WESTERN HEALTH ADVANTAGE

Utilization Management Program Description

(Includes Complex Case Management Program Overview)

2018

UM Committee:

Approval Date:

QI Committee:

Approval Date:

Board of Directors:

Approval Date:

Gary Plundo, DO, Medical Director UMC Chairperson

Don Hufford, MD, CMO/Medical Director QIC Chairperson

Previous UM Program Approval Dates:

Year	Group	Date
1998	UM & QI Committees Board of Directors	March 11, 1998 March 24, 1998
1999	UM & QI Committees Board of Directors	May 19, 1999 May 25, 1999
2000	UM & QI Committees Board of Directors	July 18, 2000 July 25, 2000
2001	UM & QI Committees Board of Directors	July 17, 2001 July 26, 2001
2002	UM & QI Committees Board of Directors	July 16, 2002 July 23, 2002
2003	UM & QI Committees Board of Directors	April 23, 2003 May 27, 2003
2004	UM & QI Committees Board of Directors	April 28, 2004 May 25, 2004
2005	UM & QI Committees Board of Directors	April 27, 2005 May 24, 2005
2006	UM & QI Committees Board of Directors	April 26, 2006 May 18, 2006
2007	UM & QI Committees Board of Directors	April 25, 2007 May 22, 2007
2008	UM & QI Committees Board of Directors	April 23, 2008 June 24, 2008
2009	UM & QI Committees Board of Directors	January 25, 2009 June 25, 2009
2010	UM & QI Committees Board of Directors	March 24, 2010 June 22, 2010
2011	UM & QI Committees Board of Directors	February 23, 2011 June 30, 2011
2012	UM & QI Committees Board of Directors	April 25, 2012 June 28, 2012

2013	UM & QI Committees	March 27, 2013
	Board of Directors	June 28, 2013
2014	UM & Quality Committees	March 26, 2014
	Board of Directors	June 23, 2014
2015	UM & Quality Committees	March 25, 2015
	Board of Directors	August 26, 2015
2016	UM & Quality Committees	March 23, 2016
	Board of Directors	August 31, 2016
2017	UM & Quality Committees	March 22, 2017
	Board of Directors	June 26, 2017
2018	UM & Quality Committees	March 28, 2018
	Board of Directors	

TABLE OF CONTENTS

1.0 Introduction

Western Health Advantage (WHA) is a state licensed health maintenance organization (HMO) that was incorporated in the state of California in 1995 as a taxable not for profit mutual benefit corporation. In 2015, WHA changed to a California nonprofit public benefit corporation. Dignity/Mercy Healthcare of Sacramento~~,~~ and NorthBay Health ~~System and the University of California Davis Health System (UCD)~~ are WHA's sponsors. WHA is licensed for commercial and exchange members in the following California counties: Sacramento, Yolo, Solano, Napa, Marin, Sonoma, Colusa, El Dorado, San Francisco, San Mateo, Contra Costa, Alameda and western Placer.

WHA uses a mixed model for service delivery and holds contracts with hospitals, multi-specialty physician medical groups and IPAs. Through its network of primary and specialty care practitioners, mental health practitioners/clinicians, hospitals, and ancillary care providers, WHA offers comprehensive and accessible health care services that encompass acute and chronic conditions of physical and/or mental origin, health promotion and wellness services, preventive health care, 24/7 nurse advice line (NAL) services, case management services, and comprehensive disease management programs.

WHA delegates Utilization Management (UM) functions related to the provision of health care services to its contracted medical groups/IPAs. The following UM functions are not delegated: out-of-network urgent care and emergency services, related hospital admissions, non-network second opinions, transplants, appeals, clinical trials, specialty pharmacy and experimental treatment requests.

WHA delegates both routine and Complex Case Management (CCM) program functions and services to its contracted medical groups/IPAs, however WHA retains responsibility at the plan level for meeting NCQA's CCM member satisfaction requirements.

Magellan/Human Affairs International of California (HAI-CA), a subsidiary of Magellan Health Services and an NCQA Accredited Managed Behavioral Health Organization (MBHO), has provided mental health and substance abuse services to WHA members since July 2001. (In January 2008, behavioral health (BH) services for UCD employees were carved out by the employer and are currently managed by OptumHealth™). Management of member grievances and first level appeals related to behavioral health are delegated to Magellan/HAI CA.

Chiropractic and acupuncture services are provided to WHA members by Landmark Healthcare, Inc., a nationally recognized Chiropractic IPA which is currently certified by NCQA for Utilization Management under its parent company, CareCore National, LLC. WHA delegates UM functions related to the provision of chiropractic and acupuncture services to Landmark.

Express Scripts®, WHA's Pharmacy Benefits Manager (PBM), has been delegated UM functions related to the administration of specific pharmacy benefits, with the exception of specialty drug authorization review and member and provider appeals related to pharmacy benefit issues. (January 2018, pharmacy benefits for CalPERS members are carved out to Optum Pharmacy by the employer group) Express Scripts® is currently certified by NCQA for Utilization Management.

Western Health Advantage has developed a comprehensive UM Program that provides a framework for monitoring the use of services, evaluating the appropriateness of care and resources, and overseeing delegated UM/CM activities to ensure compliance with contract requirements and WHA policies. The UM Program is also designed to ensure that utilization issues are identified, addressed, documented and resolved in a consistent and timely manner, compliant with all regulatory, accreditation and legislative requirements of the Department of Managed Health Care (DMHC) and the National Committee for Quality Assurance (NCQA). A designated senior physician/practitioner is actively involved in the implementation of the UM Program for both medical and BH health aspects.

WHA aims to improve health outcomes and member satisfaction through collaborative relationships with its contracted providers, Quality Improvement (QI) activities, and leveraging best practices throughout its delivery network. NCQA awarded WHA a three-year accreditation in ~~Dec~~November 2017~~4~~. WHA's current NCQA accreditation status is ranked "*Commendable*." In addition, NCQA awarded WHA an Exchange-HMO accreditation status ranked "*Accredited*" in ~~Dec~~November 2017~~4~~ and this remains the current status.

WHA does not differentiate between its commercial and exchange members when administering functions. For example, policies, procedures, processes, staff and reporting structures are developed without distinction between product lines.

2.0 Purpose

The purpose of WHA's UM Program is to ensure that all WHA members have unrestricted access to medically necessary, appropriate and timely care and services throughout the health care delivery system. The UM Program promotes consistent, objective coverage determinations and ensures that timely and appropriate healthcare services are provided when needed, in the appropriate setting, and by appropriately qualified health care professionals who consistently follow accepted standards of medical and/or behavioral health practices.

3.1 Scope

The UM Program applies to all network providers who offer services to WHA members and who make UM decisions affecting those members.

The UM Program's scope includes, but is not limited to monitoring and evaluating the services provided in inpatient/acute care hospitals, home care, skilled nursing facilities, sub-acute facilities and ambulatory settings. UM Program functions include, but are not limited to the following activities:

- Ensures compliance with accreditation and regulatory requirements related to UM Program functions;
- Monitors prior-authorization decisions for appropriateness, medical necessity and timeliness;
- Ensures consistency of UM decision-making across the healthcare delivery system;
- Establishes and maintains clinical criteria for UM decision-making and ensures that appropriate licensed professionals are involved in making authorization and appeal decisions;

- Evaluates and addresses new technology for benefit inclusion;
- Maintains member and practitioner appeals process;
- Coordinates the external review process;
- Collaborates with discharge planners and assists with follow-up services;
- Provides continuity and transition of care services;
- Coordinates referrals throughout the continuum of care;
- Measures satisfaction with UM processes and CM/CCM programs;
- Monitors the utilization of services; and
- Conducts oversight of delegated UM and CM/CCM functions.

