Humana | Healthy Horizons™ in Louisiana

Utilization Management Program Description

2024~~3~~

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1. Program Overview

Humana Healthy Horizons in Louisiana Plan's (Plan) Utilization Management (UM) Program (UM Program/Program) is person centric and focuses on increasing the members' health status and quality of care while improving population health outcomes and managing cost. The Plan coordinates with providers to meet the medical needs of our members, including but not limited to preventative care, emergent care, acute care, and post-acute care. Our fully integrated program encompasses both medical and behavioral health, works in collaboration with our Care Management (CM)~~, Chronic Care Management (CCM), and Disease Management (DM)~~ Programs, and aligns with our Population Health Strategy to provide a comprehensive approach to improving member health status. The Plan monitors and trends data related to utilization of services and authorization determinations and uses that data to identify opportunities for improvement. The various components of the UM Program are designed to guide and monitor the member's health, medical and behavioral needs throughout the healthcare delivery system continuum.

The Plan's UM Program where appropriate is evidence-based and guided by a set of Clinical Practice Guidelines (CPG) that is adopted from clinically sound and reputable agencies along with the requirements in 42 C.F.R. 438.236. These guidelines are taken from national organizations generally accepted in their fields as experts such as the American Diabetes Association (ADA), American Heart Association (AHA), and the Agency for Healthcare Research and Quality (AHRQ). While the UM Program may be guided by CPGs, the Plan does not use practice guidelines for medical necessity, coverage, or reimbursement determinations. ~~(Model Contract 2.12.12 – 2.12.12.9)~~

The Plan maintains policies and procedures with defined structures and processes for a UM Program that incorporates utilization review and service authorizations. The Plan also allows members and providers the ability to submit a request for service authorization using the forms or contact fax/phone numbers provided in both the Provider Manual and Member Handbooks and on the provider and member websites. ~~(Model Contract 2.12.3.6.6)~~. The Plan will submit these written policies to the Louisiana Department of Health (LDH) for approval as part of readiness reviews and prior to any substantive changes. ~~(Model Contract 2.12.1.2)~~ The UM policies and procedures will meet all the National Committee on Quality Assurance (NCQA) standards and include utilization management criteria and CPGs that are adopted in consultation with contracted healthcare providers, are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field, consider the needs of the Members, and are reviewed annually and updated periodically as appropriate. ~~(Model Contract 2.12.4.3-2.12.4.3.4)~~. The Plan will coordinate with LDH or other MCOs for the development of service authorization policies where appropriate to avoid providers receiving conflicting policies from different MCOs. ~~(Model Contract 2.12.8.6)~~

The Plan will submit all required UM reports as specified by LDH. ~~(Model Contract 2.12.1.4)~~

The Plan's UM Program is fully compliant with all applicable state and federal regulations including 42C.F.R. §438.210, all contract requirements including all court-ordered requirements by LDH, as well as the NCQA Health Plan Accreditation requirements for UM ~~(Model Contract 2.12.1.1 and 2.12.3.1)~~. This includes complying with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations. The Plan will comply with all requirements set forth in 42 C.F.R. Part 438 Subpart K, for all members ~~(Model Contract, Section 2.2.7.1)~~.

The Plan ensures that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 C.F.R. §438.3(I) and 42 C.F.R. §422.208. ~~(Model Contract 2.12.5.1)~~

The Plan will not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider ~~(Model Contract 2.12.6.3.2)~~.

The Plan will not use policies with an effective date subsequent to the original service authorization request date to rescind its prior authorization ~~(Model Contract 2.12.6.3.3)~~.

2. Purpose

The purpose of the UM Program Description is to outline the process for UM, including utilization review of prior authorization requests, concurrent authorization requests, and retrospective authorization requests. The description also outlines the methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of healthcare services. It also identifies the data sources and clinical review criteria used in decision making and outlines the process for documentation of the appropriateness of the clinical review, the process for conducting peer-to-peer reviews of adverse determinations, and our inter-rater reliability (IRR) process that ensures consistent application of our medical necessity criteria. The UM Program Description also includes our provisions for ensuring the confidentiality of our members' clinical information.

3. Scope

The scope of the UM Program Description applies to all eligible Medicaid members regardless of age or diagnosis and includes all care delivery settings such as primary care, specialty care, preventive care, emergency, and post stabilization care, specialized behavioral health care, post-acute care, and outpatient/ancillary services.

The Plan does not engage in the practice of medicine; nor does it act to impinge upon or encumber the independent medical judgment of treating physicians or other healthcare providers.

4. Goals

The goals of the Plan's UM Program are to provide access to quality health care services for all covered benefits delivered to all members in the appropriate care delivery setting at the appropriate time, improve our members' health status, and manage cost trends associated with UM by reducing inappropriate and duplicative services. Our UM Program also aligns with our Population Health Strategy and the Plan's ~~Bold Goal~~ goal of improving our members' number of healthy days.

5. Accountability of the Governing Body

The Corporate Internal Board/Management team has ultimate responsibility for the UM Program and has delegated authority for oversight of UM Program activities to the Plan Quality Assessment and Performance Improvement Committee (QAPIC). The Chairperson

of the QAPIC or Plan CMO presents reports to the Corporate Quality Improvement Committee (CQIC) who in turn reports to the Corporate Internal Board/Management Team on behalf of the Committee once per quarter. UM reports presented to quality committees are reviewed for Quality Improvement (QI) activities and recommendations may be made by quality committees for additional or revised QI activities. Following approval, the reports are housed on the Quality Compliance SharePoint site.

The UM Program incorporates numerous measures in order to monitor and evaluate progress toward meeting identified contract requirements as well as QI goals and to identify trends in UM. Data is collected, analyzed, trended, and monitored on a systematic basis to facilitate corporate QI and to address any barriers that may be identified. Trends can be indicators of improvement or reveal where improvement may be needed and aid the Plan in identifying and reducing inappropriate, duplicative, and overuse of health care services.

UM Data is collected through a number of various system reporting programs and dashboards to gather relevant member and provider data to review early indicators of trends for specific measures of interest. Data may be pulled in a number of ways to identify member and provider specific service types, services utilized by regions, volume of utilization, timeliness, and other ad hoc indicators based on trend. All state required reporting data will be collected as per contract requirements.

