POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Utilization Management Program Description
PAGE: 1 of 33	**REPLACES DOCUMENT:**
APPROVED DATE: 9/11	**RETIRED:**
EFFECTIVE DATE: 1/1/12	**REVIEWED/REVISED:** 2/27/13; 11/13; 1/14, 8/14, 11/14; 4/15; 9/15; 5/16, 3/17, 3/18, 2/19, 5/19, 8/19, 10/19, 11/19
REVISED EFFECTIVE DATE: 2/1/15, 12/15	
PRODUCT: Medicaid	**REFERENCE NUMBER:** LA.UM.01

SCOPE:
Louisiana Healthcare Connections (Plan) Medical Management

PURPOSE:
To describe the Utilization Management (UM) Program.

POLICY:
The Medical Management Department will maintain a Utilization Management Program Description which encompasses the functions of pre-authorization and concurrent review. The program description will be consistent with all regulatory and accrediting guidelines and standards. The document will be reviewed and revised at least annually and more frequently as needed.

The UM Program Description and related policies and procedures will be submitted to the Louisiana Department of Health (LDH) annually and subsequent to any revisions.

REFERENCES:
LA MCO RFP Amendment 11, Section 6-Core Benefits & Services, Section 8- Utilization Management, Section 13-Member Grievance & Appeals Procedure
Current NCQA Health Plan Standards and Guidelines
Code of Federal Regulations – 42 CFR 422
LAC 50:I.1101-Louisiana State Medical Necessity Criteria
CP.CPC.03 Preventive Health and Clinical Practice Guidelines
LA.UM.05 Timeliness of UM Decisions and Notifications
LA.UM.15 Oversight of Delegated UM
House Bill 424/Act 330

ATTACHMENTS:

DEFINITIONS:

REVISION LOG	DATE
Language added to meet Louisiana Contractual requirements	11/8/13
Updated reference to NCQA 2013 HP Standards and Guidelines	1/6/14
Changed Utilization Management to Medical Management, changed abbreviations	8/14
Changed QIC to QAPIC Added ® to any InterQual references Changed 14 day prior notice to 7 days to correspond to LA.UM.05 Added verbiage of timeliness to file for informal reconsideration as referenced in LA.UM.07 LA Procurement 2015 Policy Update Clarification to Pharmacist Specialist position and Pharmacy Program	11/2014
Changed NCQA to say "current" instead of a year	4/15

Changes throughout policy for updated RFP with BH carve in. Added STRS to the delegation section.	9/15
Changes to RFP references to match current RFP Title changes for nurses where needed. Grammatical changes. Removal of titles, verbiage that is not utilized.	5/16
Changed DHH to LDH, updated 2016 to 2017. Changed Case to Care Management, CMD to SVP, MA. Added Work Plan, Annual UM Program Evaluation to what MMC develops. Added Envolve where NurseWise and Cenpatico are referenced. Removed the different levels of PA/CCR and CM. Under Clinical Information, removed references about asking for coding. Changed Business to Calendar days for urgent determinations. Updated RFP references. In the Predictive Modeling section, removed info about stratification. In the Continuity & Coordination of Services sections, removed ICT and Coordination between providers. In the Out of Network Services section, removed ICT. In the Notice of Action section, added informal reconsideration and formal appeals. In the Measuring Effectiveness section, removed condition specific indicators and added TAT for decision & denial overturn rate. Removed Chronic Care Management services.	3/17
Changed CCL.001 UM Program Description to EPC.UM.01 UM Program Description. Changed Envolve People Care to Envolve People Care Nurse Advice Line where 24 hr Nurse Advice Line referenced. Changed Envolve People Care to Envolve People Care-Behavioral Health where Behavioral Health referenced. Changed OptiCare to Envolve Vision where Vision Care Services referenced. Changed National Imaging Associates, Inc. (NIA) to Magellan Healthcare (NIA). Changed US Script to Envolve Pharmacy Solutions. In Appeal of UM Decisions section, removed timeframe to appeal and State Fair Hearing Process.	3/18
Changed "LA MCO Contract" to "LA MCO RFP Amendment 11" & Added Section 6 – Core Benefits & Services, Section 13 – Member Grievance & Appeals Procedure. Changed RFP references throughout document to reflect LA MCO RFP Amendment 11 references. Added LAC 50:I.1101 – Louisiana State Medical Necessity Criteria. Updated Code of Federal Regulations' references throughout document. Removed Health Plan Advisory (HPA) 12.9 Clarification of Provider Appeals Relative to Denied Claims and Services. Removed EPC. UM.01 UM Program Description. Removed CCL.229 Utilization Management Timeliness and Notification Standards. Added LA.UM.15 Oversight of Delegated UM. Removed Readiness Review language from LA.UM.01 Policy Section. Added Senior VP, Clinical Operations, role and responsibilities throughout document where relevant. Revised Timeliness of UM Decisions section with removal of "one (1) business day of receipt of the request for services" and addition of "the lesser of two (2) business days (RFP 8.5.1.2) or three (3) calendar days (current NCQA standards) of receiving the request for needed clinical information". Added and revised Behavioral Health language throughout document where relevant. Removed CC.CM.06 from Predictive Modeling section. Removed Post Service Medical Necessity Review and Behavioral Health Services from Delegation section. Added Outpatient Therapy language to Complex Imaging Services in Delegation section.	02/19
Added statements to reflect RFP Amend 11- 8.4.2.4 & 8.4.5 requirements Removed LA.QI.08 Preventive and Clinical Practice Guidelines and replaced with CP.CPC.03 Preventive Health and Clinical Practice Guidelines in Reference section and Preventive and Clinical Practice Guidelines (CPGs) section.	5/19
Added notation related to new process for provider release of criteria and inclusion of criteria within notices of action as per new House Bill 424- Act 330 requirement Added reference to HB 424/Act 330	8/19
Added RFP language from Ipro Audit 8.4.5.2 and 8.5.4.3 Added BH Services	10/19
Added Behavioral Health Practitioners as description of Medical Directors. Remove telephonic as the way concurrent reviews are done with medical records.	**11/19**

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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer , Centene's P&P management software, is considered equivalent to a physical signature.

