authorization for services not otherwise defined in mandated clinical coverage policies. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate.

For a limited number of services, the Plan shall incorporate existing North Carolina Medicaid and NC Health Choice Fee-for-Service clinical coverage policies into the UM Program to maintain services for specific vulnerable populations, maximize federal funding, and comply with State mandates, as described in Section V.C. Table 4: Required Clinical Coverage Policies.

Through the MMC, appropriate practitioners are involved in developing, adopting, and reviewing criteria. Utilization review criteria are utilized as an objective screening guide and are not intended to be a substitute for physician judgment. Utilization review decisions are made in accordance with currently accepted medical or health care practices, while taking into consideration the individual needs and complications at the time of the request, in addition to the local delivery system available for care. The Medical Director (or other appropriate practitioner as defined in this program description), reviews all potential medical necessity denials for medical appropriateness and has authority to implement an adverse determination which results in reduction, suspension, denial, or termination of services.

In general, the Plan uses McKesson's InterQual guidelines to determine medical necessity and appropriateness of physical and/or behavioral health care. McKesson plays an integral role in healthcare, serving more than fifty percent (50%) of America's hospitals, twenty percent (20%) of U.S. physicians and ninety-six percent (96%) of the top health plans. InterQual is developed by generalist and specialist physicians representing a national panel from academic as well as community based practice, both within and outside the managed care industry. InterQual provides a clear, consistent, evidence-based platform for care decisions that promote appropriate use of services, enhance quality, and improve health outcomes. The Plan uses InterQual's Level of Care and Care Planning Criteria for Pediatric Acute, Adult Acute, Home Care, Durable Medical Equipment and Procedures to determine medical necessity and appropriateness of care. The Plan may also use the Subacute/SNF guidelines to assist in determining medical necessity for subacute or skilled nursing care for members with catastrophic conditions or special health care needs.

The Plan utilizes InterQual Criteria for psychiatric inpatient, residential/PRTF, partial hospitalization, intensive outpatient and outpatient therapy services, American Society for Addiction Medicine (ASAM) criteria for substance use services (as applicable), and state specific criteria for community based services. In addition to the national standards for medical necessity criteria, the plan will also utilize behavioral health screening tools used by providers, as defined by the state for utilization reviews, including

- EPSDT criteria for services for children,

- Level of Care Utilization System (LOCUS) scores for mental health services for medical necessity reviews for members eighteen (18) and older,
- Child and Adolescent Level of Care Utilization System (CALOCUS) scores for mental health services for medical necessity reviews for children and adolescents six (6) through seventeen (17) years old, and
- Early Childhood Services Intensity Instrument (ECSII), or
- Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Preschoolers to determine medical necessity for children ages zero (0) through five (5), or
- Another validated assessment tool with prior approval by the Department.

The Plan will also require behavioral health provider to use the Supports Intensity Scale (SIS) for I/DD services for medical necessity reviews for members five (5) years old and older. The SIS Children's version shall be used for ages of five (5) through sixteen (16). The SIS Adult version shall be used for ages seventeen (17) and older and up.

New Technology Review

In instances of determining benefit coverage and medical necessity of new and emerging technologies, the new application of existing technologies, or application of technologies for which no InterQual Criteria exists, the Plan's Medical Director consults available Medical Policy Statements. The Clinical Policy Committee (CPC) develops these statements.

The CPC is responsible for evaluating new technologies or new applications of existing technologies for inclusion as medical necessity criteria. The CPC develops, disseminates and at least annually updates clinical policies related to: medical procedures, behavioral health procedures, pharmaceuticals and devices. The CPC or assigned designee reviews appropriate information including published scientific evidence, applicable government regulatory body information, CMS's National Coverage Decisions database/manual and input from relevant specialists and professionals who have expertise in the technology. Practitioners are notified in writing through the provider newsletters and the practitioner web portal (as applicable) of new technology determinations made by the Plan. As with standard UM criteria, the treating practitioner may, at any time, request the clinical policy/criteria pertinent to a specific authorization by contacting the Population Health and Clinical Operations Department or may discuss the UM decision with the Plan Medical Director.