4.0 Benefit Coverage & Medical Necessity Determinations

WHA has several different health plan options offered to its individual members, exchange population, and employer group enrollees. Authorization decisions related to covered benefits that do not involve medical necessity decisions are based on the member's purchased health plan coverage options, which vary. Specifics for each member's selected health plan are described in their Evidence of Coverage (EOC) & Disclosure documents, along with their own copayment benefit summaries. All of WHA's plans, EOCs and copayment summaries are approved by the Department of Managed Health Care (DMHC), which is responsible for HMO licensure in the state of California. These documents are provided in new member packets, are sent to members upon request, and are available to view and/or download at any time on WHA's website.

Medical Necessity authorization determinations are reviewed by board certified medical/BH professionals on an individual case-by-case basis, taking into consideration the member's health/BH condition, needs, circumstances, covered benefits, eligibility status, medical records, provider recommendations, and other available pertinent information. Medical necessity decisions for requested services are made in part through the use of nationally recognized, evidence based review criteria, based on local and national standards of care, and relying on other professional guidelines developed by board certified, qualified medical and/or BH care professionals. Independent reviews are requested when specific expertise is needed from a board certified qualified specialist in a particular field, relevant to the requested service, to ensure that up-to-date, unbiased expert opinions are considered in the decision-making process.

5.1 Goals and Objectives

The overall goal of WHA's UM Program is to ensure the provision of appropriate, quality and cost-effective healthcare services for all WHA members. Services are to be provided in a manner consistent with all regulatory and contractual requirements and per accepted medical/behavioral healthcare policies and standards of practice. Ongoing, systematic monitoring, evaluation and reporting of provided services are carried out by UM and QI staff at both the corporate and delegated entity levels to ensure these goals are continuously being met or improved upon.

WHA's UM Program is integrated into the QI program to ensure continuous quality improvement as it relates to the quality of medical and BH care services provided to WHA members. To meet the goals of the UM Program, the objectives include, but are not limited to the following:

A. Maintain Well-functioning UM Program by:

- prioritizing and implementing UM initiatives and routinely measuring UM Program effectiveness;
- collaborating with provider network/practitioners and medical group staff;
- maintaining effective ongoing monitoring and oversight of delegated UM functions;
- identifying potential quality issues (PQIs) and reporting them to QI staff for appropriate, timely improvement interventions;
- communicating oversight audit results, including recommendations for improvement, to contracted groups and appropriate oversight committees;
- ensuring timely and appropriate corrective actions when deficiencies are noted; and
- developing opportunities for licensed staff to achieve and/or maintain certification credentials and obtain further education to promote consistency in the application of UM processes for coverage determinations.

B. Monitor Systems Impacting Delivery of Care by:

- analyzing UM indicators and comparing them against performance goals/standards and recognized benchmarks to identify outliers;
- assuring mechanisms are in place to aggregate utilization data to identify, monitor and evaluate trends, aberrant practice patterns (i.e., referrals, use of resources, over- & underutilization, etc.) and other practice/usage patterns, and recommending changes as indicated to improve outcomes;
- overseeing compliance with complex case management requirements through audits, reports and provision of appropriate feedback for improvements;
- seeking to identify best practices used in care delivery throughout the provider network, and ensuring services consistent with accepted standards of practice within the national and local medical community; and
- monitoring compliance and consistency of updated medical necessity UM criteria and practice guidelines in use.

C. Evaluate Systems that Provide Equitable Access to Care Across the Network by:

- promoting member access to medical and behavioral health services at the most appropriate and least restrictive level of care;
- monitoring member access to, and provider availability for care;
- care managing out-of-network emergency admissions;
- monitoring complex case management program elements and interventions;
- promoting timely and appropriate referrals to specialty care; and,
- enhancing processes that address both over- and underutilization of services.

D. Strengthen WHA's Involvement in the Area of New Technology Assessment by:

- providing mechanisms to evaluate and review new, investigational or experimental technology requests in accordance with WHA's policies and procedures (P&Ps) and

legislative requirements;

- providing a mechanism and process for reviewing such requests by an outside review entity, which uses appropriately qualified Board Certified specialty physician reviewers; and
- ensuring that new technologies considered by experts as meeting current acceptable standards of practice are included in benefit provisions.

E. Evaluate the Effectiveness of the Member Appeal Process by:

- monitoring overturn rates at the group level to determine appropriateness of initial denial decisions made by delegated entities; and
- monitoring appeal decision-making process and timeliness to ensure ongoing regulatory compliance.

F. Promote Initiatives of Individual and Population-based Case Management and Disease Management Programs by:

- enhancing systems and processes to identify at-risk populations for potentially preventable complications (i.e., enhancing opportunities to allow integration of the UM/CM and Care/Disease Management Programs to provide quality and cost-effective care across the continuum);
- overseeing delegated Case Management activities;
- facilitating education and wellness opportunities for members; and
- facilitating outreach activities associated with QI study initiatives.

G. Evaluate Perception of UM-related Functions & Develop Improvement Processes by:

- reviewing and evaluating responses to member experience and provider satisfaction surveys related to UM functions, and implementing processes for improvement when opportunities are identified and when positive changes can occur;
- evaluating group level experience (satisfaction) surveys for members who receive(d) complex case management assistance; and
- using member complaints/grievance and appeal data to evaluate experience (satisfaction) with UM processes, then identifying/implementing improvement interventions as identified.

6.1 UM Program Documents

A. UM Program Description

WHA's written UM Program Description is revised and updated annually based on the findings from the annual UM Program Evaluation. The UM Program Description, which is approved annually by the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC), describes the goals, scope, structure, and functional components of the UM Program.

B. UM Program Evaluation

WHA's UM Program is evaluated annually and is used for the development of WHA's UM Work Plan for the following year, and for identifying and prioritizing opportunities for improvement. Findings from the evaluation are also used to identify the need for revisions to the UM Program Description. The UM Program Evaluation is reviewed and approved annually by WHA's UMC and QIC.

C. UM Work Plan

The UM Work Plan is developed annually with input from WHA's UMC and QIC membership. The UM Work Plan outlines key UM activities that address UM Program goals and objectives and required regulatory and accreditation activities. The UM Work Plan is a dynamic document that is revised and updated as appropriate and states timeframes for completing activities and the person(s) responsible. The UM Work Plan is reviewed and approved by WHA's UMC and QIC.

7.0 Authority, Accountability and Responsibility

WHA's Board of Directors has ultimate authority, accountability and responsibility for WHA's UM Program. The Board has formally delegated the day-to-day operations of the UM Program to the UMC and to WHA's Chief Medical Officer (CMO). WHA's CEO and Senior Staff Team are responsible for assuring execution of WHA's UM Program responsibilities and the active participation of WHA's contracted medical groups/IPAs in UM Program activities.

8.1 Utilization Management Committee

WHA's UMC is a sub-committee of WHA's Quality Improvement Committee and is chaired by WHA's Medical Director. The UMC's membership is comprised of a multidisciplinary team of medical and behavioral health practitioners, along with key management staff. The committee has the authority, accountability and responsibility for WHA's UM Program, including the UM functions that have been delegated. The UMC meets at least ten (10) times per year and reports to the QIC quarterly. A quorum must be present at each meeting, which is currently defined as the presence of at least four (4) physicians and 50% plus one of the non-physician standing members. Practitioners are the only committee members with voting privileges, but others may offer opinions and recommendations. The committee chair may call additional meetings as needed.