VP Medical Management: ___Electronic Signature on File_____
Sr. VP, Medical Affairs: ___Electronic Signature on File_____

Utilization Management (UM) Program Description 2019

Louisiana Healthcare Connections
2019 UM Program Description

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Louisiana Healthcare Connections
2019 UM Program Description

PROGRAM OVERVIEW

The Louisiana Healthcare Connections (Plan) approach to UM is based on the philosophy of continuously improving the member's experience and quality of care, improving outcomes of populations, and reducing per capita cost of health care. The Plan UM, Care Management (CM), and Chronic Care Management Programs (CCMPs) will work together to promote a lifetime of healthy behaviors and outcomes. The Plan monitors trends for approvals, denials, terminations, reductions, and suspensions of services as a means to identify opportunities to refine our processes and target provider training. The Plan's continued evaluation of the comprehensive, multidisciplinary approach to Medical Management (MM) which includes UM, CM, and Disease Management (DM) is designed to maintain and improve quality, appropriateness, and accessibility of healthcare services while achieving member and provider satisfaction. Program monitoring and process improvements are performed allowing continuous compliance with both regulatory requirements and accreditation standards.

The Plan maintains a written UM Program Description (Description) that fully complies with state and federal requirements, as well as all RFP/Contract requirements for what the Description must include. We submit the Description to the Louisiana Department of Health (LDH) for written approval within 30 days of execution of a contract between the Plan and LDH, annually thereafter, and prior to any material revisions. The Description outlines our UM Program structure and processes, including assignment of responsibility to appropriate individuals, in order to promote medically necessary, fair, impartial, and consistent utilization decisions. The Description provides evidence of integrated health services and care coordination in our UM Program design, development, implementation, and review.

The UM Program adheres to current National Committee on Quality Assurance (NCQA) Health Plan Accreditation Requirements for UM; Federal regulations, including, but not limited to applicable parts of 42 CFR 422; relevant Louisiana State requirements, such as LAC 50:I.1101 for medical necessity determinations; and all related RFP/Contract requirements. The UM Program is reviewed annually and updated periodically as appropriate.

PURPOSE

The purpose of the Description is to define the structures and processes within the UM Department, including assignment of responsibility to appropriate individuals, in order to promote fair, impartial and consistent utilization decisions and coordination of care for the health plan members.

SCOPE

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, post-acute services and ancillary care services. The Plan does not engage in the practice of medicine or act to impinge or encumber the independent medical judgment of treating physicians or health care providers.

Louisiana Healthcare Connections
2019 UM Program Description

GOALS

The goals of the UM Program are to optimize member's health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM Program aims to reduce inappropriate and duplicative use of health care services and provide services that are a covered benefit, medically necessary, appropriate to the member's condition, rendered in the appropriate setting and that meet professionally recognized standards of care. The overarching goal is to help each and every Plan member achieve the highest possible levels of wellness, functioning and quality of life, while demonstrating positive clinical results. This will be achieved through the proactive identification of members with complex and/or chronic health conditions that require coordination of physical and behavioral health services to provide maximum support of the member's wellness and autonomy.

IMPLEMENTATION

The UM Program seeks to advocate the appropriate utilization of resources, using the following program components: 24-hour nurse triage, prior authorization/precertification, second opinion, concurrent review, retrospective review, care management, chronic care management, maternity management, preventive care management and proactive discharge planning activities. Additional UM Program components implemented to achieve the UM Program's goals include tracking utilization of services to guard against over- and under-utilization of services, and to create interactive relationships with practitioners to promote appropriate practice standards. Interactions with hospital discharge planners, and dialogue with the primary care provider (PCP) regarding long-term needs are initiated promptly and proactively. The PCP is responsible for assuring appropriate utilization of services along the continuum of care.

Utilization Management Process

The UM Program emphasizes an integrated approach designed to facilitate treatment through comprehensive care and collaborative support that will increase positive treatment outcomes. This holistic model of care includes the integration of both physical and behavioral health. All approved services must be medically necessary. The clinical decision process begins when a request for authorization of service is received at the Plan level. Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post-service authorization. Request types may include authorization of specialty services, second opinions, outpatient services, home and community based services, residential treatment, ancillary services, scheduled inpatient services, urgent inpatient services, including obstetrical deliveries. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

CONFIDENTIALITY

Confidential information is defined as any data or information that can directly or indirectly identify a patient or physician or as considered Protected Health Information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Plan has provisions for assuring confidentiality of clinical and proprietary information and adheres to the following: (RFP 8.1.3.7)

- Staff and consultants are required to sign a Confidentiality Statement
- All members of the Medical Management Committee (MMC) are required to sign a Confidentiality waiver

- All employees and practitioners are allowed to access and disclose confidential information only as necessary to fulfill assigned duties and responsibilities
- Medical information sent by mail or fax to the attention of the recipient is clearly marked "personal and confidential"
- All medical information is secured in a locked location with access limited to essential personnel only
- Medical information stored in the software system is protected under multiple levels of security by system configuration, which includes user access passwords
- Confidential information is destroyed by a method that induces complete destruction when no longer needed
- The Plan abides by all federal and state laws governing the issue of confidentiality

AUTHORITY

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

The Sr. Vice President of Medical Affairs (SVP, MA) provides support to the Plan's UM Program. The Plan SVP, MA, Sr. Vice President of Clinical Operations, (SVP, CO), Vice President of Medical Management (VPMM), and/or any designee as assigned by the Plan President and CEO are the senior executives responsible for implementing the UM Program including cost containment, QI, medical review activities, complex, controversial or experimental services, and successful operation of the QAPIC and MMC. A behavioral health practitioner is involved in the implementation, monitoring and directing of aspects of the UM Program. In addition to the SVP, MA, the Plan may have one or more Medical and/or Associate Medical Directors.

The SVP, MA's responsibilities include, but are not limited to, coordination and oversight of the following activities:

- Develops, implements, and interprets medical policies and procedures, including, but not limited to service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the Grievance & Appeals System
- Monitors compliance with the UM Program
- Provides clinical support to the UM staff in the performance of UM responsibilities
- Assures that the Medical Necessity criteria used in the UM process are appropriate and reviewed by physicians and other practitioners according to policy
- Assures that the Medical Necessity criteria are applied in a consistent manner

- Assures that reviews of cases that do not meet Medical Necessity criteria are conducted by appropriate physicians in a manner that meets all pertinent statutes and regulations and guidelines, and takes into consideration the individual needs of the involved members
- Reviews, approves, and signs denial letters for cases that do not meet Medical Necessity criteria after appropriate review has occurred in accordance with Plan policy
- Assures the Medical Necessity appeal process is carried out in a manner that meets all applicable contractual requirements, as well as all federal and state statutes and regulations, is consistent with all applicable accreditation standards, and is completed in a consistent and efficient manner
- Provides a point of contact for practitioners with questions about the UM process
- Communicates/consults with practitioners in the field as necessary to discuss UM issues
- Coordinates and oversees the delegation of UM activity as appropriate and monitoring of delegated arrangement to ensure it meets all applicable contractual requirements and accreditation standards
- Serves as director of the MMC and all other physician committees or subcommittees
- Collaborates with the Behavioral Health Medical Director in assuring appropriate integration of physical and behavioral health services
- Recommends and helps to monitor corrective action as appropriate for practitioners with identified deficiencies related to UM
- Serves as a liaison between UM and other Plan departments
- Educates practitioners regarding UM issues, activities, reports, requirements
- Reports UM activities to the QAPIC as needed