The first year of operations is a data collection period in new markets and targets are set based on that data. The Plan's target rates are adjusted based on these evaluations and suggestions for changes by the UM and QAPI Committees. Potential measures include but are not limited to the following:

- Acute Admits per 1000 members
- Average Length of Stay ~~Inpatient days per 1000 members~~
- Long Term Acute Care Admits per 1000 members
- Rehabilitation Admits per 1000 members
- Readmission Rates within 30 days
- Emergency Room Visits per 1000 members
- Observation Rate
- Rate of Preventive visits

Members of the Plan's market-based management team include:

- Chief Executive Officer
- Chief Health Equity Officer
- Chief Operating Officer
- Chief Financial Officer
- Contract Compliance Officer
- Chief Medical Officer
- Medical Director(s)
- Behavioral Health Medical Director(s)
- Health Services Director(s)
- UM Manager(s)
- Population Health Officer

6. UM Staff Roles and Responsibilities/Appropriate Professionals

The UM Program includes both clinical and non-clinical associates. The CMO is a senior level physician, at the Plan, who has ultimate responsibility for the oversight and overall implementation of the UM Program. Operational implementation of the UM Program activities are delegated to Medical Directors and UM Health Service Director(s). Clinical Health Professionals qualified by virtue of education, training, licensure, and experience are directly involved in decision making that requires the application of standardized clinical criteria ~~(Model Contract 2.12.5.3)~~. Medical necessity determinations will be made by qualified and trained staff in accordance with state and federal regulations.

Non-clinical associates, under the supervision of appropriately licensed health professionals, may receive and perform data entry of requests from providers for inpatient and/or outpatient services. Requests for services that do not require clinical review under the review authorization guidelines (e.g., Prior Authorization List and Referral Guidelines) are entered and processed by the non-clinical associate, who may approve, but not deny services. A clinical supervisor is available to non-clinical associates to provide guidance and to support their activities.

Requests for services that require clinical review are forwarded to a Clinical UM Reviewer for a review based on the submitted documentation and clinical guidelines. Under appropriate supervision by a Medical Director, experienced RNs, with an active and valid nursing license to practice professional nursing, utilize approved clinical criteria to perform UM activities related to medical authorizations. Utilization reviews for behavioral health UM activities are completed by licensed mental health professionals (LMHPs) with an active valid license to practice and utilize approved clinical criteria to perform UM activities related to behavioral authorizations. ~~(Model Contract 2.12.8.5)~~. The Plan will specifically assign staff to Specialized Behavioral Health Services (SBHS) and Permanent Supportive Housing (PSH) to ensure appropriate authorization of services.

Clinical UM Reviewers who make UM decisions are supervised by a Medical Director with appropriate clinical experience. Supervision includes:

- Providing day-to-day supervision of UM staff
- Participating in staff training
- Monitoring for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Monitoring documentation for adequacy
- Being available to UM staff on site or by telephone

Professional staff credentials and licenses are verified through primary sources upon hire and annually to promote compliance with regulations and copies are kept on file. If there is a change in an associate's licensing status at any time, it is the Plan's policy that the professional staff person is responsible for notifying their supervisor immediately.

Medical Directors, who are licensed physicians in Louisiana, oversee UM decisions to facilitate consistent medical necessity determinations.

Only a Louisiana licensed physician with appropriate clinical expertise in the member's condition or disease will determine service authorization request denials or authorize a service in an amount, duration, or scope that is less than requested on the basis of medical necessity ~~(Model Contract Section 2.12.5.2)~~. These adverse determinations may include:

- Decisions about covered medical benefits defined by the organization, including hospitalization and emergency services listed in the ~~Certificate of Coverage or~~

Summary of Benefits.

- Decisions about care or services that could be considered either covered or non-covered, depending on the circumstances, including decisions on requests for care that the organization may consider experimental.

The individuals making these determinations will have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions that have been taken or are pending by a hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character ~~(Model Contract Section 2.12.5.4)~~. These individuals must also attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise ~~(Model Contract Section 2.12.5.2.1)~~.

If the specific specialty or expertise is not available within the Plan's Medical Director team, the Clinical UM Reviewer may consult with board certified specialists. The Plan has access to the necessary board-certified physicians in a variety of medical specialties who are knowledgeable and formally trained in the Utilization Management (UM) process, which incorporates best practices, evidence-based standards of care, medical literature, and specialty college guidance.

Prior to making a UM decision on a highly specialized or rare UM request, board certified physicians may take the following steps to review, including but not limited to:

- Complete a preemptive review of medical literature which is specific to the UM request.
- Informally consult with other board-certified physicians
- Reach out to the requesting practitioner for clarifying condition and treatment information as well as additional clinical information, if applicable

If the case requires a specialty physician reviewer that the Plan cannot provide internally, a delegate may be utilized to obtain review for the applicable medical review determination. Delegates make the final UM decision for Humana.

7. CMO Responsibilities

The CMO is a senior level physician, at the Plan, who has ultimate responsibility for the oversight and overall implementation of the UM Program. Operational implementation of the UM Program activities are delegated to Medical Directors and UM Health Service Director(s).

8. Medical Director Responsibilities

In addition to the CMO, one or more Medical Directors, who are also physicians, as well as the Behavioral Health Medical Director provide support to the CMO. The Behavioral Health Medical Director is a senior level psychiatrist who has the responsibility for the implementation and evaluation of the behavioral health aspects of the UM Program.

The Medical Director(s), along with the UM Health Services Director(s) and the UM Manager(s) are responsible for the operational implementation, supervision, oversight, and evaluation of the UM Program.

9. Utilization Management Committee

The Utilization Management Committee (UMC) has the delegated authority and oversight of all UM Program activities and is chaired by the CMO. The UMC integrates with the Quality Improvement (QI) department and supports the Quality Assessment and Performance Improvement (QAPI) Program ~~(Model Contract Section 2.12.2)~~. UM data is reported to QAPI quarterly during the QAPI meeting. UM reports presented to QAPI are reviewed for Quality Improvement (QI) activities and recommendations may be made by QAPI for additional or revised QI activities.

The responsibilities of the UMC include:

- Monitoring providers' request for prior authorization of health care services to its members, monitoring the medical appropriateness and necessity of health care services provided to its members utilizing provider quality and utilization profiling data; and
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed; and
- Reviewing, updating, and approving policies and procedures for UM that conform to industry standards, including methods, timeliness, and individuals responsible for completing each task; and
- Monitoring consistent application of Service Authorization criteria; and
- Monitoring over- and under-utilization; and
- Review of outliers; and
- Monitoring of health record reviews ~~(Model Contract Sections 2.12.2.2.1-2.12.2.2.7)~~

Members of the UMC include but are not limited to: Physical and Behavioral Health Medical Directors, Pharmacy Director or a delegated Pharmacy Department representative, Health Services Director, Physical and Behavioral Health UM Manager(s), QM leadership, audit compliance, additional UM and QM staff and other members of Plan leadership, as appropriate. A representative of LDH will be included as a member of the UMC upon request.