Behavioral Healthcare - CMO UM Program Involvement

The HAI-CA/Magellan Chief Medical Officer (CMO) is a regular participant and voting member of WHA's UM, QI and Credentialing committees. The CMO is a licensed, board certified psychiatrist, and as the senior level practitioner for Magellan, is primarily responsible for the implementation of all the BH aspects of WHA's UM Program, including but not limited to the following activities:

- UM program implementation (triage and referral process)
- Evaluation of BH care service sites, levels of care, practitioner quality
- BH new technology assessment

- UM case reviews/authorizations
- Continuity/coordination/integration of care (med/BH comorbidities)
- Policy development
- Provider/member education (through newsletter articles)
- Peer education (onsite presentations/webinars)

A. UMC Responsibilities and Functions:

- Annual review and approval of WHA's UM Program Description, Evaluation, and Work Plan and the UM Programs/Work Plans of UM delegates
- Review and approve WHA's UM policies/procedures
- Oversee the appeal process including rendering appeal decisions and analysis of delegate appeal activity reports
- Review and approve the UM criteria used to assess medical necessity
- Annual approval of WHA's board certified consultants
- Evaluate physician practice patterns to assess over/under utilization of services
- Review UM trends and develop strategies to reduce adverse outcomes
- Develop indicators/thresholds for quality of care/service related to UM functions
- Review new technology procedures and new applications of existing technologies for inclusion in WHA's benefit package; approve/deny requests for new technologies
- Communicate standards, policies/procedures, and guidelines to providers, members and staff
- Review delegation oversight findings including CCM; request corrective action plans as needed
- Analyze member and provider satisfaction with the UM process
- Ensure regulatory and NCQA accreditation compliance as they relate to UM and CM/CCM functions
- Report UMC activities and the results of monitoring/oversight activities to QIC quarterly.

B. UMC Membership:

WHA's UMC membership includes the following:

- WHA's Medical Director, *Chairperson*
- WHA's Chief Medical Officer (CMO)
- WHA's Assistant Medical Director
- Medical Directors or other physician representatives from contracted Medical Groups/IPAs representing both primary and specialty care
- Magellan's Behavioral Health Medical Director
- WHA's Clinical Resources Manager
- WHA's Quality and Accreditation Manager
- WHA's Clinical Quality Manager
- WHA's QI Coordinator
- WHA'S Quality and Accreditation Coordinator
- WHA's Manager, Health Promotion and Disease Management
- WHA's ~~Clinical Pharmacist~~Pharmacy Director (quarterly and as needed)

- WHA's Manager of Member Services (quarterly)
- WHA's Manager of Member Relations (quarterly)
- WHA's Client Services Director
- WHA's Compliance/Legal representative (annually and as needed)
- QI/UM Managers from contracted Medical Groups/IPAs (ad hoc)
- Specialty guest physicians in those instances where committee physicians lack the required specialization/expertise to formulate a decision

9.1 UM Program Resources

A. Data Resources

WHA systematically collects, organizes and analyzes data. Data is used to assess the status of UM Program activities, to determine future improvement interventions and to meet regulatory and accreditation reporting requirements.

WHA uses the following health information/data systems to support and carryout UM Program activities:

- Facets (Trizetto)
- Salesforce
- Verscend (formerly Verisk Health) (*Medical Intelligence)* - predictive modeling
- Health Scape (risk adjustment software)
- WHA's data warehouse

The summary of information obtained from these multiple data sources results in a variety of reports created by WHA. The reports are then used to monitor a wide array of performance indicators, including those used to detect over- and underutilization of healthcare services and perform population assessments for complex case management.

The following data sources are derived from the systems mentioned above:

- Encounter and claims data
- Demographic and enrollment data;
- Pharmacy data
- Provider/member appeal and grievance data
- Provider and member satisfaction survey data
- Medical record review findings
- HEDIS outcomes
- Access and Availability audit results
- Referral, authorization and denial data (medical and BH);
- Admission/discharge data
- Contracted medical group/IPA UM semi-annual reports and annual program evaluations
- Delegation oversight audits/CAP results
- Authorization and denial (referral) tracking logs

- Nurse Advice Line data
- DM Program data
- Health Assessments (HA) results data
- Other reports unique to UM (i.e., reinsurance, indicators, etc.)

B. Staff Resources

WHA Personnel Resources for UM	FTE's
CMO	1.0
Medical Director	1.0
Assistant Medical Directors	0.3
Pharmacy Director	1.0
Clinical Pharmacist	1.0
Clinical Resources Manager	1.0
Clinical Resources Nurse	~~2.5~~3.0
Clinical Resources Pharmacy Tech Coordinator	1.0
Clinical Resources Intake Supervisor	1.0
Clinical Resources Intake Coordinator I	~~2~~4.0
Quality Management Manager	1.0 (collaborates)

1. WHA's Chief Medical Officer (CMO)

WHA's Chief Medical Officer, a currently licensed board-certified physician in the state of California (without restrictions), is responsible for providing day-to-day leadership to the UM Program.

Key UM Program Responsibilities:

- Ensures that delegation oversight activities are appropriately carried out;
- Ensures Medical Management Department readiness for regulatory and accreditation surveys;
- Participates in the development and sponsorship of UM Program documents;
- Participates in the development and interpretation of health plan benefits;
- Reviews and analyzes utilization data and reports over- and underutilization of services and provides practitioner feedback when appropriate;
- Chairs and/or appoints chairpersons for the UM Committee;
- Serves in an advisory/consultative capacity to WHA's Medical Management staff and the Plan's contracted groups;
- Performs individual clinical case review of grievances, appeals, out-of-area claims, medical necessity denials/modifications, and potential quality issues as needed;
- Participates in community advisory committees and coalitions; and
- Participates on Magellan's UM Committee.

2. WHA's Medical Director

WHA's Medical Director, a currently licensed board-certified physician in the state of California (without restrictions), is responsible for providing day-to-day leadership to the UM Program.

Key UM Program Responsibilities:

- In coordination with the CMO, ensures that delegation oversight activities are appropriately carried out;
- In coordination with the CMO, ensures Medical Management Department readiness for regulatory and accreditation surveys;
- Participates in the development and sponsorship of UM Program documents;
- Participates in the development and interpretation of health plan benefits;
- Reviews and analyzes utilization data and reports over- and underutilization of services and provides practitioner feedback when appropriate;
- Chairs and/or appoints chairpersons for the UM Committee;
- Serves in an advisory/consultative capacity to WHA's Medical Management staff and the Plan's contracted groups;
- Performs individual clinical case review of grievances, appeals, out-of-area claims, medical necessity denials/modifications, and potential quality issues as needed;
- Participates in community advisory committees and coalitions; and
- Participates on Magellan's UM Committee.

3. WHA's Assistant Medical Director

The Assistant Medical Director (AMD) is a CA-licensed physician who provides back-up support to WHA's Chief Medical Officer to whom he reports and the Medical Director. The AMD woks with the Medical Director to review special medical care and treatment requests, assist with out-of-network hospital transfers, and perform retrospective care/claims review. He also assists with appeals review along with the Medical Director and Chief Medical Officer, and chairs the UM, QI and Credentialing Committees when the Medical Director and CMO are not available.

4. WHA's Pharmacy Director

WHA's Pharmacy Director, a currently licensed pharmacist in the state of California (without restrictions), is responsible for providing day-to-day leadership to the Pharmacy UM Program.