Preventive and Clinical Practice Guidelines

The Clinical Practice Guidelines shall be based on valid and reliable clinical evidence or consensus of providers in a particular field; consider the needs of members; be adopted in consultation with contracting health professionals; be reviewed and updated periodically as appropriate; and starting in Contract Year 1, meet the clinical practice guidelines required for Health Plan Accreditation set forth by the National Committee for Quality Assurance (NCQA). 42 C.F.R. §§

438.236(b). While practice guidelines are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Sickle Cell, Immunizations, and ADHD/ADD Guidelines for both adults and children.

Practitioner Access to Criteria

At any time, treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the Plan's Population Health and Clinical Operations Department or may discuss the UM decision with the Plan Medical Director. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the Population Health and Clinical Operations Department. The manual also outlines the Plan's Population Health and Clinical Operations policies and procedures.

INTERRATER RELIABILITY

At least annually, the Chief Medical Director and VPPHCO assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the VPPHCO or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, the Plan's Population Health and Clinical Operations leadership takes corrective action. New UM staff is required to successfully complete interrater reliability testing prior to being released from training oversight. For more details around Interrater Reliability, reference CC.UM.02.05 – *Interrater Reliability* policy.

SUBMISSION OF CLINICAL INFORMATION

UM requests and supporting clinical information for review may be submitted to the Population Health and Clinical Operations Department by phone, facsimile or web portal (as available) from the servicing/managing practitioner or facility. Although a health care practitioner may designate one or more individuals as the contact for the Population Health and Clinical Operations staff, in no event does this preclude the Plan from contacting a health care practitioner or others in his or her employment when there is unreasonable delay or when the designated individual is unable to provide the necessary information or data requested.

PRIOR AUTHORIZATION

Prior authorization requires the provider or practitioner to make a formal request to the Plan prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health services proposed, including the setting in which the proposed care will take place.

Prior authorization is required for only those procedures and services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness of care review, such as non-emergent inpatient admissions (other than normal newborn deliveries), all out-of-network services and certain outpatient services, ancillary services and specialty injectable as described on the prior authorization list. Prior authorization is never required for emergency services or urgent care services. Therefore, the PHP shall not retract a prior authorization for emergency services after the services have been provided, except as provided in N.C. Gen. Stat. § 58-3-190(c).

The Population Health and Clinical Operations Department reviews the prior authorization list regularly, in conjunction with the Plan's Medical Director and VPPHCO, to determine if any services should be added or removed from the list. The Provider Services, Member Services, and Network Management departments are also consulted on proposed revisions to the prior authorization list. Such decisions are based on Plan program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Clinical Information

For medical services that the Plan has determined require prior authorization and/or certification, only the minimally necessary information is obtained. The information required is not overly burdensome for the member, the practitioner/staff, or the health care facility staff. Only information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services is collected. The Plan shall, prior to the decision on a request for prior approval, limit contacts with the requesting provider or Member (including telephone and email contacts) to those needed to obtain more information about the service request and/or to provide education about covered services. Providers and Members will not be asked to withdraw or modify a request for prior approval of a covered service in order to accept a lesser number of hours, or less intensive type of service, or to modify a SNAP (score for neonatal acute physiology) for neonatal acute physiology) score or other clinical assessment. Information needed to perform the review may include, as applicable, but is not limited to, the following information:

- Office and hospital records
- A history of the presenting problem
- Clinical or mental status exam notes
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history or assessments
- Information on consultations with the treating practitioner
- Evaluations from other healthcare practitioners and providers
- Photographs
- Operative and pathological reports

- Rehabilitation evaluations
- Printed copy of criteria related to the request
- Information regarding benefits for service or procedure
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members
- LOCUS, CALOCUS, or other level of care assessment
- Physical or behavioral health screenings and results

Clinical information received, as well as rationale for the medical necessity determination and/or leveling of care is documented and maintained in the clinical authorization system.

