New Century Health

New Century Health Utilization Management Plan

I. Background

New Century Health is a leading specialty care management company that provides innovative technology and clinical solutions that help to improve the quality of patient care, reduce administrative work associated with the delivery of care, and lower therapeutic costs for payers and physicians. The populations served by NCH are adult oncology and cardiology patients.

Currently New Century Health provides specialty care services for millions of Medicare, Commercial and Medicaid members throughout the country for an expanding roster of national and regional clients (health plans for Medicare and Commercial member plans). With a proven track record of success, our clients can achieve cost savings of up to 20% through the implementation of our specialty care management solutions while increasing the utilization of high-quality evidence-based medicine for their members.

New Century Health employs an expert staff of physicians, nurses, pharmacists and operational staff and leadership to support the health utilization management services. The Chief Executive Officer is responsible for the implementation of the strategic vision and is the oversight authority of the entire operations for the organization. New Century Health's Executive Leadership, under the guidance of the CEO, develops and implements effective corporate strategies while providing appropriate management and oversight of business processes and policies. NCH is a subsidiary of Evolent Health (EVH) and is overseen by EVH Board of Directors.

New Century Health's business model integrates evidence-based medicine, treatment care pathways, quality improvement programs, and peer-to-peer review using our web-based technology platform to reduce variations in care to our client's members. NCH offers clinical expertise and guidance in the review of prospective and retrospective review of oncology and cardiology treatment plans to support

health utilization management decisions by the client. These services are offered across all lines of business, including Medicare, Medicaid, and Commercial, depending on contractual agreements. The Company's focus on quality driven specialty care management enables payers to achieve their goals of evidence-based care and quantifiable savings.

A. Mission Statement:

To transform the delivery of oncology and cardiovascular care by aligning the distinctive capabilities of healthcare payers and specialty providers with smart technology, clinical data analytics, deep clinical expertise.

II. Scope and Objectives of the Utilization Management Program

A. The scope of the New Century Health Utilization Management Program is to:

1. Oversee all clinical activities related to the process of medical necessity utilization reviews.
2. Ensure consumers are not discriminated against in the delivery of health care services based on information acquired through a medical necessity review such as: race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRD, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.
3. All services, both clinical and non-clinical, are accessible to all members if required, and are provided in a culturally competent manner, including those with limited English proficiency or reading skills, those lacking in health literacy and those with diverse cultural and ethnic backgrounds.

B. The overall objective of the New Century Health Utilization Management Program is to provide direction and guidance for all activities related to the process of medical necessity reviews.

III. Activities of the Utilization Management Program

A. The following are classified as Utilization Management Program activities:

1. Investigate and report on new clinical practices and procedures within the industry,
2. Present, review, and place into policy new utilization review guidelines,
3. Review and approve all internal utilization review/management policies and procedures,
4. Review performance of all utilization management operations and provide recommendations for improvements toward greater efficiency, and excellence in consumer, provider, and client service,
5. Develop methods to assess quality measures for providers and clients
6. Disseminate client and provider satisfaction surveys, collect, aggregate, and develop action plans based on results.
7. Review and approve plans of action to improve results found to be unsatisfactory as a result to quality assessments,
8. Receive and analyze performance data gathered from surveys or audits on utilization, service, and satisfaction and provide recommendations to support improvement,
9. Present and monitor client and provider communication initiatives,
10. Present, monitor, and track new quality initiatives,

11. The foregoing list of duties is not exhaustive, and the Program may, in addition, perform other functions as necessary or appropriate for the performance of its duties.

B. Evaluate activities of the Utilization Management (UM) Program and report finding at least quarterly to the Utilization Management Committee (UMC) and the Quality Management and Improvement Committees (QMIC).

C. Propose improvement of evaluated Utilization Management Program activities to be included in reports to Utilization Management Committee and the Quality Management and Improvement Committees.

IV. New Century Health UM Program Structure

A. Utilization Management Manual

1. New Century Health maintains written policies and procedures that govern all aspects of the Utilization Management (UM) process in the form of guideline policies housed under an electronic share point product referred to as the Utilization Management Manual. It is the responsibility of the UM Committee to review and approve all policies, procedures and workflows associated with the UM Process prior to implementation and at least annually thereafter. New Century Health maintains and makes available upon request to enrollees and health care providers a written description of such procedures including the process for requesting authorization of service, the right to appeal an adverse determination and the process by which appeals may be requested. Currently, New Century Health is not delegated for member services, concurrent review, emergency and post- stabilization care review, or appeal process by any Health Care Plan. However, New Century Health understands that delegation of appeals may vary from client to client; therefore, appeals documentation would be developed in collaboration with the individual client to ensure that instructions accurately reflect the responsibilities of each party. New Century Health and/or the client will ensure that information regarding the appropriate external appeals process is made available to enrollees as required and upon request.

B. Medical Management Structure

1. Chief Medical Officer (CMO) – Full-time position reporting directly to the CEO. Individual is a Physician with a degree of Doctor of Medicine (MD) possessing an active unrestricted license in the United States and is board certified with post- graduate experience in direct patient care and experience in a leadership position to oversee the clinical aspects of the NCH UM program as well as knowledge of Medicare coverage criteria. Responsibilities include but are not limited to oversight of all clinical activities of New Century Health's (NCH) Benefit Management program, Accessible to the clinical staff, may serve as a clinical decision-maker, ensures that the organization has access to and utilizes qualified individuals with clinical experience for all areas covered by NCH services. Provides guidance for the clinical aspects of the NCH program. Meets periodically with field practitioners for consulting on the clinical aspect of the NCH program and other appropriate issues. Acts as the Chair of the UM Committee (and any quality or utilization committees with vacant chairs), maintaining relationships with external sources such as clients, involving network providers in New Century Health determination processes, ensuring URAC and NCQA standards are upheld in all UM determination process, and overall responsibility for all clinical and quality activities including credentialing. The CMO has oversight in making final clinical decision-making aspects of the program and ensures the NCH objectives to have qualified clinicians accountable for the decisions affecting consumers. This position reports to the Chief Executive Officer (CEO).
2. Medical Director – Full-time positions. Medical Director is a Physician with a degree of Doctor of Medicine (MD) or Doctor of Osteopathy, possessing an active unrestricted license in the