Key UM Program Responsibilities:

- The Clinical Pharmacist chairs the P&T Committee, manages specialty pharmacy authorizations, serves as the clinical interface with ESI and provides prescription drug informational support to WHA.
- Participates in oversight activities related to ESI delegation;
- Participates in Medical Management Department readiness activities for regulatory and accreditation surveys;
- Participates in the development and sponsorship of Pharmacy Program documents;
- Participates in the development and interpretation of health plan pharmacy benefits;
- Reviews and analyzes pharmacy utilization data and provides practitioner feedback when appropriate;
- Serves in an advisory/consultative capacity to WHA's Medical Management staff and the Plan's contracted groups related to pharmaceutical matters;

- Participates in individual clinical case review of pharmacy related grievances and appeals as needed;
- Participates in community advisory committees and coalitions;

5. WHA's Clinical Pharmacist

The Clinical Pharmacist is a CA-licensed clinical pharmacist who reports to WHA's Pharmacy Director. The Clinical Pharmacist participates in P&T Committee, manages specialty pharmacy authorizations, serves as ~~the~~ a clinical interface with ESI and provides prescription drug informational support to WHA. Participates in individual clinical case review of pharmacy related grievances and appeals as needed

6. WHA's Clinical Resources Manager

WHA's Clinical Resource Manager is a full-time, CA licensed registered nurse (RN) with relevant supervisory, clinical, quality and managed care experience. The Clinical Resource Manager is responsible for WHA's UM and CM/CCM program documents, policies, operations, reports, healthcare utilization management, benefit interpretation, and oversight of delegated UM and CM/CCM functions.

Key Performance Responsibilities:

- Carryout UM Program activities related to the administration of the authorization/denial processes, inter-rater reliability testing, new technology assessment, and the monitoring of over- and underutilization of services;
- Collaborate with network UM and CM/CCM staff regarding delegated functions and provide education related to current regulatory and accreditation UM requirements;
- Carryout appropriate, timely UM/CCM delegation oversight audits and activities;
- Oversee member and provider appeal process;
- Facilitate transition of care services and manage out-of-network ER admissions;
- Participate in Magellan's quarterly BH Public Policy Committee meetings;
- Participate in WHA's monthly UM and QI Committees and report on UM/CM activities/outcomes; and
- Develop, implement, and monitor corrective action plans when contracted entities fail to meet required standards.

7. WHA's Clinical Resources Nurse

The Clinical Resources Nurse (CRN) is a full-time experienced CA licensed registered nurse (RN). The CRN has a minimum of 3 - 5 years' clinical experience, with UM/CM experience in a managed care setting and/or discharge planning or commensurate expertise. The CRN is supervised by the Clinical Resources Manager and works closely with WHA's Clinical Review team of physicians and pharmacists.

Key Performance Responsibilities:

- Perform concurrent review of out-of-area emergency hospital admissions and urgent care services;

- Coordinate patient transfers from out-of-area hospitals to in-network facilities;
- Provide assistance to delegated medical group/IPA UM/CM staff and to WHA's Member Services staff with benefit interpretation;
- Coordinate referrals;
- Provide continuity/coordination of care and transition of care services;
- Process Experimental/New Technology , transplant and clinical trial, out-of-area second opinion and other plan level request
- Identify and refer appropriate cases to medical groups for Case Management assistance;
- Assist Clinical Resource Manager with annual group UM/CM Delegation Oversight audits;
- Assist with delegation improvement activities
- Assist with regulatory and NCQA accreditation audits/surveys, as needed

8. Clinical Resources Pharmacy Tech Coordinator

The Clinical Resource Pharmacy Tech Coordinator (CRPTC) is a full time trained pharmacy technician who reports to WHA's Clinical Resources Manager. The CRPTC works closely with the clinical pharmacists to review all incoming pharmacy requests, drafts denial letters based on pharmacist reviews and ensures appropriate provider and member notification after completion of authorization reviews. Assists the Pharmacy Director with preparations and serves as the scribe for P&T Committee and assists with Preferred Drug List up-dates. Participates in preparations for case review of pharmacy related grievances and appeals as needed.

9. WHA's Clinical Resources Intake Supervisor

The CR Supervisor (CR~~I~~S) assists the Clinical Resources Manager and review staff with Plan level health care referrals, ~~and~~ continuity of care and transition of care requests. The CR~~I~~S also oversees and delegates tasks to the CR Intake Coordinators and serves as team leader for day-to-day CR operations, including performing internal file audits to ensure compliance with review turnaround times and decision notifications.

10. WHA's Clinical Resources Intake Coordinator

The CR Intake Coordinator is primarily responsible for tracking and closing Plan level case files, managing incoming faxes, sending notifications of decisions to requesting parties and performing numerous other clerical duties required of a CR team member. This position also assists the CR Intake Supervisor with other administrative functions as needed.

10.1 UM Program Components

A. Clinical Criteria for UM Decisions

WHA and group UM/CM staff use specific utilization review criteria to evaluate medical or BH services for necessity. These criteria may include InterQual, MCG® (formerly Milliman Care Guidelines), Optum's *Complete Guide to Medicare Issues*, Hayes *New Technology Assessment and Experimental Treatment Guidelines* by IMedecs, Informed DNA Genetic Testing UM Guidelines, and UpToDate® decision support resources. These are objective,

evidence-based criteria developed by qualified medical professionals/practitioners with clinical expertise in their respective field. WHA's contracted NCQA Accredited MBHO, Magellan, uses its own medical necessity criteria, which are developed internally and approved for use based on required standards set by NCQA, the American Psychiatric Association, and state/federal regulatory bodies.

All criteria used for medical or behavioral health medical necessity decisions by WHA and its contracted agents, are reviewed and approved for initial and continuing use at least annually by the entities' appropriate committee(s) and by WHA's UM Committee. UMC participants involved in the internal development, review, approval and application of medical necessity criteria include actively practicing physicians and other practitioners with relevant health care expertise.

A brief description and examples/excerpts of the medical necessity criteria used by WHA and its delegates are available to physicians and members on WHA's website (www.westernhealth.com). Specific criteria used to make adverse medical necessity decisions are also cited in all member/provider notification letters, described in enrollment materials and WHA's Provider Manual, and made available upon request. When a referral is denied as a non-covered benefit, appropriate exclusion benefit language from the member's *Combined Evidence of Coverage and Disclosure Form* booklet is cited in notification letters to ensure a clear understanding of the reason for the adverse decision.

WHA and medical groups' clinical reviewers who make authorization decisions (physicians and nurses) must participate in routine inter-rater reliability (IRR) testing (initially upon hire and at least annually thereafter), to ensure consistency of decision-making among their peers. WHA's contracted medical groups/IPAs may also conduct regular file audits to ensure ongoing consistency and appropriateness of decisions. WHA monitors the groups' IRR test results as part of its annual oversight audit responsibilities and ensures implementation of appropriate improvement interventions if noncompliance is identified. In addition, WHA conducts IRR testing of its clinical reviewers including physicians, pharmacists and nurses at least annually to ensure consistency of Plan level decisions. Furthermore, periodic review of denial letters and referral tracking logs from contracted groups/entities also provides WHA's oversight staff with current information about the consistency of UM decisions made by its delegated entities.

B. Medical Necessity / Authorization Services

1. Appropriate Professionals

WHA and its contracted medical groups/IPAs must ensure compliance with the following UM practices when making medical necessity decisions:

- Specify the type of personnel responsible for each level of UM decision making;
- Use appropriately licensed professionals to supervise all medical necessity decisions;
- Ensure qualified licensed health professionals assess the clinical information used to support UM decisions;
- Ensure that a physician or other health care professional, as appropriate, reviews any non-behavioral healthcare denial based on medical necessity;

- Use psychiatrists, doctoral level clinical psychologists, or certified additional medical specialists to review any denial of BH that is based on medical necessity;
- Consult with board-certified physicians from appropriate specialty areas to assist in making medical necessity decisions determinations; and
- Distribute "Affirmative Statement" about incentives and potential conflicts of interest to all WHA network providers, practitioners and employees who make UM decisions.