Referrals
AMH/PCPs are not required to issue *paper* referrals, but are expected to direct the member's care and assist with obtaining prior authorization for referrals to certain services and all non-emergent out-of-network practitioners as noted on the Plan prior authorization list.

Second Opinions
A second opinion may be requested when there is a question concerning diagnosis, options for surgery, or other treatment of a health condition, or when requested by a member of the health care team, including the member, parent, guardian or others with custodial responsibilities. Authorization for a second opinion is granted to a network practitioner or an out-of-network practitioner, if there is no in-network practitioner available. The second opinion is provided at no cost to the member.

Extended Specialist Services
Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the policies include guidance on how members with life-threatening conditions or diseases which require specialized medical care over a prolonged period of time can request and obtain access to specialty care centers.

Out-of-Network Practitioner
If a member requires services that are not available from a qualified network practitioner, the Plan will adequately and timely (i.e. according to the Plan's practitioner availability and accessibility standards) cover services out-of-network for members. The decision to authorize use of an out-of-network practitioner is based on continuity of care, availability and location of an in-network practitioner of the same specialty and expertise, and complexity of the case. Network practitioners are prohibited from making referrals for designated health services to health care entities with which the practitioner or a member of the practitioner's family has a financial relationship.

Specialty Injectable
The Plan establishes clinical criteria for coverage of specialty injectable. Prior authorization requests that do not meet criteria are referred to the Plan Pharmacist for review and determination in collaboration with the Plan Medical Director, if needed.

CONCURRENT REVIEW
The concurrent review process assesses the clinical status of the member, verifies the need for continued hospitalization or for ongoing ambulatory care, facilitates the implementation of the practitioner's plan of care and promotes timely care, determines the appropriateness of treatment rendered, the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed,
- Whether the diagnosis is the same or changed,
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care,
- Additional days/service/procedures proposed, and
- Reasons for extension of the treatment or service.

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonic. The frequency of reviews are based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity, and are not routinely conducted on a daily basis. If, at any time, services cease to meet inpatient or ambulatory criteria, discharge criteria are met and/or alternative care options exist, the care manager contacts the facility and obtains additional information to justify the continuation services. When the medical necessity for the case cannot be determined, the case is referred to the Medical Director or appropriate behavioral health professional for review. The need for care management or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-effective alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to the Plan QI Department for investigation and resolution. Details around concurrent review can be found in CC.UM.01.07 – *Concurrent Review* policy.

Discharge Planning
Discharge planning is a method of coordinating care, controlling costs, and arranging for the appropriate services upon discharge from the hospital. For members who have not fully recovered or do not require the highly specialized and intensive services of acute hospital care, discharge planning assists the member in receiving the most timely, appropriate, safe, and cost-effective

discharge with additional health care services such as home health care or appropriate placement in an extended care facility.

Discharge planning occurs as early as possible in a member's hospital stay. The Care Manager reviews the post-hospital needs with the member, the member's family, the AMH/PCP, and other practitioners as appropriate. The Care Manager works with the UM staff of the hospital, AMH/PCP, and managing physician to arrange for services needed before the member is discharged from the hospital, as needed. Community-based agencies are included in the discharge planning as appropriate. Detailed information around discharge planning can be found in the CC.UM.01.09 – *Discharge Planning* policy.

COORDINATION OF SERVICES

Coordination of services and benefits is a key function of care management both during inpatient acute episodes of care as well as for complex or special needs cases. Coordination of care encompasses synchronization of medical, behavioral health, social, and financial services and may include management across payer sources. The Care Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medicaid is always the payer of last resort, the Plan must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by an AMH/PCP or other practitioner (with whom the member is in an active course of treatment with) termination from the Plan. The Plan assists the member as needed to choose a new AMH/PCP (or other practitioner) and transfer the medical records to the new practitioner, as appropriate. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the practitioner under certain situations. The Plan will also coordinate continuity of care with other Medicaid health plans when a new member comes onto the plan or terminates from the Plan to a new health plan.