United States, and is a board-certified physician. Is qualified to render a clinical opinion about medical conditions, procedures, or treatment under review, as determined by the CMO including knowledge of Medicare coverage criteria. Post-graduate experience in direct patient care relating to area of practice is strongly preferred. Responsibilities include but are not limited to: scheduling and oversight of reviewers; participant in the UM Committee; ongoing evaluation of current and new technologies; ongoing evaluation of the Peer Clinical Reviewers and their clinical applicability. Oversees and participates in the development and revision of New Century clinical guidelines based on specialty; oversight of the day to day activities of the Utilization Management Program. Available to consult with Practitioners in the Network as required. In addition, may act as a peer clinical reviewer. This position reports directly to the Chief Medical Officer.

3. New Century Peer Clinical Reviewer/Associate Medical Director – Full or Part time position(s) Peer Clinical Reviewers are physicians with degrees of Doctor of Medicine (MD) or Doctor of Osteopathy (DO) possessing an active unrestricted license in the United States and is board certified. Unless expressly allowed by State or Federal law or regulations, all Peer Clinical Reviewers shall be located in the State or Territory of the United States when conducting peer clinical reviewer activities. Peer Reviewers have been practicing in area(s) of specialty for a period of at least five (5) years and is qualified to render a clinical opinion about a medical condition, procedures, or treatment under review, as determined by the CMO including knowledge of Medicare coverage criteria. Responsibilities include but are not limited to: review of pended cases to obtain all necessary clinical information, and discussion(s) with referring physicians on the appropriateness of the service requested according to the clinical criteria employed by New Century Health. Peer Clinical Reviewers are accessible to Initial Clinical Reviewers and non-clinical staff as required during business hours. Only a clinical peer reviewer may render a recommended adverse determination and adverse determinations when delegated. In cases where they were not involved in the initial determination, may act as appeal reviewers, and render appeal determinations, if New Century Health has been so delegated by the client. Peer reviewers are prohibited from serving as the clinical peer reviewer for an insured if there is any potential for conflict of interest such as a clinical relationship with the insured or a financial or employment relationship with the ordering or rendering provider/facility. This position report directly to the Medical Director.
4. Senior Medical Director, Oncology – Full-time position. The Senior Medical Director, Oncology is responsible for support and assistance for all oncology administrative and clinical utilization management, peer review and quality improvement functions including knowledge of Medicare coverage criteria. This position reports to the Chief Medical Officer.
5. VP of Clinical Operations – UM – Full-time position. This position is responsible for Operations and UM functions within NCH. The VP of Clinical Ops is accountable for a synergetic execution within operations of the UM department and to achieve high customer satisfaction. This position works closely with the Chief Medical Officer and reports to the President, NCH.
6. Director, Client Services – This full-time position oversees the day-to-day activities for the Client Services Department. Responsibilities include but are not limited to, monitoring the daily logistics of the operation in the Utilization Management Department, preparation, and analysis of UM reports, ensuring department performance and staff proficiency, ensures compliance to policy and procedures, acts as a resource to non-clinical staff during business hours and interdepartmental staff. This position reports to the VP of Clinical Operations.

   Director, Nursing– The Director, Nursing manages daily operations, which include supervising the Nursing Clinical Supervisors and initial clinical reviewers within the Utilization Management Department; The goal is to achieve clinical, financial, and utilization goals through effective management, communication and role modeling. The Director functions as the internal resource on issues related to the appropriate utilization of resources, and

utilization review and management. The Director is responsible for carrying out assignments in a manner to assure success in financial management, human resources management, leadership, quality and operational management objectives. The Director participates in program development and unit performance improvement. The Director holds a current and un-restricted professional nursing license and has extensive clinical and leadership experience in utilization management and quality improvement and assurance. This position reports to the VP of Clinical Operations.

7. Director, Quality Management – The Director, Quality Management is responsible for and Quality Management Department staff; management of overall quality programs, conducts quality and compliance audits, overseeing compliance with all applicable regulations and standards. Develops the annual QA Plan for monitoring and implementing quality initiatives to maintain URAC and NCQA accreditation in Health Utilization Management. As chairman of the Quality Management and Improvement Committee [QMIC], this position devotes 50% of time to quality initiatives and quality program. The Director holds a current and un-restricted professional nursing license and has extensive clinical and leadership experience in utilization management and quality improvement and assurance. This position reports to the VP of Clinical Operations.
8. Compliance Office (CO) – This position oversees the Corporate Compliance Program, functioning as an independent and objective body that reviews and evaluates compliance issues/concerns within the organization. Responsibilities include but are not limited to acting as a channel of communication to receive and direct compliance issues to appropriate resources for implementation as well as investigation and resolution and serves as a final internal resource with which concerned parties may communicate after other formal channels and resources have been exhausted. Ensures the Board of Directors, Administration, Management and Employees are in compliance with the rules and regulations of regulatory agencies, that company policies and procedures are being followed, and that behavior in the organization meets the New Century Health's Standards of Conduct. The CO provides direct communication, as required, to the Board of Directors. This position reports directly to the Chief Executive Officer (CEO).
9. Clinical Oncology Specialist – This position holds a Doctor of Pharmacy degree (PharmD), with an active unrestricted licensure in the United States. This individual is board certified specializing in Pharmaceutical Oncology. Responsibilities include but are not limited to review of policies for pharmaceutical drugs related to oncology, monitoring the changing trends in oncology drugs, update staff on new research related to oncology drugs, and is instrumental in assisting the Chief Medical Officer in writing guidelines and pathways for cancer therapies as well as facilitating the Scientific Advisory Board for Oncology (OSAB). This position reports to the Associate Director, Pharmacy.
10. Associate Director, Pharmacy – The Associate Director, Pharmacy is responsible for the managing of the Pharmacy and Fulfillment staff. This individual oversees the workflow and implementation of NCH Pathways, Rules Manager, drug policies, drug, and clinical data in CarePro, and the pharmacy fulfillment process and inventory. This person manages drug acquisitions and holds vendor relationships with drug wholesalers and specialty pharmacy. Develops and implements clinical cost of care strategies and quality initiatives to help reduce pharmacy cost and utilization. The Associate Director holds a current and un-restricted professional pharmacist license. The position reports to the Vice President, Pharmacy.
11. Vice President, Pharmacy – The Vice President, Pharmacy is responsible for the development and leadership of the overall pharmacy strategy. This person serves as a clinical resource and consultant in all areas of pharmacy and medication management. Participates in the development of NCH drug policies and pathways. This individual oversees the workflow and implementation of NCH Pathways, Rules Manager, drug policies, drug, and clinical data in CarePro, and the pharmacy fulfillment process and inventory. Develops and

