POLICY AND PROCEDURE

POLICY NAME: Utilization Management Program Description	**POLICY ID:** LA.UM.01
BUSINESS UNIT: Louisiana Healthcare Connections	**FUNCTIONAL AREA:** Utilization Management~~Population Health and Clinical Management~~
EFFECTIVE DATE: 01/01/2012	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 2/13, 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, 2/20, 12/20, 02/21, 03/21, 5/22, 12/22, 4/23, 02/07/2024, 01/09/2025	
REGULATOR MOST RECENT APPROVAL DATE(S): Please refer to system of record – Archer	

POLICY STATEMENT:
All Areas and Departments within Centene Corporation and its subsidiaries must have written Policies and Procedures that address core business processes related to, among other things, compliance with laws and regulations, accreditation standards and/or contractual requirements.

PURPOSE:
The purpose of this policy is to describe the Utilization Management (UM) Program.

SCOPE:
This policy applies to employees of the UM Department. This includes officers, directors, consultants, and temporary workers (collectively, the "Plan").

DEFINITIONS:

Medically Necessary Services: Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the Beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the Beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Louisiana Medicaid Program. Services that are experimental, non-Food and Drug Administration (FDA) approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary~~.~~" (Model Contract 2.12.4.2).

POLICY:
The Plan maintains a UM program for all Managed Care Organization (MCO) covered Services that facilitates the delivery of high quality, cost-efficient, and effective care (Model Contract 2.12). The Population Health and Clinical Operations (PHCO) Department maintains a UM Program Description which encompasses the functions of pre-authorization and concurrent review. The program description is consistent with all regulatory and accrediting guidelines and standards. The document is reviewed and revised at least annually and more frequently as needed.

The UM Program Description and related policies and procedures is submitted to the Louisiana Department of Health (LDH) annually and subsequent to any revisions. The written program policies and procedures with defined structures and processes meet NCQA standards~~.~~ (Model Contract 2.12.1.1).

REFERENCES:
Louisiana Medicaid MCO Manual
Louisiana Medicaid MCO Model Contract
~~LA MCO Model Contract~~
NCQA Health Plan Standards and Guidelines

Code of Federal Regulations – 42 CFR 422 Medicare Advantage Program
42 CFR 438 Managed Care
42 CFR §455.1 (a) (1) Basis and scope.
LAC 50:I.1101-Louisiana State Medical Necessity Criteria
CP.CPC.03 Preventive Health and Clinical Practice Guideline Policy
LHCC Provider Manual
LA.UM.04 Appropriate Utilization Management Professionals
LA.UM.05 Timeliness of Utilization Management Decisions and Notifications
LA.UM.07 Adverse Determination (Denial) Notices
LA.UM.08 Appeal of Utilization Management Decisions
LA.UM.11 Experience with the Utilization Management Process
LA.UM.12 Emergency and Post-Stabilization Services
LA.UM.05.01 Retrospective Review for Services Requiring Authorization
LA.QI.11.03 Appeals Process
La R.S. §46:460.74. Prior Aauthorization; Ceriteria; nNotice to pProviders
Health Insurance Portability and Accountability Act of 1996

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS:
Louisiana Revised Statute §46:460.54 applies to material changes for this policy.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	Language added to meet Louisiana Contractual requirements	11/08/13
Ad Hoc Review	Updated reference to NCQA 2013 HP Standards and Guidelines	01/06/14
Ad Hoc Review	Changed Utilization Management to Medical Management, changed abbreviations	08/25/14
Ad Hoc Review	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
Ad Hoc Review	Changed NCQA to say “current” instead of a year	04/24/15
Ad Hoc Review	Changes throughout policy for updated RFP with BH carve in. Added STRS to the delegation section.	09/29/15
Ad Hoc Review	Changes to RFP references to match current RFP Title changes for nurses where needed. Grammatical changes. Removal of titles, verbiage that is not utilized.	05/24/16
Ad Hoc Review	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	03/24/17