RETROSPECTIVE REVIEW

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating practitioner without Plan notification and/or authorization and when there was no opportunity for concurrent review. The Director of Population Health and Clinical Operations or designee reviews the request for retrospective authorization. If supporting documentation satisfies the administrative waiver of notification the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting

documentation is questionable, the Director of Population Health and Clinical Operations or designee requests a Medical Director review.

SIGNIFICANT LACK OF AGREEMENT

When there is significant lack of agreement between the Plan Population Health and Clinical Operations staff and the health care practitioner regarding the appropriateness of certification during the initial review or appeal process, additional information may be requested. "Significant lack of agreement" means the Population Health and Clinical Operations employee has:

- Tentatively determined a service cannot be certified;
- Referred the case to the Medical Director for review; and
- Spoken to or attempted to speak to the health care practitioner regarding additional information.

TIMELINESS OF UM DECISIONS

Utilization management decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for practitioners to notify the Plan of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

For details regarding timeliness of UM determinations, reference NC.UM.05 - *Timeliness of UM Decisions* policy.

DENIAL NOTICES

A denial of services, also called an adverse determination or organization determination, is a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations. The Medical Director may approve an alternative to the service being requested. If the requesting provider and/or member do not agree to the alternative, the originally requested service may be denied. However, if the requesting provider and/or member agree with the alternative and the care is authorized, the requesting provider has essentially withdrawn his or her initial request and this is not be considered a denial.

Upon any adverse determination made by the Plan Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, is communicated to the member and requesting practitioner. Verbal notification of any adverse determination is also provided when applicable. All notifications are provided within the timeframes as noted in the NC.UM.05 - *Timeliness of UM Decisions and Notifications* policy. The written notification is easily understandable and includes the case-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process, and timeframes for appeal of the decision.

Practitioners are provided with the opportunity to discuss any UM denial decisions with a physician or other appropriate reviewer. The Plan Medical Director or appropriate practitioner reviewer (behavioral health practitioner, dentist, pharmacist, etc.) serves as the point of contact for the peer to peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template. Details regarding denial notices are detailed in CC.UM.07 – *Adverse Benefit Determination*

Access to Physician Reviewer

The Plan Medical Director or appropriate practitioner reviewer (behavioral health practitioner, dentist, pharmacist, etc.) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Practitioners are notified of availability of an appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, new practitioner orientation, and/or the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The Plan Medical Director may be contacted by calling the Plan's main toll-free phone number and asking for the Plan Medical Director. A Plan Care Manager may also coordinate communication between the Plan Medical Director and requesting practitioner.

APPEAL OF UM DECISIONS

A request to change or reverse a previous adverse clinical decision is considered an appeal. Appeals may be requested for benefit and/or medical necessity adverse determinations. Members, their authorized representatives (with written consent from the member as dictated by CMS or state contract), or legal representatives of a deceased member's estate may appeal adverse determinations regarding their care. A healthcare practitioner with knowledge of the member's condition, acting on behalf of the member and with the member's written consent, may file an appeal. Expedited appeals are available to members for any urgent care requests and do not require written member consent for a healthcare practitioner to act on the member's behalf. Punitive action is not taken against a practitioner who requests an expedited resolution or supports a member's appeal.

Members are provided a reasonable timeframe to file an appeal. This timeframe is no more than sixty (60) calendar days from the date of the Plan's notification of adverse determination or within the timeframes as designated by the State contract, if more stringent. The content of an appeal including all clinical care aspects involved are fully investigated and documented. Members, or their authorized representatives, have the right to submit comments, documentation, records and other information relevant to the appeal in person or in writing. A physician or other appropriate clinical peer of a same-or-similar specialty, not supervised by the individual, nor involved in the original determination,

evaluates medical necessity decisions for adverse appeal decisions. The Plan reviews, resolves, and provides the member with written or electronic notification of the decision within thirty (30) calendar days for a pre-service appeal sixty (60) calendar days for a post-service appeal, and seventy-two (72) hours/three (3) calendar days for an expedited appeal, or based on the more stringent of state or plan guidelines.