implements clinical cost of care strategies and quality initiatives to help reduce pharmacy cost and utilization. The Vice President, Pharmacy holds a current and un-restricted professional pharmacist license.

12. Oncology Pharmacist, Clinical Operations – This position holds a Doctor of Pharmacy degree (PharmD), with active, unrestricted licensure in the United States. The pharmacist' s primary responsibilities include developing innovative utilization management strategies for high-cost drugs, support policy reviews for pharmaceutical drugs and guidelines, monitoring the changing trends in oncology drugs, generates cost utilization reports, involved in clinical quality improvement activities and support pathway changes. This position reports to the Associate Pharmacy Director.
13. Initial Clinical Reviewers – Full-time position. Initial Clinical Reviewers are also known as First Level Clinical Reviewers (FLRs). They are licensed nurses (LPN/LVN/RN), holding an active -unrestricted license in the United States and have appropriate clinical background to render decisions requiring clinical judgment and experience. Additionally, radiation technologists holding a Bachelor of Science Radiologic Technology, Radiation Therapy, and certification with (American Registry of Radiologic Technologists (ARRT) in the United States with appropriate clinical background to render decisions requiring clinical judgment and experience. Initial clinical reviewers have appropriate clinical support of a licensed physician and do not issue non-certifications. Responsibilities include but are not limited to conducting initial review of clinical information in accordance with New Century Health's clinical guidelines to determine appropriateness of care or service. They may contact the ordering/referring provider to obtain additional information necessary to ensure adequate review and will approve cases based on pre-established, clinically approved criteria. Cases not under the approval of the Initial Clinical Reviewer's algorithm will be routed to a Peer Clinical Reviewer for completion of the review process. Initial Clinical Reviewers cannot issue recommendations for adverse determinations and are prohibited from serving as the clinical reviewers for an insured person if there is any potential for conflict of interest such as a clinical relationship with the insured or a financial or employment relationship with the ordering or rendering provider/facility. This position reports to the Supervisor of Utilization Management.
14. Nurse Supervisor of Utilization Management – This position holds a current and un-restricted professional nursing license (LPN/LVN/RN) with experience in utilization management. They monitor day to day nurse processes and workflows to ensure adequate coverage and adjust nurse teams accordingly. The Nurse Supervisor is responsible for implementing policies, assigning work, making short action plans to achieve targets, motivate, guide, monitor and train nurses. The Nurse Supervisor manages a team of nurses, conducts team meetings and one on one meetings each month. They escalate operational or employee issues/concerns to the Director, Nursing & QM. This position reports to the Director, Nursing.
15. Supervisor, Clinical Operations – The Pharmacy Specialist Supervisor is responsible for day to day oversight the Medication Fulfillment Team operations by ensuring all activities are performed in accordance with established policies and procedures, creating work-flows, assigning tasks, monitoring productivity of Pharmacy Specialists and addressing issues as needed, reviewing medication fulfillment daily performance reports to ensure all service level agreements are met and that regulatory requirements are attained, as well as assists in implementing contractual requirements, new procedures, and resolving operational problems. This individual will be expected to be a Subject Matter Expert in all essential duties and responsibilities of the Pharmacy Specialist staff, NCH systems, client contractual agreements and Utilization Management policies and procedures as well as have a working knowledge of HR policies and practices, medication acquisition, manage strategy to reduce cost in medication acquisition, review purchasing trends, and health plan benefit designs. This position reports to the Associate Director, Pharmacy.

16. Specialist, Clinical Operations - Full-time positions, pharmacy technicians, with an active unrestricted license in the United States. Based on client contractual agreements, the pharmacy technicians, are responsible for the coordination of medication delivery to providers and inventory management. The pharmacy technicians must be well versed in health plan benefit designs and be able to educate providers and patients on the health plan benefits. This position reports to the Supervisor, Clinical Operations.
17. Client Services Supervisor, Client Services – The Client Services Supervisor is responsible for day to day oversight of the Client Services staff operations by ensuring all activities are performed in accordance with established policies and procedures, creating work-flows, assigning tasks, monitoring productivity of Client Services staff, addressing issues as needed, reviewing Utilization Management daily performance reports to ensure all service level agreements are met and that regulatory requirements are attained, as well as assists in implementing contractual requirements, new procedures, and resolving operational problems. The individual in this role will be expected to be a Subject Matter Expert in all essential duties and responsibilities of the Client Services staff, NCH systems, client contractual agreements and Utilization Management policies and procedures as well as have a working knowledge of HR policies and practices.
18. Client Services Representatives, Coordinators, Associates, Sr. Coordinators and Sr. Associates– Full-time positions, licensed or unlicensed professionals and/or pharmacy technicians, with an active unrestricted license in the United States. Responsibilities include but are not limited to processing medical treatment requests in accordance with departmental policies, regulatory requirements, and client contractual agreements. Along with providing exceptional customer service, this role is held accountable to performance metrics to ensure service level agreements are met. This role routinely contacts the physician's offices, Health Plans, or patients to complete medical treatment requests. Answers, resolves, or escalates incoming telephone, fax, and email inquiries regarding authorization request status, office referrals, eligibility, and general inquiries.