2. Timeliness of UM Decisions

WHA and its delegated medical groups/IPAs follow DMHC turnaround timeliness standards for completing reviews, making coverage determinations and issuing notification letters. Generally, timeframes for making UM decisions are as follows:

- ***Precertification of Non-urgent Care*** (Decision) – Goal is to make decisions within 2 business days of obtaining all necessary information (CA regulations allow 5 business days)
- ***Precertification of Non-urgent Care*** (Initial Notification) – Must notify practitioners of decision within 24 hours of decision (phone, fax) and document notification.
- ***Precertification of Non-urgent Care*** (Written Notification) – Following initial notification, send written notification to member and MD within 2 business days of initial decision.
- ***Precertification of Urgent Care*** – Goal is to make decision and notify MD/group and member of decision within 24 hours (phone, fax). CA regulations allow up to 72 hours to process urgent authorization requests; timing depends on urgency of the case.
- ***Precertification of Urgent Care Resulting in Denial*** (Initial Notification) – Notify member and MD how to initiate an expedited appeal at time of initial denial notification.
- ***Precertification of Urgent Care*** – (Written Notification) - Provide member and MD written confirmation of decision within 72 hours of receipt of request (or 3 calendar days after oral notification was done).
- ***Concurrent Review*** – Make decisions for:
  - Inpatient, intensive outpatient and residential BH care within 1 business day of obtaining necessary information.
  - Ongoing ambulatory care within 5 business days of obtaining all necessary information (ex: Home Health services).
- ***Concurrent Review*** – Notify MD/provider of decisions as appropriate, within 1 business day of decision.
- ***Concurrent Review Resulting in Denial*** – Provide member, hospital and MD/group as appropriate, written confirmation of denial decision within 1 working day of original notification, including information about how to initiate an expedited appeal at time of notification (with WHA and DMHC simultaneously if member desires).
- ***Retrospective Review*** – Make decisions and notify the provider and member within 30 business days of obtaining necessary information (see Claims Review policies).
- **Prescription Medications (routine)** – Make decision and notify provider and member

within 72 hours or receipt.

- **Prescription Medications (exigent circumstances)** – Make decision and notify provider and member within 24 hours of receipt.

3. Clinical Information

Medical necessity review decisions are supported by relevant clinical data, including medical records, appropriate to each case. Reviews may require consultation with the member's treating practitioner and/or review of other documents related to the patient's diagnosis or treatment plan. Information obtained for review is treated as confidential following HIPAA Privacy and Confidentiality requirements and is not used for any purpose other than for what it was originally intended. WHA does not conduct onsite facility reviews.

C. Denials

Service requests are reviewed and approved, modified or denied. An adverse (denial/modification) medical necessity decision can only be made by an appropriately qualified physician or pharmacist reviewer, using adequate medical records, other relevant information and clinical criteria to make a well-informed and consistent determination.

All denials/modification decisions are subject to re-review/reconsideration through WHA's internal appeal process. Whether an initial denial/modification determination is made by a delegated group or issued by WHA's CMO, Medical Director, Assistant Medical Director (AMD), Clinical Pharmacist, or a review committee, each decision is communicated in writing to the involved member and providers/practitioner(s), in adherence to WHA's policies and CA regulations within required timeframes and notification parameters. Letters of notification explain the reason for the adverse decision in clear and simple language, and cite the specific criteria used to support the decision. Notification letters, faxes or attachments also provide information about the physician reviewer or body issuing the decision and explain availability to discuss medical necessity decisions and how to submit/request information used for the decision. In addition, denial/modification and appeal notification letters also provide instructions regarding member rights, including an explanation of how/when/where to request an expedited appeal or file a grievance with WHA or an outside agency, such as the Department of Managed Health Care.

Whether a standard appeal is processed through WHA or Magellan BH, each case is to be completed within 30 calendar days of receipt unless an extension is needed to obtain necessary information. If an extension is needed, written notification concerning the reason for the delay must be made to the member per CA legislative requirements, along with an explanation of the grievance process. WHA members may request an appeal, either verbally or in writing, however we encourage our members to send their request in writing whenever possible. WHA's Plan-specific appeal policies & procedures specify timeframes for issuing initial notification letters to acknowledge receipt of an appeal, describe timeframes for completing routine and expedited (fast track) appeal requests, and provide information about sending acknowledgement, extension notification and resolution letters. Appeals meeting *expedited* criteria must be completed within 72 hours of receipt or sooner

depending on the individual circumstances, medical condition/urgency and needs of the patient.

If a request for a service is denied because benefits are exhausted or are not included in the member's benefit package, UM/CM staff are available to assist the member with transitioning care/services or offering an alternative source within the network or through community resources, as appropriate to help facilitate continuity. (See WHA's *Continuity of Care* and *Case Management* UM & QI P&Ps for further details)

D. Appeals

1. Member Appeals

Member appeals are processed by WHA with the exception of behavioral health appeals which are delegated to HAI-CA (Magellan), WHA's NCQA accredited MBHO. Magellan sends regular reports to WHA to keep the Plan informed of BH UM, appeal and grievance activity and outcomes, and key representatives from both organizations participate in each other's UM, QI and Policy committees. UM and appeals information from all group activity is reported to WHA's UMC/QIC and to WHA's Board of Directors. Member appeals are not delegated to WHA's contracted medical groups/IPAs.

2. Appeal Review Meetings (ARM)

Member appeals are prepared by WHA's Member Relations Unit (MRU) and presented to WHA's appeal review physicians for review and decision-making. WHA's CMO, Medical Director and Assistant Medical Director review individual appeal cases and make determinations. If all WHA physicians were involved in making the initial adverse decision, the appeal case may be reviewed by one or more physicians who participate in the UM Committee (UMC) meetings.

When specialized expertise is needed, a board-certified network consultant may be contacted to review a case, offer recommendations and assist with the decision-making process. Other options include sending the case to WHA's contracted external review organization, IMedecs, for an independent evaluation and recommendations by a board-certified specialty expert, sending the case to WHA's contracted genetic testing external review agency, Informed DNA, for independent review and/or presenting the case to WHA's UMC for discussion and determination.

Decisions made by WHA's CMO, WHA's Medical Director, WHA's Assistant Medical Director or by WHA's UMC, are the final internal level of decision-making available to WHA members and providers unless additional information that could change the outcome is received by WHA soon after the initial decision was made. Magellan Behavioral Health is responsible for all first level BH related appeals. All second level member grievances and/or appeals of either WHA or Magellan decisions are performed by the Department of Managed Health Care (DMHC) upon a member's/representative's request. The member will most likely be advised by the DMHC to follow the health plan's appeal process first if they have not already done so. The one exception is for expedited cases involving medical necessity and experimental denials which may be appealed to WHA by the member/representative or to the Department of Managed Health Care (DMHC) simultaneously, which may include an

Independent Medical Review (IMR) at no cost to the member.

3. Provider Appeals

WHA and its delegated groups are responsible for ensuring that an appropriate provider/practitioner appeal process is in place, based on regulatory mandates. Provider appeals related to a claim denial or payment issue are referred to as provider disputes. Appeals submitted by providers that are not related to a claim or payment issue are considered to be submitted on behalf of the member and are processed according to the member appeal process.

The Provider Dispute Resolution (PDR) process, which is mandated through CA legislation, is available for all contracted and non-contracted providers. If a denial/modification decision is issued by WHA, the provider's appeal is handled through WHA's Claims department.

Most claims processing is delegated therefore most contracted and non-contracted provider disputes are handled initially at the group level. If the provider contests the group's dispute resolution decision, the dispute appeal is forwarded to WHA for second level review and decision-making. If the group's initial adverse decision was due to a medical necessity or other UM reason, the provider may request a first level appeal at the Plan level and bypass the group's appeal process.