The UMC meets at a minimum of quarterly and must have at least 50% of the UMC voting members present to establish a quorum. The Committee Chair will be the determining vote in the event of a tied vote. The UMC maintains a record of all UMC minutes, UM statistics, and recommendations for improvement of the UM Program. The UMC will submit all minutes and reports to the QIC and to LDH upon request ~~(Model Contract Section 2.12.2.2)~~.

10. UM Process

10.1. Clinical Intake Team (CIT) & UM Professionals

The Clinical Intake team (CIT) is the primary point of entry for both initial and continuing authorizations. The unit is supported by a single phone system, operating policies, procedures, and workflows. The CIT provides non-clinical staffing for the intake of both initial and continuing authorizations and data entry. Authorizations are referred to the appropriate utilization review professionals for processing. The utilization review professionals process the request reviewing the clinical criteria and refer to the Medical Director(s) as appropriate. The Plan utilizes LDH's definition of medical necessity when making all service authorization determinations ~~(Model Contract 2.12.4.2)~~. Utilization teams are led by the Associate UM Director and the Director of Health Services.

The member, their primary care provider (PCP) or treating physician is responsible for initiating a request for services. The physician is afforded several methods of obtaining an authorization including telephonically, through Interactive Voice Response (IVR), facsimile, the provider portal www.Availity.com via email at CorporateMedicaidCIT@humana.com written request, and claims.

10.2. Prior Authorization and Notification List

The Prior Authorization and Notification List represents services and medications that require medical necessity review. Services must be provided according to the utilization management criteria or Coverage Policies ~~Clinical Coverage policies~~ (see hierarchy below) and are subject to review for coverage and medical necessity.

The Plan shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals and concurrent utilization review for psychiatric admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals ~~(Model Contract 2.12.8.4),~~.

Authorizations for non-medical transportation (NEMT) services are reviewed by our transportation service vendor. Medical transportation decisions are authorized based upon LDH guidelines.

Authorizations for value-added dental services are reviewed for medical necessity by our dental services vendor. For outpatient facility services associated with dental procedures, the dental provider notifies the CIT of all planned procedures. The CIT creates and approves the authorization in the Clinical Guidance system.

Authorizations for vision services, including value added services, are reviewed for medical necessity by our vision services vendor. Vision service decisions are authorized based upon LDH guidelines.

The Plan does not require PCP referrals for any services.

Some services do not require authorization. These services include but are not limited to:

- Emergency or post-stabilization services from network providers or from out-of-network providers, including emergency behavioral health care ~~(Model Contract 2.12.8.7.1)~~
- Hospital Service authorization for non-emergency inpatient admissions for normal newborn deliveries ~~(Model Contract 2.12.8.7.2)~~
- Early and Periodic Screening Diagnostic Testing (EPSDT) screening and other appropriate services such as Flu Shots and pneumonia vaccinations for network providers ~~(Model Contract 2.12.8.7.3)~~
- Continuation of medically necessary covered services of a new member transitioning from another Managed Care Organization (MCO), regardless of whether such services are provided by an in-network provider for the first ninety (90)~~thirty (30)~~ calendar days of a new member's linkage to this Plan ~~(Model Contract 2.12.7.1.1)~~
- Service needed for crisis stabilization, including mental health

- Urgently needed care from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when the member is temporarily outside of the Plan's service area, including post-stabilization services.
- Kidney dialysis services from a Medicaid-certified dialysis facility when temporarily outside the Plan's service area
- All covered preventive services from network providers, communicable diseases, and family planning services

Providers receive annual notification of the Prior Authorization and Notification List via a mailing. The lists are also available anytime on the Plan's website Humana.com/pal.

10.3. Obtaining Clinical Information

The Plan obtains and considers all information relevant to a member's care when it makes UM-related decisions. In accordance with 42 C.F.R. §456.111 and §456.211, the Plan requires that each member's record includes information needed for the UMC to perform utilization review required. This information must include, at least, the following ~~(Model Contract 2.12.1.2.5)~~:

- Identification of the member
- The name of the member's physician
- Date of admission and dates of application and authorization of Louisiana Medicaid Program benefits if application is made after admission
- Plan of care under 42 C.F.R. §456.80 and §456.180
- Initial and subsequent continued stay review dates described under 42 C.F.R. §456.128, §456.133, §456.233 and §456.234
- Date of operating room reservation, if applicable and
- Justification of emergency admission, if applicable ~~(Model Contract 2.12.1.2.5.1-2.12.1.2.5.7)~~

Only relevant clinical information is requested to prevent the process from being burdensome for all parties involved. Additional information that the Plan may request from a member or provider may include any of the following data:

- Diagnosis and/or procedure descriptions and codes
- Facility/provider name
- Office and hospital records
- History of the presenting problem
- Clinical examination
- Diagnostic testing results
- Progress notes
- Patient psychosocial history
- Information on consults with the treating practitioner
- Evaluations from other health care practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitation evaluations

- Printed copy of criteria related to the request

- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members and/or significant others

If the Plan determines the need for additional information that was not initially requested, the UM reviewer will make a minimum of two (2) attempts to obtain the additional information that is needed. When requesting additional necessary information from providers, one (1) attempt will be made via telephonic outreach and one (1) attempt will be made via facsimile. When requesting additional necessary information from a member, a minimum of one (1) attempt will be made via telephonic outreach and one (1) attempt will be made in writing via a mailed letter ~~(Model Contract 2.12.3.6.1)~~.

10.4. Clinical Review Process

UM decisions are made as timely as possible in accordance with the member's clinical condition but not longer than within state contract and accreditation standards, whichever is more stringent.

10.4.1. First Level Clinical Review

Upon receipt of a request for service, the appropriate clinical reviewer will ensure that all necessary information is available to perform a clinical review, this information can be received via fax or electronically via Plan access to a provider's electronic health record (EHR). In the event that the necessary information is not available, the reviewer will make a minimum of 2 (two) attempts to obtain the necessary information for review. ~~(Model Contract 2.12.3.6.1.2)~~ Once the information has been received, the appropriate reviewer will review all provided documentation for medical necessity and appropriateness using the most appropriate clinical guidelines based on the member's condition. If the documentation supports medical necessity and appropriateness, the clinical reviewer approves the authorization and notifies ~~the member and~~ the provider of the approval. If the documentation does not support medical necessity, the review is then forwarded to a Plan Medical Director who will complete a second level review. If the documentation is not provided to the Plan as requested within one (1) business day of the receipt of the request, the authorization will be forwarded to the Plan Medical Director for second level review.

All first level clinical reviews are completed by RNs for medical authorizations and LMHPs for behavioral health authorizations. All clinical reviews are fully documented in the Plan's clinical documentation system which provides the authorization number, effective dates for authorization to participating providers and applicable non-participating providers. The clinical documentation system also stores and reports the time and date all service authorization requests are received, decisions made by the Plan, clinical data to support the decision, and time frames for notification of providers and members of decisions.