C. License Verification

1. New Century Health verifies and monitors licensure and credentials to ensure the quality and integrity of its' Utilization Management Department. Evolent Health's Human Resources Department performs the following:
    a. Verifies the current licensure and credentials of licensed or certified personnel, consultants or advisors upon hire or entering into an agreement through Primary Source Verification, and thereafter not less than every three (3) years for physicians and every two (2) years for nursing.
    b. Implements corrective action in response to adverse changes in licensure or certification status.
2. For clinical professionals conducting determinations for New Century Health, the same credentialing elements shall be verified, and procedures followed as for the clinical network, including but not limited to: education, training, experience, professional licenses, and certifications. For other professionals, credentials shall be verified including: education, references, experience, and continuing education.
3. Potential Peer Clinical Reviewer or Medical Directors are deemed qualified by the CMO after full review of candidate documentation.
4. Corrective Action: it is the responsibility of the employee to notify management if there is an adverse change in licensure/certification and/or sanction status. Employee must notify their respective managers and Human Resources 1 business day after they are made aware of any potential or actual adverse change to licensure, certification, or sanction status.

5. Failure to do so may be cause for immediate termination of employment or contract termination. Any such information shall be immediately reported to New Century's Utilization Management Committee for consideration and any further action.

D. Affirmative Statement

1. New Century Health's policy states that utilization review decisions are based only upon medical necessity, appropriateness of care and service, and the existence of coverage. There are no rewards, bonuses or incentives for practitioners or other individuals for issuing denials or approvals of coverage, service, or care. There are no financial incentives for utilization management decision-makers to encourage decisions that would result in underutilization or over-utilization. All medical necessity determinations are based upon nationally recognized standards of care and clinical guidelines and are not influenced by financial or in-kind incentives.

E. Confidentiality

1. New Century Health adheres to HIPAA/HITECH for the handling, releasing, storing, and transmitting of PHI. All NCH staff complete mandatory training in HIPAA/HITECH and Confidentiality upon hire and annually thereafter.
2. New Century Health's Confidentiality policy applies to all employees, committee members, board members, temporary staff, independent contractors, vendors, auditors and other individuals and companies employed by or doing business with New Century Health and having access to confidential and/or proprietary information regarding New Century Health or its clients.

F. Staff Training

1. Staff are trained in each component of the utilization review process upon orientation and throughout their career at New Century Health and their level of competency is monitored to intervene and improve established standards. All staff are given access (electronic or hardcopy) to departmental policy and procedures, regulatory compliance standards and any/all clinical decision support guidelines and tools, relating to their job tasks.
2. Non-clinical administrative, Client Services and Intake services staff education is focused on their responsibilities and limited to the process of reviewing service requests for completeness of information, collecting and transferring non-clinical data, acquiring structured clinical data for entry into the New Century Health's Information System and activities that do not require evaluation or interpretation of clinical information. Non-clinical staff does not conduct any activities that require interpretation of clinical information to include the choosing of a set of criteria to use for handling a request for healthcare services or treatment.
3. Licensed health professionals are educated through the entire process of clinical review. Nurses are trained for initial case review and to work with both the physicians and the non-clinical staff. Authorization requests that are not automatically approved by New Century Health's clinical guideline algorithms or the nurses are pended for peer clinical review by a physician. Physicians are educated on the approval process, requirements for availability in peer to peer consultation and final determinations.
4. Based upon education, training and experience, health professionals are screened for appropriateness in performing clinical tasks. Reviewers, both physicians and nurses are required to undergo annual testing in all aspects of the review process to maintain high levels of performance.

G. Operations:

1. Referrals - Client Services Staff accepts and documents the requests for referrals to network providers. Referrals to non-network providers are routed to an initial clinical reviewer/peer

reviewer for determination of medical necessity and prior authorization. In-network referrals do not require prior authorization.

2. Utilization Management

a. Emergency Services

Emergency services rendered to an enrollee are not subject to prior authorization and reimbursement of such services may not be denied on retrospective review, provided that such services are medically necessary to stabilize or treat an emergency condition.

b. Scope of Review Information

New Century Health performs clinical reviews for routine prospective review and retrospective review. NCH is not currently delegated to perform pre-elective or concurrent review for inpatient of acute or skilled admissions.

When conducting Reviews, New Century Health's Utilization Review (UR) department will accept information from any reasonably reliable source that will assist in the certification/authorization process. In addition, the utilization review staff collects only the information necessary to certify/authorize the care or treatment, frequency, or duration of services.

NCH does not routinely require physicians, hospitals, or other providers to numerically code diagnoses or procedure to be considered for certification/authorization, but may request such codes, if available.

The UM department does not routinely request copies of all medical records on all patients reviewed. Medical records are only requested when there is difficulty in making a review determination based upon the information provided with the request or during the Peer Clinical Review and then only the sections of the medical record necessary in that specific case to certify/authorize medical necessity or appropriateness of care or the frequency, duration, or extension of care and/or services being requested. The patient and provider's confidentiality is protected when NCH's UM Department obtains or shares medical information acquired.

The UM department oversees a process that allows sharing of all clinical and demographic information on individual patients among its various clinical and administrative departments that have a 'need to know', in order to avoid duplicate requests for the same information from enrollees or providers. All communication (documented calls, faxes, medical records, clinical updates) are attached in the patient's case for access by all UM staff at NCH.