INTEGRATION WITH OTHER PROGRAMS

The UM, QI, Credentialing, and the Fraud, Waste, and Abuse Programs are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to the Plan's QI Department. As the functions of UM are performed, quality indicators prescribed by the Plan as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI Department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

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

UM policies and processes serve as integral components in preventing, detecting, and responding to Fraud, Waste, and Abuse among practitioners and members. The Medical Management Department will work closely with the Plan's Compliance Officer and Centene's Special Investigations Unit to resolve any potential issues that may be identified. The Plan shall report

fraud and abuse information identified through the UM program to LDH in accordance with 42 CFR §455.1(a) (1). (RFP 8.1.22)

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

- Early Childhood Intervention
- State Protective and Regulatory Services
- Women, Infant and Children Services (WIC)
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) Health Check
- Services Provided by Local Public Health Departments
- Department of Children and Family Services
- Office of Citizens with Developmental Disabilities
- Office of Juvenile Justice

MEDICAL MANAGEMENT COMMITTEE (MMC)

Oversight and operating authority of UM activities is delegated to the MMC, which serves as the Plan's Utilization Management Committee (UMC). The MMC complies with all requirements of a UMC, which reports to the Plan's QAPIC and ultimately to the Plan's BOD. The MMC is responsible for the review and appropriate approval of medical necessity criteria and UM policies and procedures. The MMC coordinates annual review and revision of the UM Program Description, and the Annual UM Program Evaluation. These documents are presented to the QAPIC for approval. The MMC monitors and analyzes relevant utilization data to detect and correct patterns of potential or actual inappropriate under- or over-utilization. The MMC also analyzes data which may impact health care services, coordination of care and appropriate use of services and resources, as well as member and practitioner satisfaction with the UM process. The MMC also reviews the UM Department's quality and performance metrics, such as phone answer timeliness, denial and appeals volume, and outcomes of inter-rater reliability testing. Analysis of the above tracking and monitoring processes, as well as status of corrective action plans as applicable, are reported to the Plan's QAPIC.

Medical Management Committee Scope

Medical Management Committee responsibilities include coordination and oversight of the following activities:

- Oversees the UM activities of the Plan in regard to compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as the NCQA
- Develops and conducts annual review/approval of the UM Program Description, Work Plan, Annual UM Program Evaluation, guidelines, policies and procedures
- Reviews practitioner-specific UM reports to identify trends and/or utilization patterns, including medical and pharmacy related patterns and makes recommendations to the QAPIC for further review
- Reviews reports specific to facility and/or geographic areas for trends and/or patterns

- Examines appropriateness of care reports to identify trends and/or patterns of under- or over-utilization and refers identified practitioners to the QAPIC for performance improvement and/or corrective action
- Examines results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program and identify areas for performance improvement
- Provides a feedback mechanism to the QAPIC for communicating findings, recommendations, and a plan for implementing corrective actions related to UM issues
- Identifies those opportunities whereby the UM data can be utilized in the development of quality improvement activities and submitted to the QAPIC for recommendations
- Reports findings of UM studies and activities to the QAPIC
- Partners with the QAPIC for ongoing review of quality indicators

Medical Management Committee Members
The MMC is directed by the SVP, MA. The SVP, CO, VPMM and associate Medical Directors are standing members of the Committee. A Pharmacy Specialist is a member of the Committee and will assist in review of pharmacy utilization and make recommendations regarding drug utilization review activities, such as targeted prescriber and/or member education initiatives. A LDH representative, as appointed by LDH, shall be included as a member of the MMC, if requested. Additional UM/QI staff, contractor leadership as needed, and other Plan leadership may also attend the MMC as appropriate. (RFP 8.2.2)

A minimum of 50% of voting members must be present for a quorum. The MMC Chairman will be the determining vote in the case of a tie vote.

Meeting Frequency and Documentation of Proceedings
The MMC meets no less than quarterly and the VPMM maintains detailed records of all MMC meeting minutes, UM activities, CM Program statistics and recommendations for UM improvement activities made by the MMC. The MMC submits to the QAPIC all meeting minutes and written reports regarding all UM studies and activities. Meeting minutes are submitted to LDH upon request**.** (RFP 8.2.2)

UTILIZATION MANAGEMENT PROCESS

The UM process encompasses the following program components: 24-hour nurse triage, referrals, second opinions, prior authorization, pre-certification, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination. All approved services must be medically necessary. The clinical decision process begins when a request for authorization of service is received at the Plan level. Service authorization includes, but is not limited to; prior authorization, concurrent authorization and post authorization. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, scheduled inpatient services, or urgent inpatient services, including obstetrical deliveries. The process is complete when the requesting practitioner and member when applicable, have been notified of the determination.

UM Staff Qualifications and Training

Appropriately licensed, qualified health professionals supervise the UM process and all medical necessity decisions. A Louisiana licensed physician or other appropriately licensed health care professional, as indicated by case type, reviews all medical necessity denials of healthcare services offered under the Plan's medical benefits. Personnel employed by or under contract to perform UM are appropriately qualified, trained and hold current professional licensure. The Plan maintains an in-depth new employee training and ongoing training program to ensure its staff remain current on industry standards and practices.

UM employee compensation includes hourly fees and salaried positions. All medical management staff are required to acknowledge an Affirmative Statement regarding compensation annually. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations, reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is prohibited. The Plan and its delegated UM agents will not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

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

The Plan has medical and professional support staff, qualified by training, experience and certification/licensure, as applicable, sufficient to conduct daily business in an orderly manner, including having member services staff directly available during business-hours for member services consultation, as determined through management and medical reviews. The Plan maintains sufficient clinical staff, available 24 hours a day, seven days a week (24/7), to handle emergency services and care inquiries. Although the Plan does not require authorization or notification for emergency or post-stabilization services, it maintains sufficient clinical and professional support staff during non-business hours, administered through Envolve PeopleCare Nurse Advice Line (EPC-NAL), a wholly-owned subsidiary of Centene Corp. Staffing ratios are determined based on membership and state contract requirements which may include, but is not limited to the following:

Sr. Vice President, Medical Affairs (SVP, MA)/Medical Directors

The SVP, MA oversees care management and is responsible for the proper authorization and provision of care benefits and services to members. The SVP, MA reports to the CEO, and is also significantly involved in the QI Program including grievance and appeals and is the Chair of the QI Committee. The SVP, MA is a full-time physician (32 hours/week) with an active, unencumbered Louisiana license in accordance with state laws and regulations and is not designated to serve in any other non-administrative position.