	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.	
Ad Hoc Review	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.	03/23/18
Ad Hoc Review	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.	02/25/19
Ad Hoc Review	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.	05/29/19

Ad Hoc Review	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	09/24/19
Ad Hoc Review	Added RFP language from Ipro Audit 8.4.5.2 and 8.5.4.3 Added BH Services	10/24/19
Ad Hoc Review	Added Behavioral Health Practitioners as description of Medical Directors. Remove telephonic as the way concurrent reviews are done with medical records.	11/22/19
Ad Hoc Review	Included residential in the level of care Added the services include medical and behavioral Added medical advisors Clarified SVP MA responsibilities Removed DO Added annual review of program evaluation and description Added MMC scope Added staff completed UM reviews and decisions to Affirmative statement Added doctoral level clinical psychologists as authorized professional Added Behavioral Health Practitioner description Updated PA/CCR/LMHP staff description Added Clinical information description Added ASAM and BH IQ criteria Added national evidence-based guidelines Updated Communication services Added statement regarding timeliness of monitoring UM decision making Added retro timeliness Changed CCR Nurse to UM Clinical Reviewer Added denial of services section Added calendar day to informal reconsideration timeliness Grammatical changes Removed duplicate statements Removed RFP reference to 8.4.5.3 Changed Practitioner to Provider Added statement to pre-scheduled services Changed SVP of MA to Chief Medical Officer Changed SVP of CO to SVP Removed VPMM	01/24/20
Ad Hoc Review	Changed RFP to Emergency Contract Added Submission of Clinical Information Added Request for Additional Information Added statement regarding Case Management and Disease Management Add statement regarding Vendor NCQA accreditation Added Pharmaceutical Management	02/25/20
Ad Hoc Review	Added references to LA.UM.04 and LA.UM. 07 Added Emergency Contract 8.1.15, 8.1.17, 8.4.2.3, 8.5.3.2 and HB 424-Act 330 Changed Cornerstone Learning to Centene University	05/2020
Ad Hoc Review	Add Inpatient Service determination Updated Concurrent Review determination Added Amendment #3 Reference	12/30/20
Ad Hoc Review	Format and grammatical changes Changed SVP, PHCO to VPMM Added Functions of the MMC per Emergency contract section 8.2.2	02/25/21

	Added reports section per Emergency contract section 8.3 Removed duplicate words	
Ad Hoc Review	Added BH discharge planning per Emergency Contract section 6.30.2.15	03/25/21
Ad Hoc Review	Updated year to 2022 Updated Table of Contents Changed Medical Management to Population Health and Clinical Operations Changed Senior Director Pharmacy to VP of Pharmacy Operations Changed Director of Pharmacy to Pharmacy Manager Removed MM analytics Changed PA nurses to OP Utilization Managers and CCR nurse to IP Utilization Manager Added prescheduled to IP service authorization Added interventional pain management to NIA services	05/27/22
Ad Hoc Review (from 3/2022 Readiness Review)	Changed member to enrollee Updated verbiage of new Model Contract and references Reformatted to new policy template	12/01/22
Annual Review	Updated Regulatory Reporting Requirement No material changes	04/2023
Annual Review	Style Guide edits. Realigned sections. Updated references. Changed language to present tense. Under BH Level of Care added Partial Hospitalization, Day treatment headings and language to align with Model Contract 2.9.25.22. Updated verbiage with most current Model Contract and references. Replaced instance of "staff" with "employee." Under Scope added pharmacy services. Under Implementation added telemedicine and ambulatory review. Under Authority added "assessment of local delivery system" and added language to CMO's responsibilities regarding reviewing and determining coverage requests. Under Integration with Other Programs added P&T and language regarding quality of care concerns. Added to PHCOC Scope language regarding the list of services requiring PA and pharmacy timeliness reports. Added PHCOC chair statement. Under Roles and Qualifications added language for: specific State licensure, processes in place to ensure all persons are not suspended or excluded from participating in the Medicaid program, Plan does not permit decisions that result in under-utilization, Intake Operations Director/Mgr, changed Referral Specialist to Intake Specialist and added psychologist to MD under Care Mgrs. Removed references to Envolve. Updated roles and responsibilities of each employee to reflect the most current responsibilities. Changed PA/CCR/LMHP title to Care Managers to align with CC.UM.01. Added language for alternative LOC for denials to align with 2.12.3.6.5 of the Model Contract. Under PA added language to align with 2.12.8.7.	02/07/2024
Annual Review	Updated references. Updated table of contents. Removed Milliman Care Guidelines (MCG) reference. Under section "PHCOC Scope" added reference to Model Contract 2.12.2.2.1 to one of the bullets. Removed Vice President of Pharmacy Operation, Pharmacy specialist & Pharmacy Coordinator the "Roles and Qualifications" section because these roles are listed in detail in the Pharmacy Program description policies. Removed first statement	01/09/2025