10.4.2. Second Level Clinical Review

In the event that a first level review does not meet medical necessity criteria and the first level reviewer is unable to approve the authorization, the review is

forwarded to a Plan Medical Director for second level evaluation for medical necessity and appropriateness. Upon receipt of a second level review, the Medical Director will review all available clinical information and make a determination. The Medical Director will use the most appropriate clinical guidelines based on the member's condition as a guide but may use their medical judgement to issue an approval despite unmet criteria if, based on their assessment of provided clinical documentation and clinical experience, they deem that it is in the best interest of the member's health. If a Medical Director receives a second level review with insufficient or no clinical information available for evaluation, the first level reviewer has documented a minimum of two (2) attempts to obtain this information, and it has been at least one (1) business day since the date of the request for service, the Plan Medical Director ~~and~~ will issue a denial for insufficient clinical information to support medical necessity ~~(Model contract 2.12.3.6.5 and 2.12.3.6.1.2 and 2.12.3.4 and 2.12.3.6.1.2).~~

Once a determination is made, the Medical Director will route the authorization back to the appropriate UM reviewer who will make the notification to the member or their authorized representative and the provider.

The Plan will not deny continuation of higher-level services such as inpatient hospital care for failure to meet medical necessity unless the Plan is able to provide the service through an in-network or out-of-network provider at a lower level of care ~~(Model Contract 2.12.8.2)~~.

The Plan will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member ~~(Model Contract 2.12.3.2)~~.

Once an approval has been issued and the provider has been notified, the Plan will not rescind the approval unless the approval was based on grossly misleading or false information.

10.4.3. Standard Authorization

For all pre-service or standard requests, the Plan's UM Reviewers, who are licensed RNs for medical authorizations and LMHPs for behavioral health authorizations, review the provided clinical information for medical necessity and appropriateness using the appropriate clinical guidelines, which provide evidence-based best practices across the continuum of care. This review is fully documented in our clinical documentation system.

10.4.4. Expedited Authorization

In the event a provider indicates, or the Plan determines, that following the standard service authorization timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the Plan will make an expedited authorization decision. ~~and provide notice as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the receipt of the request for service~~ ~~(Model Contract 2.12.9.2.1)~~.

~~The Plan may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member requests the extension or if the Plan justifies to~~

~~LDH a need for additional information and how the extension is in the member's best interest (Model Contract 2.12.9.2.2)~~.

10.4.5. Observation Authorization

The Plan has a Common Hospital Observation Policy that aligns with LDH Common Observation Policy, when considering all observation authorization requests. The Plan will participate in an annual evaluation of this policy with the other Managed Care Organizations (MCOs) and all changes will be submitted to LDH for review and approval at least thirty (30) calendar days prior to implementation ~~(Model Contract 2.12.8.3)~~.

10.4.6. Concurrent/Urgent Authorization

All services that require authorization are subject to concurrent reviews. The Plan performs utilization review of admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals ~~(Model Contract 2.12.6.6)~~. The Plan also ensures that all inpatient psychiatric reviews are completed by an LMHP for each member referred for psychiatric admission to general hospitals and complies with the requirements set forth in state administrative rules ~~(Model Contract 2.12.6.7)~~.

For concurrent and urgent inpatient requests, the Plan's UM Reviewers, who are RNs for medical authorizations and LMHPs for all behavioral health authorizations, review the provided clinical information for medical necessity and appropriateness using the appropriate clinical guidelines, which provide evidence-based best practices across the continuum of care.

10.4.7. Retrospective and Claims Review

The Clinical Claims Review (CCR) team serves as the primary point for ~~both retrospective and~~ claims ~~reviews.~~reviews. The Plan performs utilization reviews for retrospective cases.

The CCR team operates under a single set of operating policies, procedures, and workflows, which ensure the consistent application of review criteria for authorization decisions. Consultation with the requesting provider occurs when appropriate.

For retrospective requests the Plan's ~~CCR~~ Reviewers, who are licensed RNs for medical authorizations and LMHPs for behavioral health authorizations, complete an evaluation of the clinical record received on behalf of the member for medical necessity and appropriateness using the appropriate clinical guidelines, which provide evidence-based best practices across the continuum of care.

10.5. Exhaustion of Benefits

In the event that a member exhausts coverage for a requested service and they have a need for ongoing care, the member will be provided information on alternatives for continuing care. The Plan assists with facilitating transition to an appropriate level of care and/or facilitates coordination with appropriate community resources. When a UM associate becomes aware of a member who may require assistance with transition to an appropriate level of care or

coordination with community resources, they make a referral to Care Management.

10.6. Integrated Rounds

The Plan's staff are trained on the process to identify members who will benefit from Integrated Rounds. Any UM or CM team staff can request that a member be added to the agenda for review. Members who are inpatient and who are at high risk for readmissions or a decline in their health or functional status are discussed in the integrated team meeting. Potential attendees are: Assigned CM, Assigned UM, Medical Director, Behavioral Health Director, Pharmacy associate, Care Management Manager, UM Manager and/or BH Professional. Additional attendees can be added, as needed.

10.7. Care Management Referrals

UM staff are trained on the process to refer members to Physical Health and Behavioral Health care management as appropriate to ensure that members receive ongoing care and support according to their individual health needs. UM staff will refer these members in the timeliest manner possible and document information specific to the member and their needs. This process includes members transitioning from other Managed Care Organizations (MCOs) or from Fee for Service (FFS) Medicaid who have existing Care Management services.

10.8. Behavioral Health

Utilization review is conducted by LMHPs for all behavioral health services that require prior authorization including, but not limited to inpatient psychiatric care, substance use disorder treatment, and applied behavioral analysis. Consultation with the requesting provider occurs when appropriate.

For behavioral health authorization requests, the Plan's BH UM Reviewers complete an evaluation of the clinical record received on behalf of the member for medical necessity and appropriateness using the appropriate clinical guidelines, which provide evidence-based best practices across the continuum of care.

The Plan will conduct UM functions for the Coordinated System of Care (CSoC) population as appropriate ~~(Model Contract 2.12.10.1)~~. Upon request, the Plan will provide LDH with documentation supporting how it placed appropriate limits on a service on the basis of medical necessity for individuals determined by LDH to need Specialized Behavioral Health Services ~~(Model Contract 2.12.10.4).~~.

The Plan will ensure that all placements are at the most appropriate, least restrictive, and medically necessary level to treat the specialty needs of the member. The Plan shall defer to the responsible state agencies regarding the appropriateness of residential placement options for Long Term Supports and Services outside of the scope of the Contract. Institutional placements should not be viewed as substitutes for needed behavioral health treatment ~~(Model Contract 2.9.25.22)~~.