The Medical Director (**Behavioral Health Practitioners and** Associate Medical Director(s) based on the needs of the Plan) is a physician, with an active unencumbered Louisiana license in accordance with state laws and regulations, who is required to supervise all medical necessity decisions and conducts Level II medical necessity reviews.

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Only the Medical Director or other licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall make an adverse determination based on medical necessity. Based on scope of covered benefits, professionals authorized to make a clinical denial for lack of medical necessity include licensed MDs and DOs.

Sr. Vice President, Clinical Operations (SVP, CO)

The SVP, CO oversees and directs all clinical functions for the assigned business unit based on, and in support of the Plan's strategic plan. The SVP, CO establishes the strategic vision, objectives, and policies and procedures to ensure delivery of cost-effective clinically appropriate services; evaluates performance results against established metrics and benchmarks and recommends improvement opportunities; meets and exceeds contractual obligations in utilization management and clinical outcomes; identifies innovative solutions to improve care and ensures adequate pilot projects are implemented to drive continuous clinical improvement; and oversees delivery of reports required by the contract and management.

The SVP, CO is a Medical Doctor or has a Master's degree in Nursing, Therapy, Pharmacy, Public Health/Administration or related field with experience in the Healthcare Industry. The SVP, CO has an unrestricted license as a MD, DO, APRN, PA, PT, OT, RPh, or RN in applicable states.

Vice President/Sr. Director of Medical Management (VPMM)

The VP/Sr. Director of MM is a registered nurse, physician's assistant or physician with an active unencumbered Louisiana license and experience in UM activities. The VPMM is responsible for overseeing the day-to-day operational activity of the Plan's UM Program and CM staff. The VPMM reports to the SVP, CO. The VPMM, in collaboration with the SVP, MA, assists with the development of the UM strategic vision in alignment with corporate and Plan objectives, policies and procedures.

Utilization Management Director/Manager

The UM Director/Manager is a registered nurse. The UM Director/Manager directs and coordinates the activities of the department including supervision of the referral specialist staff, prior authorization, MM analytics, concurrent review nurses and correspondence staff. The UM Director/Manager reports to the VPMM or Director of MM. The UM Director/Manager works in conjunction with the Director of MM and CM Director/Manager to execute the strategic vision in conjunction with corporate and Plan objectives and attendant policies and procedures and state contractual responsibilities.

Prior Authorization (PA) Nurses/Concurrent Review (CCR) Nurses/Licensed Mental Health Professionals (LMHP)

PA/CCR nurses and LMHPs are clinical staff with appropriate training, clinical experience and preferably UM experience. CCR nurses who coordinate discharge planning and apply approved UM medical necessity criteria for concurrent review and requests for discharge services report to and are supervised by the Director/Manager of UM. LMHPs or Registered Nurses with Behavioral Health expertise are specifically assigned to specialized

behavioral health services to ensure appropriate authorization and utilization of services. At any level, PA/CCR nurses or LMHPs are prohibited from making adverse medical necessity determinations. When a request for authorization of services does not meet the standard UM criteria, the case is referred to the Medical Director for a medical necessity review.

Referral Specialists

Referral Specialists (RS) are individuals with significant administrative experience in the health care setting. Experience with ICD-10 and CPT coding is preferred. Referral Specialists collect demographic data necessary for preauthorization and may also have the authority to approve specific services for which there are explicit criteria or algorithms. Referral Specialists cannot make clinical determinations, referring all clinical decisions to a PA/CCR nurse or LMHP. Referral Specialists report to and are supervised by a Supervisor or qualified designee.

The Plan has processes in place for assuring that all persons, whether employees, agents, contractors, or anyone acting for or on behalf of the Plan, are properly licensed at all times under applicable state law and/or regulations and are not suspended or excluded from participation in the Medicaid and/or Medicare program.

Sr. Director, Pharmacy

The Sr. Director of Pharmacy has a degree in Pharmacy with several years of clinical pharmacy care experience. The pharmacy staff performs duties to develop, direct, and implement a pharmacy benefit management program. The Pharmacy Director aids the VPMM in formulating and administering related organizational policies and procedures, including pharmacy service quality, pharmacy UM, and achievement of Company goals for pharmacy and medical programs.

Pharmacy Specialists

Pharmacy Specialists are pharmacy technicians with several years of pharmacy experience preferably in a managed care environment. This role supports the efforts of the pharmacy department in the development, coordination, and maintenance of the pharmacy program.

Pharmacy Coordinator

Pharmacy Coordinators are individuals with experience working in a pharmacy and have a minimum of a high school diploma with preferred Medicare and/or Medicaid experience. Pharmacy Coordinators support the efforts of the pharmacy department in the development, coordination, and maintenance of pharmacy programs.

Board-Certified Clinical Consultants

In some cases, such as for certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside the Plan may be contacted, when necessary, to avoid a conflict of interest. The Plan defines conflict of interest to include situations in which the practitioner, who would normally

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

Service Consultants

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

Covered Services

The Plan has available for members, at a minimum those core benefits and services specified in the Medicaid Managed Care Organization (MCO) Provider Agreement and as defined in the Louisiana Medicaid State Plan, administrative rules and Department policies and procedure manuals. Appropriate UM professionals perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state or state mental hospitals. The Plan may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Plan operates consistent with all applicable Medicaid Provider Manuals and publications for minimal coverage and guidelines. If new services are added to the Louisiana Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Provider Agreement shall be amended and the Plan given not less than 60 days advance notice of the change. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligible members under the Medicaid State Plan. The Plan will not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member.

Prior Authorization

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

Prior authorization is required for only those procedures and services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness of care review, such as non-emergent inpatient admissions (other than normal newborn deliveries), all out-of-network services and certain outpatient services, and ancillary services as described on the Prior Authorization List. Per the MCO Policy and Procedure Guide, the

Plan may place appropriate limits on a service on the basis of medical necessity or for the purposes of UM (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210. Prior authorization is never required for emergency services or urgent care services.

Centene's Corporate MM Department will review the Prior Authorization List routinely, in conjunction with the Plan's SVP, MA, SVP, CO, and VPMM, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management departments will also be consulted on proposed revisions to the Prior Authorization List. Such decisions will be based on the Plan's program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners will be appropriately notified when such modifications occur.

Clinical Information

For medical services that the Plan has determined shall require prior authorization and/or certification, only the minimally necessary information will be obtained. The information required will not be overly burdensome for the member, the practitioner/staff, or the health care facility staff. Clinical information received, as well as rationale for the medical necessity determination and/or leveling of care shall be documented and maintained in the clinical authorization system.