E. New Technology Evaluation & Benefit Inclusion

Contracted medical groups/IPAs refer cases to WHA's CMO, Medical Director or Assistant Medical Director for review when a treating physician proposes or recommends an experimental/investigational treatment, drug or procedure involving new technology. WHA uses *Hayes' New Technology Assessment* criteria and contracts with its parent company, IMedecs, to conduct independent medical reviews on individual cases and to evaluate new procedures or treatments for inclusion in WHA's benefit plans. WHA also contracts with Informed DNA for independent evaluation of requests for Genetic Testing.

IMedecs' board-certified clinical consultants perform external, independent reviews on cases (requests) that have the potential of being considered experimental or investigational, based on current scientific research and the opinion of the current, relevant medical community. WHA's CMO, Medical Director, Assistant Medical Director or WHA's UMC may also request a review from IMedecs' when an appropriately qualified health care professional is not available within WHA's provider network to offer an expert opinion needed to make a decision. Procedures and treatments assigned by Hayes with a "B" rating are reported quarterly to WHA's UMC for discussion and approval as future covered benefits. The "B" rating indicates the treatment is no longer considered experimental by the general medical community and is now an acceptable standard of care if certain clinical criteria are met. Additionally, procedures or treatments reviewed ~~by~~ through the IMR process and found to be standard of care may also be presented to WHA's UMC for discussion and approval as future covered benefits.

F. Satisfaction with UM Processes

WHA assesses member experience with the UM process with CAHPS® and

complaints/grievances and appeals analysis. Provider satisfaction is measured through WHA's annual Provider Satisfaction Survey, which is conducted by an outside vendor. Both surveys include questions related to provider accessibility and satisfaction with UM processes. Sources of dissatisfaction are identified from survey responses, analyzed for potential barriers and reported to the UMC and QIC to ensure corrective actions are developed and implemented as feasible and appropriate to improve services and future survey scores.

Additionally, delegated health systems issue their own member and provider satisfaction surveys annually or on an ongoing basis to help them identify opportunities for improvement.

G. Emergency Services

WHA and its delegated medical groups/IPAs ensure that services necessary to screen and stabilize members who present to an emergency room (ER) are provided without barriers or the need to obtain prior authorization. At a minimum, ER screening evaluations for members with a medical or behavioral health condition are automatically covered per California legal statutes. Criteria used to evaluate appropriateness of additional ER interventions and services provided during the ER visit are individually evaluated by a physician. WHA takes into consideration the ~~prudent layperson's understanding of what the member, acting responsibly,~~ member's age, personality, education, background and other similar factors in determining if it was reasonable for the member to believe~~s~~ ~~is~~ an emergency situation existed.

WHA's contracted medical groups/IPAs are responsible for reviewing in-network emergencies and urgent care services provided to assigned members within their defined service areas, while WHA is responsible for concurrent review and care management of out-of-area emergency hospital admissions and urgent care services. All situations requiring Plan level physician review or special interventions are referred to WHA's CMO, Medical Director or Assistant Medical Director for decision-making. When appropriate, medically stable members are transferred to in-network facilities to receive continuing and follow-up care from their primary care physician (PCP) or from other network practitioners. WHA works with the hospital's discharge planners and the member's medical group/IPA's medical management staff to facilitate out-of-area transfers back into the network.

H. Direct Access

Per California law, in addition to emergency care, WHA and its contracted medical groups/IPAs ensure that members have direct access to obstetrical care, routine gynecological services, annual ophthalmology examinations (when covered), and other preventive health care services from network providers without obtaining prior authorization.

I. Pharmaceutical Management

WHA's Pharmaceutical Benefits Manager (PBM), Express Scripts® is responsible for administering pharmacy benefits for WHA members (except employer group CalPERS who carved out the pharmacy benefit to Optum). Express Scripts® is responsible for claims adjudication, initial coverage determinations and development and maintenance

of the pharmacy network. WHA retains responsibility for processing all specialty and other pharmacy prior authorization requests, pharmacy related appeals. WHA's pharmaceutical management procedures are based on sound clinical evidence.

WHA's Pharmaceutical and Therapeutics (P&T) Committee reviews and approves WHA's Preferred Drug List (3-tiered and 4-tiered formulary) and pharmacy policies, which are then reviewed and approved by the QIC. Written policies address drug exceptions (if any) to the ~~formulary~~preferred drug list, after-hours access procedures, and the prior authorization process required for certain restricted or controlled drugs, etc.

WHA's clinical pharmacist collaborates with Express Scripts® to carry out WHA's drug utilization review (DUR) program. This DUR program is used to identify cases of underutilization, potential over-utilizers/substance abusers, drug-to-drug interactions, etc. These cases are referred directly to the prescribing practitioner for appropriate action and/or follow-up.

11.1 Utilization Management Activities – Ensuring Appropriate Utilization

WHA's UM and CM/CCM Program functions are detailed in specific policies and procedures (P&Ps), which are maintained in the Medical Management department and shared with delegated medical groups/IPAs to ensure compliance across the network. They are included or referenced in WHA's Provider Manual, which is distributed to WHA's contracted medical groups/IPAs on an annual basis and are also made available on WHA's website.

WHA's UM and CM/CCM P&Ps are reviewed and updated at least annually and approved by WHA's UM and QI Committees. Delegated entities are also required to maintain their own UM and CM/CCM P&Ps consistent with WHA's policies, contracts and delegation agreements.

A. Prior Authorization, Concurrent and Retrospective Review

In most instances, prior authorization and concurrent review of inpatient, outpatient and ambulatory medical and BH services are carried out by WHA's delegated entities. Out-of-~~network~~ area emergency hospital admissions and certain specialty referrals are the responsibility of the health plan.

Whether or not UM clinical staff at the medical group/IPA-level or Plan-level makes the authorization decision, each reviewer must follow the same basic review principles and adhere to written policies for completing the appropriate tasks to ensure compliance with regulatory and contractual requirements concerning turnaround times and written notifications. Authorization reviews include screening of all available/pertinent clinical and other relevant information against covered benefits and established medical necessity criteria, such as InterQual® criteria or MCG® (formerly Milliman Care Guidelines) when appropriate. Decisions are based on eligibility status, benefits and/or medical/BH necessity criteria, taking into consideration the individual circumstances and needs of the patient. When criteria are not met, first-line UM reviewers must refer the case to their Medical Director or to another appropriately qualified medical or mental health care professional or

review body for final decision-making. Nurses cannot deny or modify requests involving medical necessity assessments. Financial incentives or compensation are not linked with UM decisions or to the withholding of care, and WHA's physicians are free to discuss various treatment options with their patients, even when they may not be covered under their WHA health plan benefits.

Retrospective review of claims for services already rendered that involve medical necessity decisions are also performed by qualified clinical staff at both Plan and medical group/IPA levels, using the same process and screening criteria applied to other medical necessity decisions. Claims and other cases where first line reviewers cannot establish medical necessity through criteria are forwarded to a qualified physician/practitioner or appropriate review committee for retrospective decision-making when indicated.

B. Discharge Planning

Identifying the need for discharge planning assistance usually begins during the concurrent review process but may begin prior to an admission for members already being followed in CM or when a need is identified during the prior authorization referral process. Discharge planning functions for in-network or prior authorized admissions are delegated to the medical group/IPA. WHA's CR Nurse contacts the facility discharge planner for out-of-area emergency admissions to begin coordinating discharge planning interventions with the facility discharge planner. WHA's CR Nurse collaborates with the appropriate medical group/IPA representative and facility discharge planner and treatment team to facilitate retuning the member to appropriate in-network care when the member becomes stable. This could involve transfer of the member to an in-network hospital, to an in-network lower level of care or discharge to home with necessary outpatient services such as home health or DME from contracted vendors. If a member become clinically stable for transfer but the medical group/IPA is either unable to or chooses not to transfer the member then the medical group/IPA assumes continued coordination with the facility discharge planner as a delegated responsibility.