10.8.1. Court Ordered Assessment, Treatment, and Placement

All court-ordered Medicaid behavioral health services are subject to medical necessity review. For the service to be eligible for payment, the Plan will determine that the service is medically necessary and a covered service ~~(Model Contract 2.12.3.5)~~.

Upon request for services for court-ordered treatment, the Plan will request a copy of the order/certificate signed by the representative of the court outlining the specifics of the order. The Plan's UM Reviewers will then complete a clinical review for medical necessity and appropriateness in accordance with the standards and timeframes consistent with the service authorization type.

10.8.2. Psychiatric Residential Treatment Facility (PRTF)

The plan will cover and provide for the availability of Psychiatric Residential Treatment Facility (PRTF) services for all medically eligible members as outlined in policy and procedure titled, ~~MCD-~~LA~~-~~.CLI~~-~~.005 Psychiatric Residential Treatment Facility (PRTF) Services.

10.9. Emergency Care

Neither a referral nor an authorization is required for members to access emergency services (either in-network or out-of-network) if they present with an emergency medical condition as defined under the "any prudent layperson" law.

10.10. Second Medical Opinion

If a second medical opinion is requested, Plan staff will help the member obtain a second opinion. The second medical opinion doctor will review the member's medical history, including any test reports, and give an opinion to the member's PCP at no cost to the member. After reviewing this second opinion, the member's PCP will make the final decision about treatment.

10.11. Out-of-Network Services

If medically necessary, covered, non-emergency medical care is not available from providers in the member's Plan network, members can get this care from an out-of- network provider. Members must obtain authorization from the Plan prior to seeking care from an out-of-network provider for non-emergent care.

For coordination and continuity of care, new members transitioning to the Plan who meet certain conditions may continue to receive care from out-of-network providers in accordance with federal or individual state regulations, accreditation guidelines or the Plan guidelines. Continuity of care considerations will also be applied when providers terminate their contract with the Plan.

10.12. Informal Reconsideration/Peer to Peer Review

In the event of an adverse determination, a member or a provider/agent acting on behalf of the member, with the member's written consent, may request a peer-to-peer review, also known as an informal reconsideration by the physician or clinical peer making the adverse determination ~~(Model Contract 2.12.3.6.3 and 2.12.6.4.3.2)~~.

This informal reconsideration process allows the requestor a reasonable opportunity to present evidence, and allegations of fact or law, in person and in writing [42 CFR §438.402(c)(1)(ii) ~~(Model Contract 2.12.6.4.3.1)~~, The informal reconsideration will occur within one (1) business day of the receipt of the request and will be conducted between the provider rendering the service and the Plan's physician who made the adverse determination, or a clinical peer designated by the Medical Director, if the physician who made the adverse determination cannot be available within one (1) business day ~~(Model Contract 2.12.6.4.3.3)~~.

The informal reconsideration does not extend the thirty (30) calendar day required timeframe for a Notice of Appeal Resolution ~~(Model Contract 2.12.6.4.3.4)~~.

10.13. Appeals of Coverage Decisions

Processes which comply with all federal, state specific regulations and accreditation requirements exist by which members and, when applicable, providers can appeal a coverage decision. All adverse decisions (i.e., denials of request for services, notice of adverse action, non-coverage decisions) include notification to both the member and provider of the decision; date services end and when the member liability begins; a description of applicable appeal rights (e.g. standard or expedited); the time/date by which any appeal must be filed to take advantage of the particular appeal right; and the Plan Grievance and Appeal address and/or fax number.

Following adverse decisions (i.e., denials of request for services, notice of adverse action, non-coverage decisions) the member can then invoke their grievance and appeals/fair hearing rights. If the member should invoke their appeal rights, the Plan will keep the denied or reduced services in place until the appeal process is completed.

11. Special Investigations Unit (SIU)

The Special Investigations unit (SIU) is responsible for detection, prevention, and recommendation of process improvement for fraud, waste, and abuse. SIU staff investigates and works with appropriate law enforcement agencies when dealing with insurance fraud, waste, and abuse by members or providers.

UM staff can refer to the SIU either telephonically or via email for any suspected fraudulent or inappropriate utilization by a member or their provider. UM staff can also report any potential problems regarding utilization, including potential cases of fraud and abuse, to the Plan Compliance department for investigation and reporting.

The Plan will report fraud and abuse information identified through the UM Program to LDH in accordance with 42 C.F.R. §455.1(a)(1). ~~(Model Contract 2.12.1.2.3)~~ The SIU process is further outlined in the Humana Anti-Fraud Plan (HUM-LA-01).

12. Pharmaceutical Management

The Plan pharmacy benefits are managed by a delegate, ~~Magellan Medicaid Administration~~ Prime Therapeutics State Government Solutions LLC, who controls pharmacy costs through a variety of resources: selecting and maintaining a

cost-effective pharmacy network, utilizing state approved drug list(s) as a component of benefit design when available, and mandating generic dispensing. Humana Pharmacy Solutions (HPS) offers clinical programs and initiatives related pharmacy services.

~~Magellan~~ Prime Therapeutics ensures that providers have access to the prior authorization process for prescribed outpatient drugs and maintains prior authorization criteria and protocols that are not more restrictive than those used by the state.

For pharmacy requests and physician administered medications, medically accepted indications are defined by LDH in the Louisiana Medicaid Medically Necessary Criteria policy published here: **Medically.Necessary.Criteria.040621.pdf (la.gov)**

~~Magellan~~ Prime Therapeutics also operates a prospective (at point-of-sale) drug utilization review (DUR) program that complies with 42 CFR 438.3(s)(4).

HPS operates a retrospective DUR program at the direction of LDH that complies with 42 CFR 438.3(s)(4)

~~For pharmacy requests and physician administered medications, medically accepted indications are defined by LDH in the Louisiana Medicaid Medically Necessary Criteria policy published here: **Medically.Necessary.Criteria.040621.pdf (la.gov)**~~

13. Access to Plan Services for Members and Providers

13.1. Members and Providers

For verification of eligibility, plan benefits, claim status or inquiries, members can call Member Services at the toll-free number printed on their Plan Member Identification Card. The Member Service's normal business hours are 7 AM - 7 PM Central Time, Monday through Friday.

Members always have the option to access needed information by using the Automated Information Line or via www.humana.com.

Providers can communicate with the Plan by calling the IVR toll-free number. The IVR gives them the opportunity to create an inpatient or outpatient telephonic authorization request using speech or keypad options. At any time, if the caller chooses to opt out, a representative will assist them. Providers have access to authorization requests at www.humana.com or Availity Essentials process on the provider portal. All cases not requiring a UM review will be given an authorization number at the time of the call.