Referrals

A referral is considered a request to the Plan for authorization of services as listed on the Prior Authorization List. PCPs are not required to issue paper referrals, but are required to direct the member's care and must obtain a prior authorization for referral to certain specialty physicians and all non-emergent out-of-network providers as noted on the Prior Authorization List.

Second Opinions

A second opinion may be requested when there is a question concerning diagnosis or options for surgery or other treatment of a health condition, or when requested by any participant of the member's health care team, including the member, or parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion will be granted to a network practitioner or an out-of-network practitioner, if there is no in-network practitioner available. The second opinion will be provided at no cost to the member.

Extended Specialist Services

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

Out-of-Network Provider

If a member requires services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider will be based on continuity of care,

availability and location of an in-network provider of the same specialty and expertise, and complexity of the case. Network providers are prohibited from making referrals for designated health services to health care entities with which the provider or a member of the provider's family has a financial relationship.

Medical Necessity Review

Covered services are those medically necessary health care services provided to members as outlined in the Plan's contract with the State. Medical necessity means the covered services prescribed are based on generally accepted medical practices in light of conditions at the time of treatment. Medically necessary services are those that are:

- Appropriate and consistent with the diagnosis of the treating practitioner and the omission of which could adversely affect the member's medical condition
- Compatible with the standards of acceptable medical practice in the community
- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms
- Not provided solely for the convenience of the member, the physician, or the facility providing the care
- Not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage
- There must be no other effective and more conservative or substantially less costly treatment, service and setting available
- The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise

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

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

A *Level I review* is conducted on covered benefits by a PA nurse, CCR nurse, or LMHP who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. A Level I review is conducted utilizing applicable clinical and payment policies or McKesson's InterQual® criteria, while taking into consideration the individual member needs and clinical setting at the time of the request, in addition to the local delivery system available for care. At no time shall a Level I review result in a reduction, denial, or termination of service. Adverse determinations can only be made by a Medical Director, or qualified designee, during a Level II review.

A *Level II review* is conducted on a case-by-case basis by an appropriately licensed practitioner or other healthcare professional as appropriate. For instance, if the request is for behavioral health services, a qualified behavioral health practitioner will be consulted during the review. If the request is for dental services, a qualified dental practitioner will conduct the Level II review.

Automatic referral for Level II review includes requests for services or procedures that require review due to not having existing medical necessity criteria, or are potentially experimental or new in practice. A Level II review is also indicated when the request does not meet the existing medical necessity criteria. All Level II reviews shall be conducted with consideration given to continuity of care, individual member needs at the time of the request, and the local delivery system available for care. A board-certified consultant may be used in making a medical necessity determination.

Affirmative Statement about Incentives

All individuals involved in the UM decision making process at the Plan, attest via an Affirmative Statement about Incentives, acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care, and that the Plan shall ensure 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 CFR §438.3(i) and 42 CFR §422.208. Staff must attest to this upon employment and annually thereafter. The Affirmative Statement about Incentives module may be found in the Cornerstone Learning Center (Cornerstone on Demand) - NCQA Affirmative Statements about Incentives. (RFP 8.1.21)

Clinical Criteria

The goals of the UM Program are to optimize members' health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM Program aims to reduce inappropriate and duplicative use of healthcare services and provide services that are a covered benefit, medically necessary, appropriate to the member's condition, rendered in the appropriate setting and meet professionally recognized standards of care. To that end, the clinical decision criteria utilized aligns the interests of the health plan, the practitioner, and the member. The UM criteria are nationally recognized, evidence-based standards of care and include input from recognized medical experts. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. UM criteria are utilized as an objective screening guide and are not intended to be a substitute for physician judgment. UM decisions are made in accordance with currently accepted medical or health care practices, while taking into consideration the individual member needs and complications at the time of the request, in addition to the local delivery system available for care. The Medical Director reviews all potential medical necessity denials for medical appropriateness and is the only one with authority to implement an adverse determination which results in reduction, suspension, denial, or termination of services.

In general, the Plan uses Medical/Clinical policies and McKesson's InterQual® guidelines to determine medical necessity and appropriateness of physical health care. InterQual® is a recognized leader in development of clinical decision support tools. InterQual® is developed by generalist and specialist physicians representing a national panel from academic, as well as community based practice, both within and outside the managed care industry. InterQual® provides a clear, consistent, evidence-based platform for care decisions that promote appropriate use of services, enhance quality, and improve health outcomes. The Plan will use InterQual®'s Level of Care and Care Planning Criteria for Pediatric Acute, Adult Acute, Home Care, Durable Medical Equipment (DME), and appropriate Substance Use Disorder criteria to

determine medical necessity and appropriateness of care. The Plan may also use the sub-acute/skilled nursing guidelines to assist in determining medical necessity for sub-acute or skilled nursing care for members with catastrophic conditions or special health care needs. The Plan will provide the criteria utilized to LDH for written approval annually.

New Technology Review

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

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

Preventive and Clinical Practice Guidelines (CPGs)

While CPGs are not used as criteria for medical necessity determinations, the Medical Director and UM staff will make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines will include, but not be limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Sickle Cell, Immunizations, and ADHD/ADD Guidelines for both adults and children. As detailed in the associated QI policy CP.CPC.03 Preventive Health and Clinical Practice Guidelines, the Plan adopts guidelines from nationally recognized associations or societies. If guidelines are developed internally they are reviewed and approved through the CPC with representation from appropriate board certified specialists. Adopted CPGs are listed on the Plan's public website.

Practitioner Access to Criteria

Treating practitioners may request UM criteria at any time via an exclusive email box dedicated to PA Criteria Requests or pertinent to a specific authorization request by contacting the Plan's MM Department or may discuss the UM decision with the Plan Medical Director. The dedicated PA Criteria Request email box will be monitored 7 days a week including holidays and weekends by UM Management with representation from both Physical and Behavioral staff. Designated staff from both Physical and Behavioral Health will ensure that the correct criteria sets are provided with each response to provider

inquiries via PA Criteria mailbox within 24 hours of receipt of request. In addition, each contracted practitioner will receive a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the MM Department. Members may also request copies of UM criteria or CPGs. Providers can also utilize the Provider Portal to find InterQual® *Smart Sheets* for adult and pediatric procedures, DME, and imaging. *Smart Sheets* offer providers a "smart checklist" customized for each service, including the appropriate procedure code, which allows us to efficiently share key aspects of our criteria with providers and reduce denials due to incorrect or missing information.