C. Continuity of Care and Transition of Care

Members with certain acute or chronic conditions receiving current or ongoing treatment from a non-network provider at the time of enrollment with WHA, or whose network provider is terminated mid-treatment, may receive transition assistance from a Clinical Resources Nurse (CRN) through WHA's Continuity of Care (CoC) program. When a member qualifies for CoC program services, WHA's CRN works with case managers at WHA's contracted medical groups/IPAs to assist members with obtaining specialty referrals and authorizations as needed, and provides help to gradually transition ongoing needed care into the provider network when appropriate and without disruption or delay of services. WHA ensures that its delegated medical groups/IPAs follow WHA's CoC directives and reviews their policies for consistency with the Plan's relevant CoC policies and procedures. Ultimately, WHA and its contracted medical groups/IPAs must provide medically necessary care and treatment to qualified individuals even if the provider is not in WHA's network, until such time as the member is considered stable for transfer to another provider of like-specialty who is in the WHA network and willing and able to assume care of the new patient.

D. Routine and Complex Case Management (CM/CCM)

All WHA members (any age) are eligible to receive Case Management services when indicated. WHA delegates both routine and Complex Case Management (CM/CCM) functions to its contracted medical groups/IPAs and performs oversight activities to ensure delegates are meeting contractual requirements, current NCQA CCM standards and any related regulatory requirements.

WHA and its delegates actively attempt to identify members with multiple and/or complex conditions who might benefit from CCM services through various mechanisms, including but not limited to: proactive population assessment, review of claims/encounter data, pharmacy data, hospital admission/discharge data and data collected through various UM processes. Furthermore, potential CM/CCM candidates may be referred through Disease Management programs, by discharge planners, BH representatives and UM staff, practitioners or self-referrals.

WHA requires that its contracted medical groups/IPAs incorporate certain diagnoses into their CCM screening criteria. Delegates may establish additional criteria for identifying/accepting members into their CM/CCM programs, but must include WHA's minimum requirements, which include the following conditions or situations:

- Catastrophic
- End-stage respiratory failure
- Patients with multiple diagnoses, rare high-risk chronic diseases
- Patients with developmental disabilities that require multiple services
- Chronic illnesses that result in high utilization
- Serious Mental Illness (including Autism Spectrum Disorders)

Delegates manage their CCM members of all ages using evidence-based clinical guidelines and CCM systems that allow for automatic documentation of interventions, along with online prompts to ensure ongoing and timely follow-up with participating members. Delegates conduct a comprehensive initial assessment of the member by evaluating health status, clinical history, medications, ability to carry out the activities of daily living, mental health and cognitive status, cultural and linguistic needs, preferences or limitations, visual or hearing needs, caregiver resources, involvement and willingness, available benefits, community resources, and an assessment of life planning activities (e.g., advance directive).

For cases opened to CCM, nurses develop a detailed CM plan that is patient-centered with prioritized goals addressing anticipated member self-management aspects related to their personal health condition(s). Progress in meeting goals is intermittently assessed and documented, as well as barriers that interfered with attaining established goals. Case managers are also responsible for developing schedules for timely follow- up with members receiving CCM services, and for making referrals to disease management programs when indicated. See Addendum A and CCM policy and procedure for additional information about WHA's CCM Program.

WHA's oversight responsibilities related to CCM include annual audits with review of CM program/policies and files and ~~semi-annual~~monthly CM/CCM activity reports. Semi-annually, WHA also conducts member satisfaction surveys to evaluate their experience with the groups' CCM programs. In addition, member complaints and inquiries related to Case Management are also reviewed as part of WHA's annual CM/CCM Program evaluation. WHA and its delegated medical groups/IPAs assess the effectiveness of the CCM Program using a minimum of three (3) measures, which include ER and readmission measures, and member satisfaction survey results Findings from analyzing this data are used to identify and implement CCM Program improvement opportunities if any, at least once a year.

E. Second Opinions

WHA and its contracted medical groups/IPAs provide second opinions for members at the request of their treating physician or at the member's request when certain conditions and criteria are met, as defined by regulatory statutes and when deemed appropriate by WHA. Second opinions are arranged with appropriately qualified health care professionals of like-specialties within the network if available, in a timely and convenient manner to the patient, and appropriate to the urgency of his/her medical condition and situation. Second opinions are provided outside the network if an appropriately qualified specialist, relevant to the patient's unique condition or treatment needs is not available within the Plan. Co-payments for non-network second opinions are consistent with in-Plan co-payments, and specialists providing the second opinion services are required to provide both the member and referring physician with a report of his/her findings and recommendations.

F. Monitoring Over- & Underutilization

To identify potential or actual inappropriate under- or overutilization of services, WHA and its delegated medical groups/IPAs monitor the use of services and utilization of health care resources on an ongoing basis and review a formal report at least once a year. This is primarily accomplished through the collection and analysis of encounter data and claims information. Capitated medical groups/IPAs routinely report encounter/claims data, but they also provide self- reported utilization data to WHA's Medical Management staff regarding inpatient and outpatient services semi-annually. These UM reports include trending data, analysis and corrective actions that are specific to the particular reporting organization. Referral logs showing authorization/denial activity are sent to the Plan by the groups/IPAs on a monthly basis.

WHA creates and analyzes Plan-wide and medical group/IPA-specific utilization reports at least once a calendar year. WHA's CMO presents this information to the UMC and QIC for discussion and recommendations. In addition, WHA monitors and analyzes data related to the Advantage Referral program and reports information about this unique open access program to keep stakeholders informed of referral activity, practice patterns and related costs. Utilization findings are ultimately reported to WHA's Board of Directors.

12.0 Triage and Referral for Behavioral Health (BH) Care

WHA delegates responsibility for the provision of behavioral health services to HAI-CA/Magellan for the majority of WHA members, with the exception of UCD employees whose BH and substance

abuse benefits have been carved out by their employer to OptumHealth™. WHA members do not require a referral from their PCP to access BH services, but they do need to notify Magellan of their BH needs to ensure services are covered benefits and provided by a network practitioner. Magellan staff, under the supervision of a CA licensed psychiatrist, make BH triage and referral decisions. Triage and referral protocols are based on sound clinical evidence and currently accepted practices within the industry, and address mental health care and substance abuse services as described in Magellan's written UM Program Description and policies. Access to emergency care and other necessary BH care services is available 24 hours/day, 7 days/week.

13.0 Delegation of UM Functions

WHA delegates UM activities to contracted entities that meet WHA's standards for delegation. All delegation activities are based on a pre-delegation (due diligence) assessment and on ongoing and annual monitoring activities, including annual oversight audits of program documents, processes, services and files that ensure continuing compliance with WHA's performance standards and QI goals. In addition, delegated medical groups/IPAs must adhere to all contractual, regulatory and NCQA accreditation requirements. Written and signed Delegation Agreements delineate specific responsibilities for WHA and the delegate and are signed by both parties.