Independent/External Appeals

The Plan's appeal process, as applicable per State contract, includes a level of independent, external review (State Fair Hearing, External Review Agency etc.) of final determinations. The Plan provides an explanation of the appeals process and the right to an independent review of adverse determination according to the requirements of the state to all members upon enrollment and annually thereafter. This process is explained in the Member Handbook, member newsletters, member educational flyers, adverse determination notifications, and may be posted at network provider offices. All materials are produced in English, Spanish, and additional languages as needed. Members and practitioners, who appeal on behalf of members, are also made aware that once the grievance/appeal process has been exhausted, they may request an Administrative Law/State Fair hearing as defined in the state and/or federal administrative code.

EXPERIENCE WITH UM PROCESS

Annually, the Plan evaluates both member and provider experience with the UM process. Mechanisms of information gathering may include, but are not limited to satisfaction survey results (e.g. CAHPS), member/provider grievances/complaints and appeals that relate specifically to UM, provider satisfaction surveys with specific questions about the UM process, and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, the Plan develops an action plan and interventions to improve on the areas of concern, which may include staff retraining and member/provider education.

COMMUNICATION

Members and practitioners can access UM staff through a toll-free number at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TDD/TTY services for deaf, hard of hearing or speech-impaired members are available. The phone numbers are included in the Member Handbook, on the web and in all member letters. Additionally, language assistance for members to discuss UM issues are provided either by bilingual staff or through language line services.

Inbound and outbound communications may include directly speaking with practitioners and members; or fax, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title, and organization name when initiating or returning

calls regarding UM issues. After normal business hours and on holidays, calls to the UM Department are automatically routed to the twenty-four (24) hour nurse line. Twenty-four (24) hour nurse line is not a delegated UM entity and therefore does not make authorization decisions. Twenty-four (24)-hour nurse line staff accepts authorization information for next business day response by the Plan or notifies the Plan on-call staff in cases requiring immediate response.

The Plan's Population Health and Clinical Operations Department is available to coordinate services for members with urgent and emergent care, including ambulance services, to promote timely access to and delivery of necessary health services. As part of the triage process, UM/CM staff may direct the member, as appropriate, to their AMH/PCP or an emergency department. Under no circumstances does the Population Health and Clinical Operations staff offer medical advice. At any time, members may also contact the twenty-four (24) hour nurse line, the medical triage phone service which provides twenty-four (24) hour healthcare assistance and advice.

REQUESTING COPIES OF MEDICAL RECORDS

Population Health and Clinical Operations staff does not routinely request copies of medical records on all patients reviewed. During prospective and concurrent telephonic review, copies of medical records are only required when difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay. In those cases, only the necessary or pertinent sections of the record are required. Medical records may also be requested to complete an investigation of a member complaint/grievance/appeal or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times. Unless modified by state code and or federal regulations, health care practitioners will not be reimbursed for the reasonable costs for providing medical information in writing including copying and transmitting any requested patient records or other documents. Members requesting a copy of the Plan's designated record set are not be charged for the copy.

SHARING INFORMATION

The Plan's Population Health and Clinical Operations staff share all clinical and demographic information on individual patients among various divisions (e.g. certification, discharge planning, care management) via the clinical documentation system to avoid duplicate requests for information from members or practitioners.