New Century Health UM process is composed of three (3) review levels. They are Non-Clinical (pre-screening), Initial Clinical Reviewers and Peer Reviewers.

c. Pre-Screening for Review of Request:

The Client Services Staff and Intake Coordinators who are non-clinical staff, complete a pre- screening review of all service requests submitted to NCH for member eligibility and completeness of information required to process the request. They collect and transfer any/all of non-clinical data, such as member demographic information, employer name, insurance information, dates of treatment, physician name, facility name, etc., into NCH's clinical system. In addition, they can collect and transfer into the system structured clinical data utilizing explicit approved scripts or algorithms. Any missing information will be requested by the IC's by telephone or fax per CMS Guidance on Outreach for Information to Support Coverage decisions.

The Client Services Staff and Intake Coordinators will process the request depending on the approved policies or established workflows by New Century Health to follow regulatory guidelines, or contractual agreements. NCH does not issue non-certifications based on an initial screening of a request. Client Services and IC's do not evaluate or

interpret any clinical information. The Client Services and IC's may, however, inform practitioners or their staff of procedure codes that do not require pre-certification.

Client Services and IC's do not conduct any activities that require interpretation of clinical information, including but not limited to, the choosing of a set of criteria to use for management of a request for healthcare services or treatments.

Healthcare professionals (UM Nursing staff, CMO, Medical Directors) are available to the Client Services and IC's during normal business hours to ensure support while they are pre-screening the requests. Client Services and IC's are periodically monitored for written and telephonic activities by the Client Services and Intake Departments Supervisors to ensure they are performing within the scope of their job descriptions as dictated by specific State laws and Standards of the accrediting agencies.

d. Initial Clinical Reviewers of the Request

The individuals conducting the Initial Clinical Review are health care professionals with an active, unrestricted professional license or certification held in the United States, with the scope of practice relevant to the clinical areas managed by NCH UM department. NCH refers to UM Nurse Reviewers (RN, LVN, and LPN) as first level reviewers (FLR) in the clinical documentation system.

During the course of conducting reviews, the Initial Clinical Reviewer has access to consultations with a New Century Health Licensed Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO), licensed health professional in the same licensure category as the ordering provider or a Health professional with the same clinical education as the ordering provider in clinical specialties where licensure is not issued. UM Nurses can reach CMO, Medical Directors or Peer Reviewers one-on-one in the office, via phone or email. UM Department also has semi-monthly Clinical Review Meetings for case discussions, clinical education and/or discussion on clinical or operational issues.

Initial Clinical Reviewers review requests for authorizations to determine if the request meets standards for medical necessity during prospective or retrospective reviews. New Century Health is not currently delegated for concurrent inpatient reviews by any contracted health plan. Initial Clinical Reviewers can issue certification decision based on a medical necessity criteria match. Cases not approved by nurse reviewers are moved to the Clinical reviewer queue in the system for audit tracking of case transfer and assignment.

Initial Clinical Reviewers cannot issue adverse determinations, or non- certifications. Dose modifications or any changes to a prescriptive medication request are outside of the Initial Clinical Reviewer's scope of practice in Utilization Management. Such requests must be escalated to a Physician Peer Reviewer. NCH does not issue adverse determinations or non-certifications based on the initial reviewer feedback. Initial clinical reviewers may assist in the notification process for adverse determinations or non-certifications once determined by the physician.

e. Peer Clinical Reviewers of the Requests

Peer Clinical Reviewers are clinicians that hold an active unrestricted license or certificate (Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO), to practice medicine in the United States with knowledge of Medicare coverage criteria. Licensed health professional in the same licensure category as the ordering provider or a Health professional with the same clinical education as the ordering provider in clinical specialties where licensure is not issued. The Peer Clinical Reviewer is qualified, as determined by the NCH Medical Director, to render a clinical opinion relative to a medical condition, procedure or treatment requested.

NCH UM department conducts Peer Clinical Reviews for medical necessity on all requests where a certification is not issued through initial clinical review or initial

screening. These reviews are conducted for the evaluation of medical necessity of health care services, procedures, and facilities under the provision of the applicable benefit plan.

The Peer Clinical Reviewers are available to discuss review determinations with attending physicians or other ordering providers during business hours. This 'peer to peer' conversation may be accomplished by telephone, in-person meetings or electronically and is performed in a timely manner, usually within one (1) business day. When the original Peer Clinical Reviewer is not available, another designated Peer Clinical Peer is available. All case documentation is maintained in the system so all NCH UM staff have access to the communication and clinical records.

The goal of the 'peer to peer' conversation is to allow the treating provider an opportunity to discuss the case treatment plan and the UM determination prior to the initiation of an adverse determination and the appeal process. It is not an appeals process. NCH offers a proactive peer-to-peer conversation prior to issuing a recommended adverse determination to the health plan. Peer to peer calls are made by peer reviewers in an attempt to modify and/or understand the clinical reasoning for a request that does not initially meet medical necessity criteria. The peer to peer conversation can result in a modification/change to the request to enable authorization, can result in an authorization when clinical details/information (not previously submitted) are provided to justify the variance or conversation, the lack of conversation or lack of return call can result in a recommended adverse determination/denial to the health plan client.

When/if the 'peer to peer' conversation does not resolve a difference of opinion, the requesting physician is informed of the NCH policy to escalate the issue to the health plan as a recommended adverse determination. If the health plan agrees with the recommended adverse determination/denial, the issued adverse determination/denial will include the health plan's appeal process. When NCH is delegated for adverse determinations/denials, an adverse determination will be issued, and NCH will send adverse determination/denial letters to the member and provider with the rationale for the adverse determination and the health plan's appeals process.