UM staff are available 24 hours per day/7 days per week which includes ~~A~~access to staff by members and practitioners regarding UM issues which includes the following seven~~six~~ factors:

- Availability of staff at least eight (8) hours a day, regardless of time zone, during normal business days for inbound calls regarding UM issues
- Ability of staff to receive inbound communication after normal business

hours regarding UM issues

- Communications received after normal business hours are returned ~~on~~no later than the next business day and communications received after midnight on Monday-Friday are responded to on the same business day
  - Toll-free number: ~~(~~1-800-448-3810
  - Fax~~-~~: 833-974-0059
  - Email~~–~~: CorporateMedicaidCIT@humana.com
- Outbound communication from staff regarding inquiries about UM during normal business hours, regardless of time zone, unless otherwise agreed upon
- Staff identifies themselves by name, title and organization name when initiating or returning calls regarding UM issues
- Tailored communication strategies to overcome barriers provided at no cost to the member:
  - A toll-free number ~~or staff that accept collect calls~~
  - TDD/TYY services or sign language interpreters
  - Written materials available in large print, Braille, or read to members

- Written or verbal communication in languages other than English
- Sign language and language interpretation support during provider appointments

- Access to staff for callers with questions about the UM process

To communicate with both members and providers, the Plan has developed a website at **www.humana.com.** Each member can access My Humana through their personalized home page and record their personal health information. Other features include a Health Library, Health Tools, Health Programs, benefit and claims information, and entrance to their protected Communication Center to read their personalized targeted preventive health reminders. Also, the Plan uses Voice Activated Technology (VAT) to telephonically reach our members about certain health conditions. Several publications are available, in hard copy, to members on request.

Onsite staff follow facility policies in terms of registration and communication. Onsite associates wear badges that identify them as a Plan associate and schedule reviews in advance where requested.

13.2. Nurse Advice Line

Nurse Advice Line is a nurse triage and health planning service available 24 hours a day, seven days a week. The Plan members can talk to an RN about any immediate medical concerns, obtain health planning and support assistance, or access an audio health library by calling the toll-free telephone number on the back of their Member ID Card. The Nurse Advice Line provides members access to a library of audio information on a variety of healthcare topics.

Nurses communicate member-specific recommendations including self-treatment options or by directing members to their physician, an emergency room or an urgent care facility. The nurse advice line staff nurses are not authorized to make UM determinations and the Plan's corporate clinical leadership provides oversight of the activities of this entity.

14. Clinical Criteria, Coverage, and Guidelines

14.1. Clinical Criteria and Guidelines

UM decisions are made using established utilization management criteria or Coverage Policies that are objective and based on medical evidence.

Criteria or Coverage Policies are created and established internally by the Plan with support from our corporate partners. These documents will be eligible for review by our internal MDs and our external network provider partners who participate in our Provider Advisory Council (PAC) which meets on a quarterly basis. The PAC consists of external network providers representing a variety of specialties which includes Internal Medicine, Pediatrics, Obstetrics/Gynecology, and Psychiatry. These providers practice in various settings including public institutions, community-based centers, and private institutions. The documents are sent a week prior to the quarterly meeting and the agenda allows time for discussion and provider feedback to allow for process improvement with the goal

of minimizing provider abrasion and improving member outcomes and experience. The Plan will take the feedback collected and evaluate for potential modifications to process and document.

The documents are then evaluated and approved, on an annual basis, through the Plan's Health Guidance Organization and/or Louisiana Medicaid UMC.

All review decisions are based on the information collected at the time of the request. Any information obtained during this process will be used solely for the purposes of UM, quality management, discharge planning, case management, and claims payment.

Clinical Reviews will be performed in order to make benefit coverage determinations.

Coverage determinations will be decided based on the Medicaid Criteria Hierarchy for Medical Services. The following are the resources and clinical review criteria that are used in decision making, all apply irrespective of the order listed ~~(Model Contract 2.12.1.2.1)~~:

- Benefit Grid
- Medical/Clinical Coverage Policies
- Provider Manual
- Member Manual
- Milliman Care Guidelines (MCG)
- American Society of Addiction Medicine (ASAM) for substance use disorder (Model Contract 2.12.4.4-2.12.4.4.3)
- Peer Reviewed Literature

The Plan maintains corporate licensure for use of MCG, nationally recognized, evidence-based criteria to support effective UM. This nationally recognized criteria were selected by the Plan as it is based on clinically validated best practices that support optimal clinical decision-making and is consistent with the state and federal laws, regulation, rules, the State Plan, and waivers applicable to managed care ~~(Model Contract 2.12.4.1 and 2.12.4.4.)~~. Annual review of MCG criteria is completed by Humana physicians and subject matter experts. Based on this review, Humana transitions to the new MCG care guidelines version on an annual basis.

~~For pharmacy requests and physician administered medications, medically accepted indications are defined by LDH in the Louisiana Medicaid Medically Necessary Criteria policy published here:~~
~~Medically.Necessary.Criteria.040621.pdf (la.gov)~~

Criteria are used by the professional staff and Medical Directors as guidelines only. In no way are they to be used to replace the clinical judgment of the professional staff or the Medical Directors. These guidelines represent the "usual" case scenario. However, it is recognized that not all situations are represented by the criteria sets. Therefore, the professional review staff and the Medical Directors must consider the individual patient's circumstances, and the capacity, adequacy, and diversity of the local delivery system when making

review determinations. Factors considered when applying criteria to a given individual include but are not limited to:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment, when applicable

In addition, consideration is also given to the characteristics of the local delivery system available to specific patients, including:

- Availability of subacute care facilities or home care in the organization's service area to support the patient after hospital discharge.
- Coverage of benefits for subacute care facilities or home care where needed.
- Availability of inpatient, outpatient, and transitional facilities
- Local hospitals' ability to provide all recommended services within the estimated length of stay.

The Plan understands that the Medicaid Executive Director, in consultation with the Medicaid Medical Director, may require the Plan to authorize services on a case-by-case basis ~~(Model Contract 2.12.8.1)~~.

Plan Medical Coverage Policies are available on humana.com. In compliance with LA R.S. 46:460.51(15) & 460.74, each denial notice contains instructions on how to request the criteria utilized to make the adverse determination.

Providers can access clinical coverage policies on the provider portal. They may also request prior authorization review criteria used to make medical necessity determinations by sending an email to LAMCDCriteriaRequest@humana.com. Prior authorization requirements will be furnished to the requesting provider within 24 hours of request. Upon request by a member, their representative, or LDH, the Plan will provide the specific criteria utilized to make the decision. The Plan will make its decisions for UM, member education, coverage of services, and other areas to which the criteria apply in a manner consistent with the guidelines ~~(Model Contract 2.12.3.6.4)~~. The process to obtain criteria is communicated at least annually in Humana's provider newsletter, 'Humana Physician News' and in the Provider Manual.