	from section "Clinical Criteria". Removed sentence "The Centene Clinical Policy Committee (CPC) develops these statements", from New Technology Review section. Under the "Inter-rater Reliability" section added Vice President of medical affairs, the plan & clinical criteria team. Removed sentence "Providers are appropriately notified when such modifications occur." from the Prior Authorization section. Added calendar days in the "Timeliness of UM Decisions" section. Removed last sentence in section "Requesting Copies of Medical Records". Removed "Pharmaceutical Management, Preferred Drug List & Pharmacy Benefit Manage" from the Emergency Services section. Added reference to Model Contract 2.8.1.4.9 to the "Care Transition" section. Removed content from the "Delegation" section.	

POLICY AND PROCEDURE APPROVAL

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

Utilization Management (UM) Program Description 20254

Program Overview
The Louisiana Healthcare Connections (Plan) approach to UM is based on the philosophy of continuously improving the enrollee'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) 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 PHCO which includes UM, CM, and Disease Management (DM) is designed to maintain and improve quality, appropriateness, and accessibility of healthcare services while achieving enrollee 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 that fully complies with state and federal requirements, as well as all contract requirements for what the Program Description must include. The Program Description is submitted 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 Program 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 Program 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 Louisiana administrative Code 50:I.1101 for medical necessity determinations; and all related contract requirements. The UM Program is reviewed annually and updated periodically as appropriate.

Purpose
The purpose of the Program 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 enrollees.

Scope
The scope of the UM Program is comprehensive and applies to all eligible enrollees 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, residential and ancillary care services. The services include medical, behavioral, and pharmacy 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.

Goals
The goals of the UM Program are to optimize enrollee'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 enrollee'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 enrollee achieve the highest possible levels of wellness, functioning and quality of life, while demonstrating positive clinical results. This is achieved through the proactive identification of enrollees with complex and/or chronic health conditions that require coordination of physical and behavioral health services to provide maximum support of the enrollee'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, telemedicine, prior authorization/precertification, second opinion, concurrent review, retrospective review, ambulatory review, care management, chronic care management, maternity management, preventive care management and proactive discharge planning activities for both medical and behavioral health (BH) care. 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 providers 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.

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~~:~~ (Model Contract 2.12.1.2.2)~~:~~

- ~~Staff~~Employees and consultants are required to sign a confidentiality statement.
- All members of the Population Health and Clinical Operations Committee (PHCOC) are required to sign a confidentiality waiver.
- All employees and provider 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 employees 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 enrollees. 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 PHCOC, including the review and appropriate approval of medical necessity criteria and protocols, and UM policies and procedures. The PHCOC 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 Chief Medical Officer (CMO) provides support to the Plan's UM Program. The Plan CMO, Vice President of PHCO, (VPPHCO), and/or any designee as assigned by the Plan President and Chief Executive Officer (CEO) are the senior executives responsible for implementing the UM Program including cost containment, QI, review activities pertaining to utilization review, complex, controversial or experimental services, and successful operation of the QAPIC and PHCOC. In addition to the CMO, the Plan may have one or more medical directors and/or medical advisors.