14.0 Monitoring & Oversight of Delegated UM Activities

WHA's Medical Management clinical staff performs oversight activities of the delegated UM and CM/CCM functions and present audit findings, summary reports/analyses and corrective action plans (CAPs), if any, to the UMC and QIC for review and approval at least quarterly. Delegation oversight activities include but are not limited to:

- Monitoring each delegated/entity for its UM processes and ability to render appropriate and timely determinations within WHA's standards for functions related to prospective, concurrent, expedited, and retrospective reviews;
- An annual onsite audit of delegated UM and CCM functions including file review;
- Reviewing and approving the delegate's written UM Program and UM/CCM processes, work plans, annual UM Program evaluation, and UM/CCM policies and procedures;
- Reviewing and updating delegation agreements as needed;
- Evaluating semi-annual UM/CCM reports from the delegated entities and recommending improvement interventions as indicated;
- Reviewing medical group/IPA denial logs, files and letters for appropriate language, content, timeliness and other regulatory compliance factors.

UM indicators are continuously monitored, measured and trended over time to identify special causes of variation. Reports are submitted to the UMC and QIC, which are responsible for providing structured guidance and oversight of WHA's UM Program. Recommendations for improving member healthcare and services are communicated directly to the specific contracted medical groups/IPAs, as well as to the practitioners/providers involved in individual situations when known. WHA's QIC may recommend a focused audit and/or request the development and implementation of a corrective action plan from the delegated medical group/IPA.

If for any reason WHA believes delegated functions are not being carried out in accordance with the

terms of the contract/delegation agreement, or performance issues or quality of care concerns are identified, steps will be taken to resolve the issue. The focus of all corrective actions is to be educational and consultative rather than punitive, however WHA may revoke delegation of activities if the medical group/IPA is not, or cannot perform the delegated functions in accordance with the standards established by WHA, a regulatory body or NCQA accreditation requirements.

ADDENDUM A

Complex Case Management Program

2018

WESTERN HEALTH ADVANTAGE

Complex Case Management Program Description
(Overview)

2018

Introduction

Western Health Advantage (WHA) delegates most Complex Case Management (CCM) program services and functions to its contracted Medical Groups/IPAs (groups), which include the following health care organizations: Hill Physicians IPA, Mercy Medical Group, Meritage Medical Network IPA, NorthBay Medical Group, Woodland Medical Group, John Muir Health, Canopy Health and UC Davis Medical Group. Although delegated groups may conduct their own annual population assessments to identify appropriate CCM program candidates, and may conduct their own satisfaction surveys regarding the members' experience with CCM program services, WHA retains primary responsibility for these two program components to ensure plan-wide compliance. (For details about the CCM program, see WHA's Complex CM P&P)

Delegated groups must develop and maintain their own written CCM program descriptions, policies, staff, processes and systems to effectively manage CCM services provided to WHA members. These program elements must be reviewed, updated and approved by appropriate leadership/committees at least annually. To secure and maintain delegation status, WHA's contracted groups must base their programs on contractual and regulatory requirements, and adhere to all current NCQA accreditation standards for complex case management. Delegation agreements between WHA and its delegated entities (which include responsibility grids), specify CCM program delegation and reporting requirements.

To ensure ongoing compliance, WHA performs routine monitoring activities throughout the year, including review of the groups' current CCM program documents and policies, self-reported CCM activity data and evaluation of group level quality improvement activities (i.e., projects, interventions and outcomes). WHA also conducts annual CCM delegation oversight audits, which include onsite face-to-face meetings with group CM leadership to discuss current staff resources, processes and improvement projects/strategies, firsthand review of their current CCM tracking systems, and individual case file reviews.

To provide clarity and promote compliance, WHA's plan level CCM P&P is shared with provider groups/staff when updated and posted on WHA's website. WHA also provides delegates with frequent educational information about NCQA CCM program requirements and plan expectations via in-service training sessions, direct mailings, e-mails and phone calls.

Complex Case Management

Complex Case Management is defined by NCQA as the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Since complex management is considered an opt-out program, all eligible members have the right to participate or decline participation.

In general, members requiring CCM services have conditions where the: 1) degree and complexity of their illness or condition is typically severe; 2) level of management necessary is typically intensive; and 3) amount of resources required for the member to regain optimal health or improved functionality is typically extensive.

Goal

The goal of CCM is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a case management plan with performance goals, monitoring and follow-up.

Evidence

WHA and its delegated groups use evidence from MCG® Chronic Care Guidelines, InterQual®, clinical practice guidelines, Hayes' *New Technology & Assessment* criteria, clinical pathways developed by specialty practitioners, and other resources to develop CCM programs. Scientific evidence from clinical or technical literature or through government research sources or recommendations may also be used to determine the types of cases needing these services. For example, certain at-risk ACA exchange members may be identified as appropriate candidates for CCM services using low-income zip codes.

WHA uses diagnostic codes, clinical criteria, predictive modeling, risk assessment software, other data and resources to identify individual members and certain populations appropriate for CCM services. WHA also relies on CCM services to assist new enrollees with Continuity of Care issues to navigate the system and help with their transition of care to WHA network providers when appropriate.

Data and Criteria for Identification

WHA and its delegated groups review data from a variety of sources to determine appropriate criteria for identifying and referring members for CCM interventions. Emphasis is placed on proactive identification of eligible members using available risk assessment data systems and predictive modeling software. In addition to some groups using their own predictive modeling software & reporting tools, WHA provides group representatives with hands-on training and access to its Verscend® (former Verisk) *Medical Intelligence* risk assessment software. Verscend® (formerly Verisk) software provides program leaders and analysts with plan-wide, group and member-specific encounter, utilization and claims/cost data for provided health care services, including pharmacy and behavioral health services. This data and new software/tools are now being used by WHA and its delegated groups for population assessments and other reports to identify appropriate candidates for Case Management and Chronic Disease Management (DM) program services.

Services Offered

Although certain populations are identified as candidates for CCM Program services based on predictive modeling and risk assessment analyses, WHA also provides individual health plan members the opportunity to receive CCM program services when indicated, at no cost to the

member. Anyone may request CCM services for a member, including the member, physician or other clinician, caregiver, designated representative, health plan or other interested party.

Group CCM program services are provided by a qualified, experienced nurse case manager (CM) who is assigned to the member's case. The CM is responsible for explaining the program services to the member or his/her representative, and for offering the member/rep the option of accepting or declining program services. If the member accepts, the assigned CM works directly with the member or his/her representative and other partners as needed to develop a patient-centered care plan with realistic goals, then assists the member in achieving those goals as feasible.

Simple or routine CM services include, but are not limited to providing patient education and assistance in navigating the healthcare system, such as facilitating access to providers and services by working with clinicians to obtain referrals, authorizations and appointments, and assisting new health plan members with transitioning their care to WHA network providers when the time is appropriate.

Members who qualify for the Complex CM program typically need more comprehensive services due to complicated health conditions requiring multiple services from a wide variety of specialty providers. CCM patients often require long-term and intensive assistance from their assigned CM, who coordinates their care with other clinicians to ensure their health care needs are appropriately met. Many of WHA's groups use a team approach for CCM, which requires sharing and integrating medical and other relevant information with staff providing health services to the patient, such as the PCP, hospitalist, discharge planner, pharmacist, dietician, social worker, etc. Together with the patient/rep and assigned CM, the team members collaborate to develop and carry out an effective CCM care and treatment plan for the patient with attainable goals.

Case Management Integration

In addition to identifying appropriate candidates for CCM services through proactive predictive modeling and receiving direct referral requests from the sources previously mentioned, CCM services may also be identified and referred through other programs, such as WHA's Nurse Advice Line, DM vendor Optum (formerly Alere)™ Wellness programs, and Magellan BH (co-morbidity referrals).

When members receive services from other vendors while they are opened in CCM, the CM is responsible for sharing relevant information with the other vendors (following HIPAA regs) and the member's PCP, and for collaborating and coordinating all care to ensure integration and continuity for the patient. The CM may also identify and refer members to other program services requiring integration/collaboration of services such as DM, Palliative Care programs or Hospice Care.