Inter-rater Reliability (IRR)

At least annually, and 90 days after initial training is completed for newly hired staff, the SVP, MA and VPMM assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. This mechanism is to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider, as appropriate. The assessment is performed as a periodic review by the VPMM or designee to compare how staff members manage the same case or some manner in which the staff members and physicians evaluate determinations, or may perform periodic audits against criteria. Results are reviewed by the MMC. When an opportunity for improvement is identified through this process, the Plan's MM leadership takes corrective action.

An inter-rater reliability (IRR) assessment is a performance-measurement method used to measure the level of consistency with determining medical necessity needs for members among the Plan's UM staff. Adherence to organizational MM criteria or standards is the goal of the IRR assessment program and determines whether the raters have been consistently trained and are applying that training in a consistent fashion. The analysis is intended to gauge the raters' observations and reactions resulting from a specific situation. All UM licensed review staff undergo annual IRR testing for specific service types.

Communication

Members and practitioners can access UM staff through a toll-free number during normal business hours (Monday through Friday, 8 a.m. to 5 p.m., Central Time**)** for inbound or outbound calls regarding UM issues or questions about the UM process. Inbound and outbound communications may include directly speaking with practitioners and members, or fax, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). After normal business hours and on declared State holidays, calls to the UM department are automatically routed to EPC-NAL**.** EPC-NAL is not a delegated UM entity and therefore does not make authorization decisions. EPC-NAL staff will take authorization information for next business day response by the Plan or notify the Plan on-call nurse in cases requiring immediate response.

The Plan's MM Department is available to coordinate services for members with urgent and emergent care, including ambulance services, to promote timely access to and delivery of necessary health services. As part of the triage process, UM/CM staff may direct the member, as appropriate, to their PCP or Emergency Department (ED). Under no circumstances will the MM

staff offer medical advice. At any time, members may also contact EPC-NAL, the medical triage phone service which provides 24-hour healthcare assistance and advice.

Submission of Clinical Information

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

Significant Lack of Agreement

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

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

Access to Physician Reviewer

The Plan Medical Director or appropriate practitioner reviewer serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Practitioners are notified of availability of an appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Practitioner Orientation, and/or the Practitioner Newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The Plan Medical Director may be contacted by calling the Plan's main toll-free phone number and asking for the Plan Medical Director. A Plan Grievance and Appeals coordinator may also coordinate communication between the Plan Medical Director and requesting practitioner.

Requesting Copies of Medical Records

MM staff does not routinely request copies of medical records on all patients reviewed. During prospective and concurrent ~~telephonic~~ review, copies of medical records will only be required when difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay. In those cases, only the necessary or pertinent sections of the record will be required. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities will be maintained at all times. Unless modified by state statute and/ or federal regulations, health care practitioners will not be reimbursed for the reasonable costs

for providing medical information in writing including copying and transmitting any requested patient records or other documents. Members requesting a copy of the Plan's designated record set will not be charged for the copy.

Sharing Information

The Plan's MM staff will share all clinical and demographic information on individual patients among various divisions (e.g. certification, discharge planning, care management) to avoid duplicate requests for information from members or practitioners.

Practitioner – Member Communication

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

- The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. Any information the member needs in order to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or absence of treatment. The member's right to participate in decisions regarding his or her health care including the right to refuse treatment, and to express preferences about future treatment decisions

Timeliness of UM Decisions

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

For all pre-scheduled services requiring prior authorization, the provider must notify the Plan within seven (7) days prior to the requested service date. Facilities are required to notify the Plan of all inpatient admissions and long-term care facility admissions within one (1) business day following the admission. Prior authorization is never required for emergent care services. Once the member's emergency medical condition is stabilized, notification of hospital admission or authorization for follow-up care is required as stated above. (RFP 8.5.4.2)

The Plan will make determinations for standard, non-urgent, pre-service prior authorization requests within two (2) business days of receiving the needed clinical information, but no later than fourteen (14) calendar days of receipt of the request. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. The Plan will make determinations for urgent concurrent, expedited continued stay and/or post stabilization review within the lesser of two (2) business days (RFP 8.5.1.2) or three (3) calendar days (current NCQA standards) of receiving the request for needed clinical information. The Plan will make determinations for standard, non-urgent, pre-service prior authorization requests within fourteen (14) calendar days of receipt of the request. A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by the Plan. If the request does not meet the definition of urgent

care, the request may be handled as a new request and decided within the timeframe appropriate for the type of decision (i.e., pre-service and post service). (RFP 8.5.1.1 – 8.5.3.2)

Concurrent Review

The concurrent review staff assesses the clinical status of the member, determines the need for continued hospitalization, evaluates for alternative care options, facilitates the implementation of the plan of care, promotes timely delivery of care, and engages in proactive discharge planning. The concurrent review staff determines the appropriateness of treatment rendered, the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

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

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site, via exchange of hard-copy documentation, via remote EMR access, or telephonic. The frequency of reviews are based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity, and are not routinely conducted on a daily basis. If, at any time, services cease to meet inpatient criteria, discharge criteria are met and/or alternative care options exist, the CCR Nurse contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for the case cannot be determined, the case is referred to the Medical Director for review. The need for CM or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-effective alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern will be referred to the Plan QI Department for investigation and resolution.

Provision of an Urgent Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening is initiated if the individual meets one criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from the Plan for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours after the referral and full medical information is received by Plan. The screen to determine appropriate treatment shall be completed within 24 hours of the Plan's referral after the referral and full medical information is received by Plan. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric

hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized. (RFP 8.4.5.3)

Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the Plan shall notify the provider and individual requesting the screen of the results in writing within 48 hours of receipt of the request by the Plan. If denied, the Plan shall notify the individual requesting the screen immediately, and within 48 hours of receipt of the request by the Plan provide written notification of the results to the provider and individual requesting the screen. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so. (RFP 8.4.5.3)

Concurrent utilization reviews are administrative in nature and should not be reported to LDH in encounter data. These reviews are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient psychiatric hospital may be admitted by hospital staff. However, LDH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment. (RFP 8.4.5.2)

Discharge Planning

Discharge planning is a method of coordinating care, managing costs, and arranging for the appropriate services upon discharge from the hospital. For members who have not fully recovered or do not require the highly specialized and intensive services of acute hospital care, discharge planning assists the member in receiving the most timely, appropriate, safe, and cost-effective discharge with additional health care services such as home health care or appropriate placement in an extended care facility.

Discharge planning should occur as early as possible in a member's hospital stay. The CCR Nurse reviews the post-hospital needs of the member with the member, the member's family, and the PCP. The CCR Nurse works with the UM/CM/Discharge Planning staff of the hospital, PCP and managing physician to arrange for services needed before the member is discharged from the hospital, as needed. Community based agencies are included in the discharge planning as appropriate.