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

- Assists in developing/revising, implementing, and interpreting 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 and appeals system.
- Monitors compliance with the UM Program.
- Provides clinical support to the UM ~~staff~~employees 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 providers 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, regulations, and ~~P~~plan policy, and takes into consideration the individual needs of the involved enrollees and assessment of the local delivery system.
- Reviews and determines coverage of requests for health care services that are based on applicable criteria including state, national, and local coverage determinations, nationally established guidelines, InterQual® ~~or Milliman Care Guidelines (MCG)~~ criteria or other evidenced based medical literature which includes but is not limited to Hayes Criteria and established corporate-written clinical policies.

- Reviews, approves, and signs denial letters for cases that do not meet medical necessity criteria after appropriate review has occurred in accordance with ~~P~~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 providers with questions about the UM process.

- Communicates/consults with providers 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.

- Participates in and provides oversight of the PHCOC and all other physician committees or subcommittees.

- Assures there is appropriate integration of physical, behavioral, and social health services for all ~~P~~plan enrollees.

- Recommends and helps to monitor corrective action as appropriate for providers with identified deficiencies related to UM.

- Serves as a liaison between UM and other ~~P~~plan departments.

- Educates providers regarding UM issues, activities, reports, requirements.

- Reports UM activities to the QAPIC as needed.

Integration With Other Programs

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

Any adverse information or quality of care concern that is gathered through interaction between the Plan UM employees and the provider or facility staff is also vital to the recredentialing process. Such information may relate, for example, to specific ~~care management~~CM 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 CMO or ~~m~~Medical ~~d~~Director determines if the information warrants additional review by the Credentialing Committee. If committee review is not warranted, the information is filed in the provider's folder and is reviewed at time of the provider's recredentialing.

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud, waste, and abuse among providers and enrollees. The Plan works closely with the Plan's Compliance Officer and Centene's Special Investigations Unit to resolve any potential issues that may be identified. The Plan reports fraud and abuse information identified through the UM program to LDH in accordance with 42 CFR §455.1(a) (1)~~.~~ (Model Contract 2.12.1.2.3).

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

- Early ~~C~~childhood ~~i~~intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) ~~H~~health ~~C~~check

- Services provided by local public health departments
- Area Agencies on Aging (AAA)
- Community agencies for senior living
- Community based services for BH
- Department of Children and Family Services
- Office of Citizens with Developmental Disabilities
- Office of Juvenile Justice

Population Health and Clinical Operations Committee

Daily oversight and operating authority of UM activities is delegated to the PHCOC, which serves as the Plan's UM Committee (UMC). The PHCOC complies with all requirements of a UMC, which reports to the Plan's QAPIC and ultimately to the Plan's BOD. ~~-~~The PHCOC is responsible for the review and appropriate approval of medical necessity criteria and UM policies and procedures. The PHCOC coordinates annual review and revision of the UM Program Description, and the Annual UM Program Evaluation. These documents are presented annually to the QAPIC for approval. ~~–~~The PHCOC monitors and analyzes relevant utilization data to detect and correct patterns of potential or actual inappropriate under- or over-utilization. ~~–~~The PHCOC also analyzes data which may impact health care services, coordination of care and appropriate use of services and resources, as well as enrollee and provider satisfaction with the UM process. The PHCOC 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 for consistent application of medical necessity criteria. 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. (Model Contract 2.12.2.1)

PHCOC Scope

PHCOC responsibilities include coordination and oversight of the following activities (Model Contract 2.12.2.2):