PRACTITIONER – MEMBER COMMUNICATION

The Plan's UM Program in no way prohibits or otherwise restricts a healthcare professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical or behavioral care or treatment options, including any alternative treatments that may be self-administered;

- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or absence of treatment;
- The member's right to participate in decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

EMERGENCY SERVICES

Emergency department services are available twenty-four (24) hours/day seven (7) days/week. Prior authorization is not required for emergency services and coverage for such is based on the severity of the symptoms at the time of presentation. Emergency services are covered inpatient and outpatient services furnished by a qualified practitioner that are needed to evaluate or stabilize an emergency medical condition. The Plan covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

An emergency medical condition is a medical condition 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 placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. The Plan also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a Plan network practitioner, or Plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as previously stated.

Although the Plan may establish guidelines and timelines for submittal of notification regarding the provision of emergency services, including emergent admissions, the Plan does not refuse to cover an emergency service based on the practitioner's or the facility's failure to notify the Plan of the screening and treatment within the required timeframes, except as related to any claim filing timeframes. Members who have an emergency medical condition are not be

required to pay for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

PHARMACEUTICAL MANAGEMENT

The Pharmacy Management Program is overseen by the Chief Medical Director, VPPHCO or the Vice President of Pharmacy Operations or the Plan Pharmacist. All policies and procedures utilized by the Plan related to pharmaceutical management include the criteria used to adopt the procedure as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually and updated as new pharmaceutical information becomes available. Pharmacy policies and procedures are made available to practitioners via newsletter and/or the plan website.

PREFFERED DRUG LIST

The corporate preferred drug list (PDL) was created to offer a core list of preferred medications to all health plans. The corporate PDL serves as a basis for the Plan PDL. The corporate PDL is developed and maintained by the corporate Pharmacy and Therapeutics (P&T) Committee. The Plan P&T Committee determines which drugs from the corporate PDL are incorporated into the Plan PDL. The Plan PDL is available on the Plan website or in hard copy upon request.

PHARMACY BENEFIT MANAGER

The Pharmacy Benefit Manager (PBM) is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, customer service, pharmacy help desk, prior authorization (where state law allows), clinical services and quality improvement functions. The PBM may accomplish those tasks either internally or through contracted vendors. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity, Envolve Pharmacy Solutions is monitored according to the delegation policies and processes as discussed later in this document.

The pharmacy prior authorization (PA) process promotes the most appropriate utilization of selected high risk and/or high cost medications, and those subject to a high potential for abuse. This process is delegated to the PBM, and administered in accordance with applicable state and federal requirements, NCQA standards, and recognized high quality practice standards. The PA criteria for approval of drug coverage are developed, reviewed, and approved by the Health Plan P&T Committees in conjunction with the PBM. In addition, prior authorization criteria are consistent with review of current pharmaceutical and medical literature, peer reviewed journals, and professional standards of practice.

BEHAVIORAL HEALTH MANAGEMENT

The Company and its health plans comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) as it applies to its Medicaid Managed Care

Organizations as described in section 1903(m) of the Social Security Act (the Act); Medicaid Alternative Benefit Plans (ABPs) as described in the Act; and Children's Health Insurance Programs (CHIP) under title XXI of the Act. The Company and its health plans also ensure that any benefit limitations for mental health or substance use disorder (MH/SUD) benefits are comparable to those for medical/surgical benefits and do not impose less favorable benefit limitations on MH/SUD benefits compared to medical/surgical benefits, including with respect to annual and lifetime dollar limits, financial requirements, or treatment limitations (see COMP.46).

TRIAGE AND REFERRAL FOR BEHAVIORAL HEALTH

The Company and its health plans do not have a centralized triage and referral process; members accessing care with contracted providers *do not* require a referral from their AMH/PCP nor an assessment. Plan staff assists members with locating a network behavioral health provider as needed. Plan members calling for assistance in accessing behavioral health or substance abuse services are referred with appropriate urgency to the applicable care setting and treatment resources.

BEHAVIORAL HEALTH LEVELS OF CARE

The Plan ensures members receive high quality behavioral health care services, in the least restrictive setting to meet their individualized needs. The Plan has defined the following levels of care and described the minimum services associated with each level of care; each level of care includes individualized treatment planning that addresses the member's behavioral health (i.e. mental health and/or substance abuse) needs. Levels of care may be available as a covered benefit; covered benefits vary by Plan contract and may have associated coverage limitations.