Per contractual agreements, New Century Health is delegated for adverse determinations. Recommended adverse determinations are based on medical necessity and can only be made by a physician reviewer, the Medical Director, or the Chief Medical Officer of New Century Health. When New Century Health is delegated for adverse determinations, this determination will be made by a physician reviewer, the Medical Director, or the Chief Medical Officer of New Century Health. Written recommendations for recommended adverse determinations (RAD), and adverse determination notification/denial will include: reason for determination, clinical rationale(s) for denial; applicable appeal rights based upon the client contract and line of business; and notice of the availability, upon request of the provider/enrollee or designee, of the clinical review criteria relied upon to make such determination.

f. Access to UM Staff

New Century Health provides a toll-free line (888) 999-7713 to access staff related to health utilization management activities and all NCH staff. NCH normal business hours are Monday through Friday 5:00am to 5:00pm Pacific Standard Time, excluding holidays. NCH has additional coverage to reach UM clinical staff after hours or on weekends for cases involving urgent care. NCH hours of operation are based on covering all time zones that NCH conducts at least 2% or more of UM activities.

NCH UM staff can be reached following the message prompter to select UM staff, UM nurses for oncology and cardiology, option for NCH direct connection via staff name directory or operator assistance. Outgoing calls relating to UM issues are made during normal business hours, unless otherwise previously arranged. Calls received after hours are returned within one (1) business day.

Providers can submit authorization requests by web-based portal, fax, or telephone. Providers can access the portal twenty-four hours a day/seven days a week (24/7) for multiple services which include but are not limited to: submitting a request, discontinue a request, withdraw of a request, documentation submission, and status check.

g. Timeframes for UM Determinations

New Century Health will process requests for authorization of services in a timely manner and will provide notice to members, their legal representatives, and providers in accordance with applicable regulatory and accreditation standards, and/or contractual agreements. Time frames associated with authorizations are monitored through the QM program. In the absence of more rigorous contractual agreements, federal, state, or other accreditation standards, New Century Health will comply with timeframes established by URAC and/or NCQA. NCH follows the more stringent timeframe for compliance.

h. Prospective Reviews

i. For Medicare: Standard (non-urgent) requests shall be completed within seventy-two (72) hours for Part B and Part D drugs or fourteen (14) days for pre-service requests.

ii. For Commercial/Exchange: Standard (non-urgent) requests shall be completed within fifteen (15) days or less (or based on contractual agreement) of the receipt from the requesting provider. A non-urgent request may be extended one-time for a period up to fourteen (14) additional days to clarify any issues that would prevent a determination. Patients will be notified of the extended timeframe prior to the initial fourteen (14) days of review.

iii. Urgent requests shall be completed as soon as possible, but not to exceed twenty-four (24) for Medicare Part B and Part D drugs or seventy-two (72) hours for pre-service requests from the receipt of request from the provider (or sooner based on contractual agreements).

iv. Retrospective Reviews requests shall be completed within a thirty (30) calendar day timeframe or less (or based on contractual agreement). This will allow time for additional information to be obtained in order to make a determination. A retrospective request may be extended for an additional fourteen (14) calendar days to clarify any/all issues that would prevent a determination. Patients will be notified of the extended timeframe prior to the initial fourteen (14) days of review.

i. Medicaid Managed Care Timeframes (New York)

i. Expedited Prospective (urgent) Requests shall be completed no more than twenty-four (24) hours from receipt of the request.

ii. Standard Prospective(non-urgent) Requests shall be completed within twenty-four (24) hours after all necessary information is received but not more than 14 days from the receipt of the request.

3. Appeals

a. New Century Health is not delegated or contracted by clients to issue non- certification decisions and/or handle the appeals process of adverse determination; those decisions are rendered by the client (payer) and follow the client's internal process for appeals. If in the future event New Century Health is delegated appeals per written agreement with a client, NCH would follow its organization's policy, *UM_1019 Adverse Determination Appeals Process Policy and Procedure*.

H. Clinical Guidelines:

1. New Century Health's clinical guidelines are objective and based on current medical evidence-based guidelines, are continually reviewed for consistency with nationally recognized guidelines and are maintained by a panel of American Board-Certified Physicians.

New Century Health has automated the authorization process to ensure the most appropriate care/service is consistently provided. Clinical guidelines are developed following New Century Health's policy and procedure *UM_1010 Utilization Management Criteria Development.*

2. New Century Health's clinical guidelines include procedures for applying criteria based on the needs and special circumstances of the individual patient and the characteristics of the local delivery system.
3. Clinical guidelines are continuously reviewed against current literature and approved standards of practice. Inter-rater reliability testing is performed annually, to include all members of the UM staff and Peer Clinical Reviewers, to monitor the consistent application of the clinical guidelines by all UM personnel. In cases where the UM staff or Peer Clinical Reviewers do not demonstrate consistency, the guidelines are re-evaluated to determine if they are understandable and easily applied. Review and revision of clinical guidelines occurs at least annually but as often as necessary to ensure quality of care and service.
4. Providers and/or treating facilities may request a free copy of New Century Health clinical guidelines and the most current Provider Manual by contacting New Century Health, at 915 W. Imperial Highway, Suite 200, Brea, CA 92821 or by calling 888-999-7713.
5. Upon request, patients, providers, ordering physicians or facilities rendering service will be provided the specific clinical criteria and rationale utilized to make certification decisions or utilized to recommend an adverse determination to the client (health plan) that issues a non-certification determination.

I. Reports

1. New Century Heath will collect, analyze, and report all portions of the UM cycle, to include access standards, referrals, and authorizations, and will use such data to improve effectiveness, efficiency, and quality of the overall UM program.
2. New Century Health will distribute annual client and provider satisfaction surveys, collect and report data to individuals involved in the process and use data to improve quality of client and provider services.
3. New Century Health's Utilization Management Committee will conduct a yearly evaluation of its Utilization Management Program, analysis of its results with recommendations for improvement, and provide a final report to the Quality Management and Improvement Committee to include, minimally, the following criteria:

New Century Health UM Program Evaluation & Reports		
Element	Frequency	Responsible Party
Review of UM Plan/ P&P	Reviewed, at minimum, on an annual basis and submitted to the UM Committee for review and approval. Additional reviews and updates may be conducted as needed in response to changes in regulatory/ accreditation standards or new business.	Chief Medical Officer, UMC, Director, Quality Management, VP-Clinical Operations
Review of UM clinical criteria	At least annually but as often as necessary to ensure clinical appropriateness and compliance with nationally recognized treatment guidelines.	Chief Medical Officer, NCH's American Board-certified Physicians, and Pharmacists (Scientific Advisory Board)
UM Staff and Peer Clinical Reviewers Inter- Rater Reliability Surveys	Annually with submission to the UMC/QMIC	Director, QM, QM Clinical Informatics Manager
Client and Practitioner UM satisfaction survey	Annually with summary report to UMC and QMIC	VP of Network Operations, Chief

		Growth Officer
Utilization data review	Monthly with annual summary report to the QMIC	VP-Clinical Operations
Call Management - adequacy of staff resources as measured by: 1. Average time to answer 2. Abandonment rate 3. Timeliness of decision making a. Expedited b. Standard c. Retrospective	Monthly with annual summary report to the QMIC and monthly to UMC.	Director, Client Services, VP- Clinical Operations
Staff training 1. Regulatory Compliance 2. URAC	Annually	Compliance Officer or Quality Management

V. UM Plan Approval

POLICY NUMBER UM_1032	**SUBJECT** UM Plan and Description		**DEPT/PROGRAM** UM Dept	**PAGE 14 OF 19**
DATES COMMITTEE REVIEWED 01/04/12, 03/07/12, 04/06/12, 03/05/13, 04/09/14, 06/05/14, 01/19/15, 12/26/15, 01/10/17, 08/16/17, 12/12/17, 06/07/18, 01/03/19, 10/09/19, 11/13/19, 12/11/19, 01/08/20, 12/09/20, 01/28/21, 05/07/21, 08/11/21, 08/26/21, 09/27/21, 01/25/22, 02/09/22, 05/03/22	**APPROVAL DATE** May 3, 2022	**EFFECTIVE DATE** May 3, 2022	**COMMITTEE APPROVAL DATES** 03/07/12, 04/06/12, 03/05/13, 03/26/14, 04/01/14, 06/05/14, 12/24/14, 01/19/15, 12/09/15, 12/26/16, 01/10/17, 08/16/17, 09/13/17, 01/17/18, 06/08/18, 01/07/19, 10/09/19, 11/13/19, 12/11/19, 01/08/20, 12/09/20, 01/28/21, 05/07/21, 08/11/21, 08/26/21, 09/27/21, 01/25/22, 02/09/22, 05/03/22	
RIMARY BUSINESS OWNER: UM		**COMMITTEE/BOARD APPROVAL** Utilization Management Committee		
URAC STANDARDS HUM v8: CPE HP 4-1; OPIN 2-1; OPIN 2-3; OPIN 3-1; RM 3-2; UM 1-1; UM 4-1; UM 5-1; UM 5-2; UM 6-1; UM 6-3; UM 8-1; UM 9-1; UM 10-1; UM 10-2; UM 11-1; UM 12-1; UM 12-3; UM 16-1; UM 17-1	**NCQA STANDARDS** UMA 1; UM 1; UM 2; UM 4		**ADDITIONAL AREAS OF IMPACT**	
CMS REQUIREMENTS 42 CFR 422.152 (b) (3); 42 CFR 422.568 (a) (d) (e); 42 CFR 422.570 (c)	**STATE/FEDERAL REQUIREMENTS**		**APPLICABLE LINES OF BUSINESS** All	

(2) and (d); 42 CFR 422.572 (a) – (c); 42 CFR 422.572 (e); Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance 01.2020, Section 10.5.1, 10.5.2, 10.5.3, 40.10, 40.12.1		

Date: 05/03/2022

Signature of Approval by UM Committee Chairperson
Andrew Hertler, MD, FACP
Chief Medical Officer

UM Plan – Addendum: Georgia Statures

New Century Health shall abide by the statures within the State of Georgia when certified and conducting clinical reviews as a Private Review Agent in the State of Georgia, to include: O.C.G.A. TITLE 33 Chapter 46
GEORGIA CODE, and the Rules of Comptroller General Office of Commissioner of Insurance, Certificate of Private Review Agents. Chapter 120-2-58(01 – 09).

120-2-58-.05 Requirements for Utilization Review.

(1) Private review agents shall have sufficient staff to facilitate review in accordance with review criteria and shall designate one or more individuals able to effectively communicate medical and clinical information.
(2) Private review agent shall provide access to its review staff by a toll free or collect call telephone line during normal business hours. A private review agent shall have an established procedure to review timely call backs from health care providers and shall establish written procedures for receiving after-hour calls, either in person or by recording.
(3) Private review agent shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency and duration of services. All requests for information shall be made during normal business hours.
(4) Private review agents shall identify themselves prior to collecting necessary information.
(5) Private review agents shall establish and follow procedures and rules for on-site medical facility review.
(6) In the event a private review agent questions the medical necessity or appropriateness of care, the following procedures will apply:

1. The attending health care provider shall have the opportunity to discuss a utilization review determination promptly by telephone with an identified health care provider representing the private review agent and trained in a related medical specialty. If the determination is made not to certify, an adverse determination exists.

2. Reconsideration of an adverse determination occurs when any questions concerning medical necessity or appropriateness of care are not resolved under subparagraph (a) above. The right to appeal an adverse determination shall be available to the enrollee and the attending physician or other ordering health care provider. The enrollee or enrollee's representative shall be allowed a second review by another identified health care provider in an appropriate medical specialty that represents the private review agent.