- 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, ~~W~~work ~~P~~plan, ~~A~~annual UM ~~P~~program ~~E~~evaluation, guidelines, policies, and procedures and the list of services requiring prior authorization.
- Monitors reports for timeliness of behavioral, non-behavioral, and pharmacy trends and/or utilization patterns and makes recommendations to the QAPIC for further review.
- Reviews provider-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.
- Monitors the medical appropriateness and necessity of healthcare services provided to enrollees~~.~~ (Model Contract 2.12.2.2.2).
- Examines appropriateness of care reports to identify trends and/or patterns of under- or over-utilization and refers identified outlier providers to the QAPIC for performance improvement and/or corrective action.
- Examines results of annual enrollee and provider satisfaction surveys to determine overall satisfaction with the UM Program and identify areas for performance improvement.
- Reviews the effectiveness of the utilization review process and make changes to the process as identified.
- Provides a feedback mechanism to the QAPIC for communicating findings, recommendations, and a plan for implementing corrective actions related to UM issues.
- Reviews application of clinical practice guidelines used by Provider Quality Monitoring Program (PQMP).

- 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.
- Reviews the written strategy for conducting medical record reviews, reporting results, and the corrective action plan. The strategy is provided annually.
- Reviewing, updating, and approving policies and procedures for UM that conform to industry standards, including methods, timelines, and individuals responsible for completing each task (Model Contract 2.12.2.2.1).
- Monitoring providers' requests for prior authorization of health care services to its enrollees~~.~~ (Model Contract 2.12.2.2.3).
- Monitoring consistent application of service authorization criteria~~.~~ (Model Contract 2.12.2.2.4).
- Monitoring over- and under-utilization~~.~~ (Model Contract 2.12.2.2.5).
- Review of outliers~~.~~ (Model Contract 2.12.2.2.6).
- Monitoring of health record reviews~~.~~ (Model Contract 2.12.2.2.7).
- Oversight and review of the completion of the Annual UM Health Equity analysis.

PHCOC Members

The PHCOC is directed by the CMO. The VPPHCO, and associate Medical Directors are standing enrollees of the Committee. A ~~P~~pharmacy ~~S~~specialist is an enrollee of the Committee and assists in review of pharmacy utilization and make recommendations regarding drug utilization review activities, such as targeted prescriber and/or enrollee education initiatives. A LDH representative, as appointed by LDH, is included as a member of the PHCOC, if requested. Additional UM/QI ~~staff~~employees, contractor leadership as needed, and other ~~P~~plan leadership may also attend the PHCOC as appropriate~~.~~ (Model Contract 2.12.2.2).

Plan's PHCOC is comprised of the following members:

- Network providers representing the range within the network and across the service area.
- Plan CMO/medical director.
- Plan VPPHCO
- Plan executive leadership, UM, and QI employees.
- Other operational employees as requested, e.g., network/contracting, enrollee/provider services, compliance/regulatory, pharmacy.
- LDH representative, if requested.

A minimum of 50% of voting enrollees must be present for a quorum. The PHCOC Chairman is the determining vote in the case of a tie vote.

The PHCOC is chaired by a ~~P~~plan medical director and may be co-chaired by a network physician; this activity may be delegated to another physician member or the VPPHCO for a specific meeting as needed.

Meeting Frequency and Documentation of Proceedings

The PHCOC meets no less than quarterly and the VPPHCO maintains detailed records of all PHCOC meeting minutes, UM activities, CM ~~P~~program statistics and recommendations for UM improvement activities made by the PHCOC. The PHCOC submits to the QAPIC all meeting minutes and written reports regarding all UM studies and activities. Meeting minutes are submitted to LDH upon request~~.~~ (Model Contract 2.12.2.2).

Utilization Management Process

The UM Program emphasizes an integrated approach designed to facilitate treatment through comprehensive care and collaborative support that increases positive treatment outcomes. This holistic model of care includes the integration of both physical and behavioral health. 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. Service authorization criteria are consistent with applicable federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan and Waivers (Model Contract 2.12.4.1). Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, scheduled inpatient services, residential services, or urgent inpatient services, including obstetrical deliveries. The process is complete when the requesting provider and enrollee (when applicable) have been notified of the determination.