Acute Psychiatric Inpatient Hospitalization

Acute hospitalization is the highest level of care for psychiatric and substance abuse services; this facility-based care may occur in a psychiatric or detoxification unit of a general hospital or at a free standing psychiatric facility. Key elements include: the facility is licensed as a hospital, twenty-four (24) hour medical and nursing care is provided, and care is supervised by behavioral health specialists. This level of care also includes twenty-three (23) hour observation beds or beds that provide an equivalent or greater intensity of nursing and medical care.

Crisis Stabilization

Crisis stabilization services provide twenty-four (24) hour medical and nursing care, serving as a diversion to acute psychiatric inpatient services. Crisis stabilization services are provided by behavioral health specialists at facilities which are not licensed as hospitals.

Residential Treatment
Residential treatment describes a longer term twenty-four (24) hour program for severe mental disorders and/or substance use disorders. Care at a Residential Treatment Center (RTC) or Psychiatric Residential Treatment (PRTF) is medically monitored, with twenty-four (24) hour onsite nursing services and medical provider availability. This level of care is expected to provide a range and intensity of diagnostic, therapeutic, life skills, rehabilitation and milieu-behavioral health services that cannot be provided by a combination of outpatient or community-based services. Each member's treatment plan should address their specific mental health and/or substance abuse needs, set discharge criteria, identify barriers to discharge, and ensure the treatment is the least restrictive option. Family therapy should occur two (2) - three (3) times/week to ensure the member can successfully reintegrate back to their home and community, unless there is an identified valid reason why this is not clinically appropriate or feasible.

Partial Hospitalization
Partial hospital programs provide services at least four (4) hours/day for three (3) days/week. These facility-based services are of similar intensity to acute hospital services (e.g. on-site nursing, psychiatric, and behavioral health services are available as needed by the member), but are provided less than twenty-four (24) hours/day. A specific treatment goal for this level of care is improving symptoms and level of functioning sufficiently for the member to return to a lesser level of care. Partial hospital programs for children and adolescents are expected to have family therapy sessions at least once a week.

Day Treatment
Day treatment programs can be either free-standing or hospital-based and provide frequent behavioral monitoring, and intervention and access to frequent medication management by a behavioral health specialist when necessary. Individuals in this level of care are unable to be treated by or have not responded to behavioral health services such as individual/family/group therapy, medication management, etc. and are experiencing an exacerbation of a longstanding psychiatric disorder, are at risk of deteriorating, or cannot reach identified goals due to significant functional impairments associated with the mental health diagnosis. The program must provide an integrated program of rehabilitation counseling, education, therapeutic, and/or family services at least 25 hours in a week to address an individual's mental health and/or substance abuse needs, with a specific treatment goal of reduction in severity of symptoms and improvement in level of functioning sufficient to return the enrollee to a lower level of care.

Intensive Outpatient
Intensive outpatient programs must provide an integrated program of rehabilitation, counseling, education, therapeutic, and/or family services preferably nine (9) hours in a week (minimum of six (6) hours a week) to address an individual's behavioral health needs. A specific treatment goal of this level of care is reduction in severity of symptoms and improvement in level of functioning

sufficient to return the enrollee to outpatient treatment follow-up and/or self-help support groups.

Community Based Services
Community-based services, where available, should be utilized when traditional services, such as therapy and/or medication management have been attempted and are inadequate to prevent a member from deteriorating and requiring a higher level of care. For children and adolescents, requests for this level of care must clearly document that the child is at imminent risk of out-of-home placement due to functional impairments associated with a behavioral health diagnosis. In all cases, the treatment plan should use techniques that are time-limited and support the goal of enhanced autonomy and the least restrictive environment possible. The treatment plan should be updated monthly and reflect efforts to reduce the frequency of service or clinical documentation for inability to decrease the usage of community based services.