14.2. Covered Services

As a part of the Plan's UM Program, all covered benefits are administered within the guidelines of medical necessity and within scope, duration, or amount that is not less than the Medicaid FFS Plan. All covered benefits and services are outlined in the Plan's policy and procedure titled, ~~MCD~~ LA~~-~~.CLI~~-~~.~~001~~ 006 Covered Benefits and Services.

The Plan will permit Indian Enrollees to obtain MCO Covered Services from out-of-network Indian Health Care Providers (IHCP) from whom the member is otherwise eligible to receive such services ~~(Model Contract 2.9.26.4)~~.

14.3. New and Emerging Technology

Medical/Clinical coverage policies are developed using the following hierarchy of resources as indicated and appropriate:

- LA Managed Care Organization Manual and Benefit Grid
- LDH Provider Manuals
- Milliman Care Guidelines (MCG)
- Existing Humana Medical/Clinical Coverage Policies
- Peer Reviewed Literature

The ~~Technology Assessment Forum (TAF)~~Medicaid Clinical Policy Adoption (MCPA) forum of the Plan's Health Guidance Organization is responsible for developing Humana's coverage decisions and policy development regarding emerging technologies (devices and medical/behavioral procedures) using the practice of evidence-based medicine when criteria for the specified service is not dictated by the Louisiana Department of Health. Both medical and behavioral health physicians are involved in the decision-making process as voting members of the committee. Humana reviews information from appropriate government regulatory bodies (e.g., FDA, CMS).
Following extensive literature review, including but not limited to articles in peer-reviewed literature and recommendations from professional societies, a position paper is developed for presentation to the Corporate TAF. This group meets at least quarterly to determine Humana's coverage guidelines. The group is comprised of Humana Medical Directors, practicing physicians, and representatives from Legal, Claims, Member Services, Product Development and Provider Relations. After a final coverage decision is rendered, the results are reviewed by Plan Medical Directors to determine if the Humana coverage decision is aligned with the Louisiana Department of Health Medicaid Covered Services policy. If the coverage decisions for the new and emerging technology is in alignment, a Humana Healthy Horizons in Louisiana policy will be drafted and reviewed per the Policy Management policy document. If the policy is approved, it is then posted on the Medical/Clinical Coverage Policy intranet site for use by all Plan clinical staff and Medical Directors, as well as the Provider Medical Resources Clinical Coverage Policy internet website, for use by providers, employers and members. Medical Coverage Policies are reviewed at least annually and revised as needed.

Updates to criteria are made available from vendors as well as the TAF to reflect changes in practice standards. The Plan involves practitioners in the annual review and approval of all clinical criteria. The TAF Committee may seek consultation from external experts and participating providers. The information they will be expected to provide will include manufacturer affiliations, evidence-based review of technology and bibliography of evidence utilized. Comments from Plan Medical Directors and practicing participating providers are solicited, and all comments and suggestions are forwarded to the vendors for their consideration. All clinical criteria are approved annually through the Clinical Quality Improvement Committee.

15. Performance Monitoring, Evaluation, and Trending of Utilization

The UM Program incorporates numerous measures in order to monitor and evaluate progress toward meeting goals. Data is collected, analyzed, trended and monitored on a

systematic basis to facilitate corporate QI and to address any barriers that may be identified. Trends can be indicators of improvement or reveal where improvement may be needed and aid the Plan in identifying and reducing inappropriate, duplicative, and overuse of health care services.

15.1. Monitoring of Over-and Under-Utilization

Utilization indicators are selected and monitored to detect utilization trends indicative of over- and under-utilization. Leaders target specific measures to monitor for over and underutilization of services and set targets for reduction in inappropriate utilization and low value care, as well as goals to increase in appropriate high value care. We use our first year of operations as a data collection period in new markets and set targets based on that data.

Our target rates are adjusted based on these evaluations. Potential measures can include but are not limited to the following:

- Acute Admits per 1000 members
- ~~Inpatient days per 1000 members~~Average Length of Stay
- Long Term Acute Care Admits per 1000 members
- Rehabilitation Admits per 1000 members
- Readmission Rates within 30 days
- Emergency Room Visits per 1000 members
- Observation Rate
- Rate of Preventive visit

As part of the Plan's Quality Assurance and Performance Improvement (QAPI) program and reviewed as a component of the UMC, trends of over and underutilization of services are identified, reviewed, and acted on. The reports on over and underutilization are included on the annual Quality Improvement Work Plan and findings are included in the annual Quality Improvement Evaluation. The plan analyzes available data ensure that our members are properly accessing care. Analysis, barriers/opportunities, and action items will be reported through the QAPI Committee for review. Collectively this will ensure that appropriate utilization of services to members is rendered.

Where trends are identified in either over or under utilization of services, the Plan will take a collaborative approach to address those trends. The UM team will work with our Quality team, our Medical Director(s), our UM clinical team, our CM clinical team, and, when applicable, our provider relations team, along with both the provider and the member to ensure a holistic approach to correct any trends that have been identified. Goals and action plans are reviewed and discussed based on trend analysis and findings.

In addition, members who are identified as having inappropriate, duplicative or over utilizers of health care services are referred to Case Management for education.

15.2. Inter-rater Reliability Monitoring

Inter-rater reliability (IRR) assessment, for physician and non-physician reviewers, is not performed sooner than 90 days of performing medical necessity reviews and

at least annually thereafter to measure the consistency in which clinical criteria is applied when making UM determinations. The goal for the IRR exam is 90% for all reviewers. If a reviewer is not successful with the IRR, a corrective action plan will be put in place, a remediation training will be provided to the reviewer, and they will be retested within thirty (30) days of the initial test. This activity serves to identify any issues with the criteria application skills of the reviewer, and to act upon opportunities to improve the process ~~(Model contract 2.12.5.3).~~.

15.3. Satisfaction with the UM Process

Member and practitioner satisfaction with the UM process is monitored at least annually by the Plan. Mechanisms for evaluating member satisfaction include: CAHPS 4.0H Survey (questions 22 and 26 of the Medicaid insured version), ECHO (Behavioral Health) survey and tracking member complaints and compliments that relate specifically to UM. Information about practitioner and provider satisfaction with UM is collected at least annually by way of a satisfaction survey; the Plan also tracks practitioner complaints that relate specifically to UM and solicits feedback from network practitioners serving on health plan committees. The information is evaluated and used to improve satisfaction with the process.

16. Associate Education and Training

Associates receive adequate orientation and continuing education/training in their job responsibilities including but not limited to:

- New Hire Onboarding/Orientation
- Goals & objectives, policies and procedures, and responsibilities
- Accreditation and regulatory standards
- Ethics and HIPAA requirements
- ~~Perfect~~ Customer Service training

Continuing education and training are provided routinely to re-enforce performance critical to meeting customer and performance expectations and as needed to correct or enhance compliance with performance expectations.