The Plan does not require providers to perform any treatment or procedure that is contrary to the provider's conscience, religious beliefs, or ethical principles in accordance with 42 CFR 438.10. If a provider declines to perform a service because of ethical reasons, the ~~member~~enrollee should be referred to another provider licensed, certified, or accredited to provide care for the individual service, or be assigned to another PCP licensed, certified, or accredited to provide care appropriate to the ~~member~~enrollee's medical condition. The Plan does not prohibit or restrict a provider from advising a enrollee~~member~~ about ~~his or her~~their health status, medical care, or treatment, regardless of whether benefits for such care are covered services or if the provider is acting within the lawful scope of practice. Furthermore, if the Plan elects not to provide, reimburse for, or provide coverage of a counseling or referral services because of an objection on moral or religious grounds, it furnishes information about the services it does not cover. If the Plan does not, because of moral or religious objections, cover the services the enrollee seeks, the Plan directs the enrollee to contact the Enrollment Broker for information on disenrollment procedures~~.~~ (Model Contract 2.13.6.2.16).

Roles and Qualifications

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. This licensure is specific to the state of contract if required by state regulations. Employees who are not qualified healthcare professionals, who are under the supervision of appropriately licensed healthcare professionals may approve services when there are explicit UM criteria, and no clinical judgment is required. The Plan maintains an in-depth new employee training and ongoing training program to ensure its staff remain current on industry standards and practices. 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 program.

UM employee compensation includes hourly fees and salaried positions. All PHCO ~~staff~~employees completing UM reviews and decisions are required to acknowledge an ~~A~~affirmative ~~S~~statement regarding compensation annually. Compensation or incentives to employees 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 providers or patients is prohibited. The Plan and its delegated UM agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

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

The Plan has medical and professional support ~~staff~~employees, qualified by training, experience and certification/licensure, as applicable, sufficient to conduct daily business in an orderly manner, including having enrollee services ~~staff~~employees directly available during business-hours for enrollee services consultation, as determined through management and medical reviews. The Plan maintains sufficient clinical ~~staff~~employees, 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~~employees during non-business hours. Staffing ratios are determined based on membership and state contract requirements which may include, but is not limited to the following:

Chief Medical Officer (CMO)/Medical Directors

As previously stated, the CMO oversees ~~utilization management~~UM and is responsible for the proper authorization and provision of care benefits and services to enrollees. The CMO 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 CMO 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~~BH providers 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. Only the medical director or other licensed clinical professionals with appropriate clinical expertise in the treatment of an enrollee's condition or disease makes 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 medical doctors (MD)~~s~~, and doctoral-level clinical psychologists.

Behavioral Health Provider

A ~~behavioral health~~BH provider is involved in implementing, monitoring, and directing the ~~behavioral health~~BH care aspects of the Plan's UM program. A ~~behavioral health~~BH provider may participate in UM rounds to assist in identifying behavioral health care needs and integrating behavioral and physical care. ~~Behavioral health~~BH providers also participate on various ~~P~~plan committees. The BH~~behavioral health~~ provider may be a medical director and a ~~P~~plan medical advisor and must be a physician or appropriate ~~behavioral health~~ BH provider (i.e., ~~behavioral health~~BH provider with a clinical doctor of philosophy (PhD) or doctor of psychology (PsyD)).

Vice President of Population Health and Clinical Operations (VPPHCO)

The VPPHCO is a registered nurse with experience in UM and ~~care management~~ ~~(~~CM~~)~~ activities. The VPPHCO is responsible for overseeing the day-to-day operational activities of the Plan's UM ~~p~~Program. The VPPHCO reports to the Plan ~~p~~President and CEO or ~~c~~Chief ~~o~~Operating ~~o~~Officer (COO). The VPPHCO, in collaboration with the ~~chief medical director~~CMO, assists with the development of the UM strategic vision in alignment with the corporate and ~~P~~plan objectives, policies and procedures.

Utilization Management Director/Manager

The UM Director/Manager is a registered nurse or appropriate licensed BH professional. The UM Director/Manager directs and coordinates the activities of the department including supervision of the outpatient utilization managers and inpatient utilization managers. The UM Director/Manager reports to the VP of the Department. The UM Director/Manager works in conjunction with the VP of the Department and CM director/manager to execute the strategic vision in conjunction with corporate and ~~P~~plan objectives and attendant policies and procedures and state contractual responsibilities.