Outpatient Treatment
Outpatient treatment may be comprised of evaluation services, individual, group, and/or family therapy, and medication management services provided by behavioral health specialists. The treatment plan should be updated monthly (every thirty (30) days) and reflect efforts at targeting symptom reduction, increase community tenure, and enhance independence.

DISEASE MANAGEMENT
Disease management is a multidisciplinary, continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management programs generally are offered telephonically, involving interaction with a trained nursing professional, and require an extended series of interactions, including a strong educational element. The Plan's programs emphasize prevention and members are expected to play an active role in managing their diseases. The Plan may delegate management of specific condition/disease management programs. The Plan's programs are described detail in associated policies or individual Disease Management Program Descriptions.

CARE MANAGEMENT
Care management or care coordination is a collaborative process of assessment, planning, coordinating, monitoring, and evaluating the services required to meet an individual's needs. Care management serves as a means for achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The goal of care management is provision of quality health care along a continuum, decreased fragmentation of care across settings, enhancement of the member's quality of life, and efficient utilization of patient care resources. The CM helps identify appropriate providers and facilities throughout the continuum of services, while

ensuring available resources are being used in a timely and cost-effective manner. In order to optimize the outcome for all concerned, care management services are best offered in a climate that allows direct communication between the CM, the member, and appropriate service personnel, while maintaining the member's privacy, confidentiality, health, and safety through advocacy and adherence to ethical, legal, accreditation, certification, and regulatory standards or guidelines. The Care Management Program is described detail in the Care Management Program Description.

PROGRAM EVALUATION

The UM Program is evaluated at least annually, and modifications to the program made as necessary. The Chief Medical Director and VPPHCO may use the following to evaluate the impact of the UM Program along with other sources:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- Drug Utilization Review (DUR) profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the MMC for review, action and follow-up. The final document is then submitted to the Board of Directors/governing body and/or QIC for approval.

DELEGATION

The Plan may elect to delegate various UM activities to entities that demonstrate the ability to meet the Plan's UM standards and standards for delegation, as outlined in the UM work plan and policies and procedures. The Plan conducts ongoing oversight and annual review of each delegate's UM program as outlined in the Oversight of Delegated UM policy. Delegation is dependent upon the following factors:

- A pre-delegation review is necessary to determine the ability to accept delegation.
- Once the delegate is determined to be capable of fulfilling the responsibilities of delegation, a delegation agreement is executed with the organization to which the UM activities have been delegated, clarifying the responsibilities of the delegated group and the Plan. The agreement also specifies reporting requirements, and the standards of performance to which the contracted group has agreed.
- The delegated group must conform to the Plan's UM standards; including timeframes outlined in the Plan's policy and procedure NC.UM.05 - *Timeliness of UM Decisions and Notifications*.

- The delegated group is responsible for providing the Plan with a written UM Program Description/Plan for annual review and approval by the Plan's QIC.
- The delegated group is responsible for submitting utilization reports, to include monthly utilization summaries, high cost days, and quality assurance/improvement issues, as applicable.

The Plan retains accountability for any functions and services delegated and as such monitors the performance of the delegated entity through the following vehicles:

- Annual approval of the delegate's UM program (or portions of the program that are delegated), as well as any significant program changes that occur in between.
- Routine reporting of key performance metrics that are required and/or developed by Plan's Chief Medical Director, and the MMC.
- Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to Plan standards and state program requirements.

In the instance where the delegate is NCQA accredited, the Plan may assume that the delegate is carrying out responsibilities in accordance with NCQA standards and revise the annual audit or evaluation, per state or CMS contract requirements. At the time of pre-delegation the Plan must evaluate the compatibility of the delegate's UM Program with the Plan's UM Program. Once delegation is approved, the Plan requires that the delegate provide the appropriate reports as determined by the Plan to monitor the delegate's continued compliance with the needs of the Plan. The Plan annually reviews the delegate's ongoing accreditation status.