(7) The private review agent shall have written procedures for providing notification of its determinations regarding all forms of certification in accordance with the following:

1. When an initial determination is made to certify, notification shall be provided promptly either by telephone, in writing or electronic transmission to the attending health care provider, the facility rendering service as well as to the enrollee. Written notification shall be transmitted within two (2) business days of the determination.
2. When a determination is made not to certify, the attending physician and/or other ordering health care provider or facility rendering service shall:
    a. Be notified by telephone within one (1) business day.
    b. Be sent a written notification within one (1) business day, which also shall be sent to the enrollee. The written notification shall include: principal reason(s) for the determination and instructions for initiating an appeal of the adverse determination.
3. The private review agent shall establish procedures for appeals to be made in writing and by telephone. The private review agent shall notify the health care provider and enrollee in writing of its determination on the appeal as soon as possible, but in no case later than sixty (60) days after receiving the required documentation to conduct the appeal.
4. The appeals procedure does not preclude the right of an enrollee to pursue legal action.

Pennsylvania Addendum:

This section cited in 28 Pa. Code §9.631 (relating to content of an application for an HMO certificate of authority); 28 Pa. Code § 9.741 (relating to applicability); and 28 Pa. Code §9.751 (relating to UR system description).

§ 9.753. Time frames for UR.

(a) A concurrent UR decision shall be communicated to the plan, the enrollee and the health care provider within 1-business day of the receipt of all supporting information reasonably necessary to complete the review. The plan shall give the enrollee and the health care provider written or electronic confirmation of the decision within 1-business day of communicating the decision.

(b) A prospective UR decision shall be communicated to the plan, enrollee and health care provider within 2-business days of the receipt of all supporting information reasonably necessary to complete the review. The plan shall give the enrollee and the health care provider written or electronic confirmation of the decision within 2-business days of communicating the decision.

(c) A retrospective UR decision shall be communicated to the plan, the enrollee and the health care provider within 30 days of the receipt of all supporting information reasonably necessary to complete the review. The plan shall give the enrollee and the health care provider written or electronic confirmation of its decision within 15-business days of communicating the decision.

(d) A grievance review decision shall comply with the requirements and time frames set out in §9.705 and §9.707 (relating to internal grievance process; and external grievance process).

Connecticut Addendum:
Utilization Review, Adverse Determination, Appeals and Grievances Timeframes

New Century Health is *not currently delegated* member services, member notifications, concurrent reviews, adverse determinations, appeals and grievances, if in the future New Century Health is delegated with these activities, New Century Health will abide by the statues set in the State of Connecticut PA No 19-117 Section 241 to Section 243

New Century Health is *currently delegated* utilization reviews for urgent, non-urgent pre-service requests and retrospective requests. New Century Health follows the timeframes set forth in the state of Connecticut PA No 19-117 Section 241 to Section 243 or timeframes agreed contractually with New Century Health's health plan client whichever is more stringent.

Sec. 241. Subdivision (1) of subsection (c) of section 38a-591d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

1. (A) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination and except as specified under subparagraph (B) of this subdivision, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than [seventy-two] forty-eight hours after the health carrier receives such request or seventy-two hours after such health carrier receives such request if any portion of such forty-eight-hour period falls on a weekend, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments.

   (B) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination, for an urgent care request specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than twenty-four hours after the health carrier receives such request, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments.

Sec. 242. Subdivision (1) of subsection (d) of section 38a-591e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(d) (1) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative, in writing or by electronic means, of its decision within a reasonable period of time appropriate to the covered person's medical condition, but not later than:

(A) For prospective review and concurrent review requests, thirty calendar days after the health carrier receives the grievance;

(B) For retrospective review requests, sixty calendar days after the health carrier receives the grievance;

(C) For expedited review requests, except as specified under subparagraph (D) of this subdivision, [seventy-two] forty-eight hours after the health carrier receives the grievance or seventy-two hours after such health carrier receives such grievance if any portion of such forty-eight-hour period falls on a weekend; and

(D) For expedited review requests of a health care service or course of treatment specified under

subparagraph (B) or (C) of subdivision (38) of section 38a-591a, twenty-four hours after the health carrier receives the grievance.

Sec. 243. Subdivision (1) of subsection (i) of section 38a-591g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(i) (1) The independent review organization shall notify the commissioner, the health carrier, the covered person and, if applicable, the covered person's authorized representative in writing of its decision to uphold, reverse or revise the adverse determination or the final adverse determination, not later than:

(A) For external reviews, forty-five calendar days after such organization receives the assignment from the commissioner to conduct such review;

(B) For external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, twenty calendar days after such organization receives the assignment from the commissioner to conduct such review;

(C) For expedited external reviews, except as specified under subparagraph (D) of this subdivision, as expeditiously as the covered person's medical condition requires, but not later than [seventy-two] forty-eight hours after such organization receives the assignment from the commissioner to conduct such review or seventy-two hours after such organization receives such assignment if any portion of such forty-eight-hour period falls on a weekend;

(D) For expedited external reviews involving a health care service or course of treatment specified under subparagraph (B) or (C) of subdivision (38) of section 38a-591a, as expeditiously as the covered person's medical condition requires, but not later than twenty-four hours after such organization receives the assignment from the commissioner to conduct such review; and

(E) For expedited external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, as expeditiously as the covered person's medical condition requires, but not later than five calendar days after such organization receives the assignment from the commissioner to conduct such review

Adverse Determination Review

When New Century Health is delegated Adverse Determination, all Adverse Determinations are based on medical necessity and must be issued by a *peer clinical reviewer* [CT Statues Section 38a-591a (7)*] New Century Health adheres to the most stringent timeframe to maintain compliance.

*Section 38a-591a(7) - “Clinical peer” means a physician or other health care professional who (A) holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and (B) for a review specified under subparagraph (B) or (C) of subdivision (38) of this section concerning (i) a child or adolescent substance use disorder or a child or adolescent mental disorder, holds (I) a national board certification in child and adolescent psychiatry, or (II) a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable, or (ii) an adult substance use disorder or an adult mental disorder, holds (I) a national board certification in psychiatry, or (II) a doctoral level psychology degree with training and clinical experience in the treatment of adult substance use disorders or adult mental disorders, as applicable

Medical Criteria

Links to clinical criteria used in adverse determination are accessible on New Century Health’s website.