Intake Operations Director/Manager

The Intake Operations Director/Manager directs and coordinates the activities of the department including supervision of the intake specialists, denials, appeals, and correspondence employees. The Intake Operations Director/Manager reports to the VP of Intake Operations.

Care Managers

Care managers are nurses or appropriate licensed mental health professionals (LMHP) with clinical and preferably UM and/or CM experience. There are several levels or types of ~~CMs~~care mangers within the organization and as such may be referenced with alternate titles such as: prior authorization nurse, concurrent review nurse, discharge planning nurse, hospital care manager, complex care manager, catastrophic care manager, disease care manager, care manager I, care manager II, etc., hereinafter collectively referred to as care managers. Care managers who coordinate discharge planning and apply approved UM medical necessity criteria to new or continued service requests and for concurrent review and requests for discharge report to and are supervised by the director/manager of UM. Care managers who are responsible

for the daily coordination of ~~care management~~CM and similar specialty programs report to the director/manager of CM. Care managers 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 ~~m~~Medical ~~d~~Director or ~~p~~Psychologist for a medical necessity review.

Intake Specialists

Intake specialists are individuals with significant administrative experience in the health care setting. Experience with ICD-10 and Current Procedural Terminology (CPT®) coding is preferred. Intake specialists work with providers to collect demographic other data necessary for preauthorization and may also have the authority to approve specific services for which there are explicit criteria or algorithms. Intake specialists cannot make clinical determinations, referring all clinical decisions to a care manager. Intake specialists report to and are supervised by the Director/Manager of Intake Operations or qualified designee.

~~Vice President of Pharmacy Operations~~

~~The Vice President of Pharmacy Operations (VPPO) is a registered pharmacist with experience in UM activities. The VPPO is responsible for overseeing the day-to-day operational activities of the Plan's pharmacy program. The VPPO reports to the Plan chief medical director. The VPPO, in collaboration with the pharmacy benefit manager (PBM), assists with the development of the pharmacy UM strategic vision in alignment with the corporate and Plan objectives, policies and procedures~~.

~~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 ~~m~~Medical ~~d~~Director may utilize a board-certified consultant from the appropriate specialty for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside the Plan may be contacted, when necessary, to avoid a conflict of interest. The Plan defines conflict of interest to include situations in which the provider, 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 provider who made the original request or determination.

Service Consultants

UM employees 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 is contacted. Specialty service consultants may include but are not limited to; occupational therapist, physical therapist, speech therapist, physician assistant, and certified nurse provider, etc.

Covered Services

The Plan has available for enrollees, at a minimum those core benefits and services specified in the Medicaid Managed Care Organization (MCO) Provider Agreement, Attachment B MCO Covered Services, and as defined in the Louisiana Medicaid State Plan, administrative rules and ~~D~~department policies and procedure manuals (Model Contract 2.4.1.1). 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 (Model Contract 2.12.8.4). The Plan has available the expertise and resources necessary to ensure the delivery of quality healthcare services to its enrollees in accordance with the Model Contract and prevailing medical community and national standards (Model Contract 2.4.1.1). 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 is amended and the Plan given not less than 60 days advance notice of the change. Services are 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 enrollees under the Medicaid State Plan. The Plan does not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of diagnosis, type of illness or condition of the enrollee. (Model Contract 2.4.1.3, 2.12.3.2, 2.12.3.3).

The pPlan covers medically necessary services that address the prevention, diagnosis and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability. (Model Contract 2.4.1.6.1).