Retrospective Review

Retrospective review is an initial medical necessity decision for care or services that have already been provided to a member, but for which authorization or timely notification to the Plan was not obtained due to extenuating circumstances related to the member (i.e. member was unconscious at presentation, member did not have their Medicaid card or otherwise indicated Medicaid coverage, services authorized by another payor who subsequently determined member was not eligible at the time of service). The same medical necessity review process as described above will be used to make the retrospective determination. A decision will be made within thirty (30) calendar days following receipt of all necessary information for any qualifying service, not to exceed 180 days from the date of service**.** (RFP 8.5.3.1)

Emergency Services

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

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

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

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

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

Notice of Action

Upon any adverse determination for medical or behavioral health services made by the Plan Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the requesting practitioner, and the member when applicable. Verbal notification of any adverse determination will also be provided when applicable. All notifications will be provided within the timeframes as noted in LA.UM.05 Timeliness of UM Decisions and Notifications policy. The written notification will be easily understandable and will include the member specific reason/rationale for the determination, specific criteria, and a copy of the criteria used to make the decision; or

instructions on how to obtain a copy housed within the public domain, as well as the availability, process and timeframes for appeal of the decision.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. The Plan Medical Director or appropriate practitioner reviewer serves as the point of contact for the informal reconsideration/peer to peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable and is included in the standard denial letter template. The informal reconsideration must be requested within ten (10) days of the date of the adverse decision letter. It is not a prerequisite, nor does it supersede the member's right to file an appeal.

Appeal of UM Decisions

A request to change or reverse a previous adverse clinical decision is considered an appeal. Appeals may be requested for benefit and/or medical necessity adverse determinations. Value-added services and non-covered services are not subject to appeal and fair hearing rights. A denial of these services will not be considered an action for purposes of grievances and appeals. Members, authorized representatives (with written consent from the member as dictated by State contract), or legal representatives of a deceased member's estate may appeal adverse determinations regarding care. A healthcare practitioner with knowledge of the member's medical condition, acting on behalf of the member and with the member's written consent, may file an appeal. Expedited appeals are available to members for any urgent care requests and do not require written member consent for a healthcare provider to act on the member's behalf. Punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. **(**RFP 13.7.1)

The Plan provides an explanation of the appeals process and the right to a State Fair Hearing of adverse determination to all members upon enrollment and annually thereafter. This process is also explained in the Member Handbook, member newsletters, member educational flyers, adverse determination notifications, and may be posted at network provider offices. All materials are produced in English and are available in additional languages upon request. Members and practitioners, who appeal on behalf of members, are also made aware that once the grievance/appeal process has been exhausted, they may request a State Fair Hearing as defined in the state contract.

Satisfaction with UM Process

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

Behavioral Health Services

The Plan is responsible for providing basic and specialized behavioral health benefits and services to all members as provided in a medical practitioner's office. The Plan strongly supports the integration of both physical and behavioral health services through screening and strengthening prevention/early intervention at the PCP level of care. The Plan does not have a centralized triage and referral process; members accessing care with contracted providers do not require a referral from their PCP nor an assessment. The Plan will assist members with scheduling referred services with appropriate urgency to the applicable care setting and exchange appropriate information with those providers to ensure coordination and continuity of care.

Behavioral Health Levels of Care

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

Acute Psychiatric Inpatient Hospitalization

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

Crisis Stabilization

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

Residential Treatment

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

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

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

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

Mental Health Parity and Addiction Equity Act of (MHPAEA) of 2008
The Plan is committed to compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (45 CFR Parts 146 and 147). The Plan ensures compliance with MHPAEA requiring parity of both quantitative limits (QTLS) applied to Mental Health/Substance Use Disorder benefits and non-quantitative limits (NQTLS). The Plan administers benefits for Substance Use Disorder (SUD) and/or services for mental health conditions as designated and approved by the state-specific contract and Plan benefits. MHPAE does not preempt State law, unless such law limits application of the act. The Plan ensures non-quantitative treatment limitations (NQTL) are applied with a fair and equitable approach that takes into account recognized clinically appropriate standards of care.

Monitoring Over and Under-Utilization
The Plan has in place an ongoing mechanism to reduce inappropriate and duplicative use of health care services. The Plan uses prospective claims review software, post payment claim review software and utilization reporting to monitor for potentially inappropriate or duplicative services including those which may be considered fraud or abuse of the Medicaid Program.

The Plan will report fraud and abuse information identified through the UM Program to LDH's Program Integrity Unit in accordance with 42 CRF §455.1(a)(1).

Predictive Modeling

The Plan will use Impact Pro®, a predictive modeling software to identify and stratify members eligible for CM. Impact Pro uses medical claims data (office, emergency department, outpatient, and inpatient levels of care), pharmaceutical claims data and laboratory reports, updated weekly, to identify and assign a risk score to the Plan's membership. Members may also be identified through additional sources, including, but not limited to: inpatient census reports, health risk screening, data from UM/CM processes, new member welcome calls, member self-referral, and physician referral.

Continuity and Coordination of Services

Coordination of services and benefits is a key function of CM both during inpatient acute episodes of care, as well as for complex or special needs cases. Coordination of care encompasses synchronization of medical, behavioral, social, and financial services and may include management across payor sources. Realizing that Medicaid is always the payor of last resort, the Plan will coordinate benefits with other payors including Medicare, Worker's Compensation, and commercial insurance. in order to maintain access to appropriate services.

Out-of-Network Services

As previously noted above, the Plan will evaluate the need for out-of-network services for the provision of care for which the Plan's network is unable to provide. Members may access any Medicaid provider for emergency services and family planning services regardless of provider's participation in the Plan's network.

Provider Termination

Members will be notified of a PCP termination from the Plan's network or of specialist termination for those members in active treatment with that provider. In order to ensure appropriate continuity and transition of care, the Plan will allow continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred to a network provider without interruption of care, whichever is less. Continuation of care with the terminated provider is allowed under certain circumstances if the provider is not termed due to a quality issue. When a member changes physicians due to termination from network or by member choice, the Plan will assist with transfer of the medical records to the new provider as needed.

Behavioral Health Care Services

The PCP shall provide basic behavioral health services, such as treatment for minor depression and ADHD. The PCP should refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services. In order to ensure continuity and coordination of care for members who appear to need specialized behavioral health services or who may require inpatient/outpatient behavioral care services, the Plan's Integrated Care Team (ICT) will be responsible for referring to the behavioral health team. The Plan will work with members and providers to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health provider.