All associates are expected to complete mandatory corporate and departmental training associated with ethics, protected health information, HIPAA requirements, accreditation and regulatory standards and utilization review processes.

All clinical associates are also expected to maintain current licensure in their field(s) of practice, obtain CEU/CME credits as required by their licensure, and attend the clinical CEU/CME and educational in-services as directed by leadership.

Only licensed nurses and physicians who continue to successfully meet the competency expectations participate in the utilization review process.

17. Delegation Oversight

Prior to allowing an entity to perform any UM activities on behalf of the Plan, an extensive review of the entity's ability to carry out the proposed activities is conducted. Contracts are developed and signed that clearly identify the responsibilities of all parties. For some

delegated entities weekly or monthly meetings may be arranged to work through the day-to-day issues and to facilitate coordination of care. Delegated entities performing UM/Medicaid Health Services activities are required to provide a copy of their UM/Health Services Program documents (UM/Health Services Program, Work Plan evaluations, policies, and procedures) annually for review. Reports are requested and reviewed and audits are conducted at specified periods. Annual evaluations are performed and may include on-site visits. Member complaints, as well as utilization indicators, are monitored to evaluate equitable access and satisfaction.

Delegated entities may be required to submit QI plans for evaluation by the Medical Director and/or the market UM on a periodic basis until gaps are closed. The Plan maintains the rights to terminate suspend or impose corrective action at any time with regard to any delegated activities.

18. Confidentiality, Conflict of Interest, and Incentives

18.1. Confidentiality/HIPAA

The Plan's UM staff routinely deals with highly sensitive information about both members and providers. The documents that are created and/or obtained as a part of the clinical management process are considered confidential and privileged information (PHI) and are maintained in compliance with applicable federal and state regulations. All employees, Committee members, and consultants are required to sign a Confidentiality Agreement at the time of hire. A reaffirmation of the Confidentiality Agreement is signed annually.

Medical information is entered into systems that are password protected. Complete medical records are not routinely requested, and specific reasons must be given when portions of the record are requested. All medical record documentation obtained in the course of clinical review is considered strictly confidential and is retained in a secured environment. If a member or provider appeal is initiated, the documentation is shared with the appropriate internal staff in order to avoid unnecessary re-requests for confidential information. All medical records are held in strictest confidence and meet with HIPAA Guidelines for protected health information (PHI). Any medical records used for studies or teaching purposes are blinded. Reports used for data analyses or trending do not use member names. All committee proceedings, minutes and internal memos regarding UM Health Services activities are to be considered confidential and proprietary and all discussion within the committee forum is not to be shared outside the meeting, particularly in regard to clinical and peer review. Actions of the Committee may be shared on a need-to-know basis ~~(Model Contract 2.12.1.2.2)~~.

18.2. Conflict of Interest

All Plan associates (to include the Board of Directors, committee Members, and consultants) are required to sign a Conflict-of-Interest Statement at the time of hire and attest to the absence of a conflict of interest annually through the ethics training.

18.3. Affirmative Statement Regarding Incentives

There are no incentives for associates to limit care provided to members or to deny requests for covered medically necessary care. The Plan's UM decision process is based only on the appropriateness of care and service, and existence of coverage. The Plan does not specifically reward practitioners or other

individuals for issuing denials of coverage. The Plan does not offer financial incentives for UM decision-makers to encourage decisions that result in under-utilization. The Plan conveys this information to members via the Member Handbook, to all Plan Associates via the employee website and to providers by way of a Provider Manual and/or the Provider Newsletter, *'Humana Physician News'* ~~(Model Contract 2.12.5.1)~~.

19. Compliance with Regulatory and Accrediting Bodies

All Medicaid plans have systems in place to evaluate compliance with all state and federal regulatory bodies that have oversight of MCOs. Those bodies currently include the NCQA, CMS, and other applicable state and federal agencies.

In order to maintain good standing with all appropriate federal, state, accreditation agencies and local licenses, certification, contracts and other forms of qualifications or renewals the market activities include, but are not limited to:

- Providing due process of member appeals and/or grievances including expedited appeals.
- Implementing a quality management process that provides a mechanism for evaluating the quality of care provided to members.
- Obtaining all necessary regulatory approvals of service areas forms, rates, and marketing materials.
- Participating in and/or cooperating with all site visits, examinations, inquiries or investigations.
- Preparing and implementing all changes to regulatory legislation, rules or policies.
- Monitoring all changes to regulatory legislation, rules or policies.
- Preparing and submitting all required regulatory reports and other filings in a timely manner.
- Preparing, implementing and monitoring corrective action plans as needed.

20. Annual Evaluation

The Plan evaluates the UM Program annually to determine if it remains current and appropriate and to determine if modifications to the UM Program are needed. The evaluation is completed by the UM Health Service Director(s) and the evaluation will include:

- The UM Program structure
- The UM Program scope, processes and information sources used to determine benefit coverage and medical necessity
- The level of involvement of the senior-level physician and designated behavioral health care practitioner in the UM Program
- Applicable results of the member and provider satisfaction surveys
- Member complaint and grievance and appeal data
- Provider complaint and grievance and appeal data
- Applicable DUR
- Any other relevant UM data

There is consideration of members' and practitioners' experience data when evaluating the UM Program. The Plan updates the UM Program based on this assessment. The evaluation is presented to the Plan QAPIC for approval. Based on the annual evaluation, the UM Health Service Director(s) review and revise the UM Program as necessary.

21. UM Program Approval

The Plan's Medicaid Utilization Program Description is reviewed, revised as needed, and approved, annually by the UMC and QAPIC.

APPROVAL DATE: ~~March 7, 2024~~

~~Shelly Gupta~~Dr. Maria Treme, MD
Interim Chief Medical Officer

Marjorie Person, MD
BH Medical Director

VERSION CONTROL:

Version Review & Approval History			
Review Date	**Purpose of Review**	**Reviewed By:**	**Additional Comments:**
06/26/2023	**Formatting adjustments. Suggestions from NCQA internal audit team were incorporated to increase compliance.**	**Nicole Thibodeaux**	**Version control table added. Grammar and spelling adjustments. Added approval date and signature lines.**
08/17/2023	**Added delegated pharmacy services effective 10/01/2023**	**Nicole Thibodeaux**	
11/09/2023	**Formatting adjustments to spacing. Added Outline format. Added NCQA required language.**	**Nicole Thibodeaux**	**NCQA QI3D compliant language added to section – Exhaustion of benefits. Language further describing the TAF Committee added under 'New and Emerging Technology" section.**
9/16/2024	Annual Review Completed by UM Teams and leadership.	Nicole Thibodeaux	