CARE TRANSITION

The Plan will provide active assistance to members when transitioning into or out of the Plan, including transition to another MCO or other programs. In the event a member entering the Plan is receiving medically necessary covered services at the time of enrollment, the Plan will honor a transition period for continuation/coordination of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The Plan will require prior authorization for continuation of select services as noted on the Prior Authorization List beyond thirty (30) calendar days. The Plan will allow continuation of such medically necessary services without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers during the transition period. During the transition period, the Care Manager will notify the new PCP of member's selection, initiate a request of transfer for the member's medical files, transition medically necessary services to a network provider (if applicable) and all other requirements for new members. Providers are required to send a copy of the member's medical record and supporting documentation, at no charge to the member, to the new PCP within ten (10) business days of receiving the PCP's request. For members in active care transitioning out of the Plan, the Care Manager will communicate active services and coordinate with the receiving entity to ensure a smooth transition without interruption of care.

Pregnant Women

In the event a member entering the Plan is receiving medically necessary covered services in addition to, or other than, prenatal services the day before enrollment into the Plan, the Plan shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The Plan shall provide continuation of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The Plan may require prior authorization for continuation of the services beyond thirty (30) calendar days; however the Plan is prohibited from denying authorization solely on the basis that the provider is non-contract provider**.** (RFP 6.32.1)

In the event a member entering the Plan is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment into the Plan, the Plan shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as the Plan can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health. (RFP 6.32.2)

In the event a member entering the Plan is in her second or third trimester of pregnancy and is receiving medically-necessary covered prenatal care services the day before enrollment into the Plan, the Plan shall be responsible for providing continued access to the prenatal care provider (whether contract or non- contract provider) for sixty (60) days post-partum, provided the member is still eligible for Medicaid, or referral to a safety net provider if the member's eligibility terminates before the end of the post-partum period. (RFP 6.32.3)

Continuity for DME, Prosthetics, Orthotics, and Supplies
In the event a Medicaid member entering the Plan is receiving Medicaid covered DME, prosthetics, orthotics, and certain supplies and services, whether such services were provided by another MCO or Medicaid fee-for-service, the Plan will be responsible for the costs of continuation of these services, without any form of prior approval and without regard to whether such services are being provided by contract or noncontract providers. The Plan will provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The Plan will also honor any prior authorization for DME, prosthetics, orthotics and certain supplies and services issued while the member was enrolled in another MCO or the Medicaid fee-for-service program for a period of ninety (90) calendar days after the member's enrollment in the Plan. **(**RFP 6.37)

Measuring Effectiveness
Effectiveness of UM Program will be measured, at minimum, on an annual basis. Methods of evaluation include the following, but not limited to:

- Utilization data, such as frequency of ED visits or inpatient admissions
- Self-reported member and provider information such as satisfaction (CAHPS) with the program, level of understanding of the communication process with providers.
- Turn Around Times for Decision/Determination Notification
- Denial Overturn Rate (% of denials overturned on appeal)

This measurement and analysis will be documented as part of the annual UM Program Evaluation.

PROGRAM EVALUATION

The UM Program will be evaluated at least annually, and modifications made as necessary. The SVP, MA, SVP, CO, and VPMM will evaluate the impact of the UM Program by using:

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

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

DELEGATION

The Plan may elect to delegate various UM activities to entities that demonstrate the ability to meet the Plan's UM standards and standards for delegation, as outlined in the UM Program and policies and procedures. The Plan conducts ongoing oversight and annual review of each

delegate's UM Program as outlined in LA.UM.15 Oversight of Delegated UM policy. Delegation is dependent upon the following factors:

- A pre-delegation review is necessary to determine the ability to accept delegation. Once the delegate is determined to be capable of fulfilling the responsibilities of delegation, a Delegation Agreement is executed with the organization to which the UM activities have been delegated, clarifying the responsibilities of the delegated group and the Plan. This agreement will specify the standards of performance to which the contracted group has agreed
- The delegated group must conform to the Plan's UM standards; including timeframes outlined in the Plan's policy and procedure LA.UM.05 Timeliness of UM Decisions and Notifications
- The delegated group is responsible for providing the Plan with a written UM Program Description/Plan for annual review and approval by the Plan's QAPIC
- The delegated group is responsible for submitting utilization reports, to include monthly utilization summaries, days, and quality assurance/improvement issues

The Plan retains accountability for any functions and services delegated and, will monitor the performance of the delegated entity through the following vehicles;

- Annual approval of the delegate's UM Program (or portions of the program that are delegated), as well as any significant program changes that occur in between
- Routine reporting of key performance metrics that are required and/or developed by Plan's Delegated Vendor Oversight Department and the Utilization Management Committee
- Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to Plan standards and state program requirements

The Health Plan retains the right to reclaim the responsibility for performance of delegated functions, at any time, if the delegate is not performing adequately.

24-Hour Nurse Triage Line

Management of a 24-Hour Nurse Advice line is the responsibility of EPC-NAL. The following activities as further clarified and defined have been assigned to EPC-NAL:

- 24-hour nurse advice and emergency triage
- After-Hours/Emergency outage member and provider services hotline
- Select outbound member call campaigns
- Access to MM administrative "on-call" staff for urgent/emergent authorization needs

Complex Imaging/Outpatient Therapy Services

Medical necessity review for select complex imaging services and outpatient and home health physical, occupational and speech therapy has been delegated to Magellan Healthcare-National Imaging Associates (NIA). The following activities, as related to these benefits and as further defined in the associated delegation agreement, have been delegated to Magellan Healthcare (NIA).

- Select Utilization Management Services

Vision Care Services

Management of routine vision care services is delegated to Envolve Vision. The following activities, as further clarified and defined in the associated delegation agreement, have been delegated to Envolve Vision:

- Benefit management
- Provider network development and maintenance
- Credentialing and re-credentialing
- Claims processing and payment

Pharmacy Program

Centene Corporation is a fully integrated government services managed care company with health plans in several states, including the Plan. Due to differences in state regulations, Centene's Board of Directors delegates responsibility to the Plan President/CEO who coordinates the provision of pharmacy services with Centene's contracted pharmacy benefit manager (PBM), Envolve Pharmacy Solutions**.** In turn, Envolve Pharmacy Solutions is contractually responsible for implementing Centene's Pharmacy Program including benefit design, the Preferred Drug List (PDL), drug utilization review (DUR), the prior authorization (PA) process, pharmacy network management, pharmacy help desk, customer service functions, clinical reviews, and reporting. Pharmacy claims are adjudicated through the CVS platform.

The Pharmacy Program applies to all Plan members eligible to receive the pharmacy benefit. The scope of the program is to:

- Ensure that pharmacy benefit services provided are medically necessary
- Promote safe and cost-effective drug therapy
- Manage pharmacy benefit resources effectively and efficiently while ensuring that quality care is provided
- Ensure that members can easily access prescription services
- Actively monitor utilization to guard against over-utilization of services and fraud or abuse