Medical Necessity Review

Covered services are those medically necessary health care services provided to enrollees as outlined in the Plan's contract with the State and/or Centers for Medicare & Medicaid Services (CMS), or enrollee's evidence of coverage. Medical necessity means the covered services prescribed are based on generally accepted medical practices considering conditions at the time of treatment. Medically necessary services are those that are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the enrollee's medical or behavioral healthBH 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 enrollee, the physician, or the facility providing the care.
- Not primarily custodial care unless custodial care is a covered service or benefit under the enrollee's evidence of coverage and appropriate; and
- There must be no other effective and more conservative or substantially less costly treatment, service and setting available.
- The individual making these determinations is required to attest that no adverse determination is 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.

The individual making determinations attests that no adverse determination is made regarding any medical procedure or service outside of the scope of the individual's expertise (Model Contract 2.12.5.2.1). The Plan arranges for another level of care if appropriate when the Plan denies a service authorization request. (Model Contract 2.12.3.6.5).

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

A Llevel I review is conducted on covered benefits by a clinical UM designee care manager who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. A level I review is conducted utilizing applicable clinical and payment policies, Change Healthcare's InterQual criteria, the American Society of Addiction Medicine's (ASAM) criteria, applicable state or company developed clinical policy, while taking into consideration the individual enrollee needs and clinical setting at the time of the request, in addition to the local delivery system available for care. Other factors that must be considered when applying criteria to a given individual situation includes the enrollee's age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable. At no time does a level I review result in a reduction, denial, or termination of service. Only the mMedical dDirector or other licensed clinical professionals with appropriate clinical expertise in the treatment of an enrollee's condition or disease make

adverse determinations or authorize a service in an amount, duration or scope that is less than requested based on medical necessity. (Model Contract 2.12.5.2).

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 BH services, a qualified behavioral healthBH practitioner is consulted during the review. If the request is for dental services, a qualified dental practitioner conducts the level II review. Automatic referral for level II review includes requests for services or procedures that require benefit determination, services that do 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 following a level I review. All level II reviews are conducted with consideration given to continuity of care, individual enrollee 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 Aaffirmative Sstatement about iincentives, acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care, and that the Plan ensures that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any enrollee in accordance with 42 CFR §438.3(i) and 42 CFR §422.208 (Model Contract 2.12.5.1). EmployeesStaff must attest to this upon employment and annually thereafter. The Affirmative Statement about Incentives module may be found in the Centene University - NCQA Affirmative Statements about Incentives.

Clinical Criteria

The goals of the UM Program are to optimize enrollees' 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 enrollee'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 provider, and the enrollee. 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 enrollee needs and complications at the time of the request, in addition to the local delivery system available for care. The mMedical dDirector (or other appropriate provider as defined in this program descriptions), 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 Change Healthcare's InterQual guidelines to determine medical necessity and appropriateness of physical and/or behavioral healthBH care. Change Healthcare plays an integral role in healthcare, serving more than fifty percent50% of America's hospitals, twenty percent20% of U.S. physicians and ninety six96% percent of the top health plans. InterQual is developed by generalist and specialist physicians representing a national panel from academic, as well as community-based practice, both within and outside the managed care industry. InterQual provides a clear, consistent, evidence-based platform for care decisions that promote appropriate use of services, enhance quality, and improve health outcomes. The Plan uses InterQual's level of care and care planning criteria for pediatric acute, adult acute, home care, durable medical equipment (DME), and procedures to determine medical necessity and appropriateness of care. The Plan may also use the sub-acute/skilled nursing facility (SNF) guidelines to assist in determining medical necessity for sub-acute or skilled nursing care for enrollees with catastrophic conditions or special health care needs. The Plan utilizes InterQual guidelines for BH inpatient, residential/psychiatric residential treatment facility (PRTF), partial hospitalization, intensive outpatient, and outpatient therapy services. The Plan also uses ASAM criteria for substance abuse. The Plan provides 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 mMedical dDirector first consults available clinical policies. The Centene Clinical Policy Committee (CPC) develops these statements.

The Centene Clinical Policy Committee~~CPC~~ is responsible for evaluating new technologies or new applications of existing technologies for inclusion as medical necessity criteria. The Clinical Policy Committee~~CPC~~ develops, disseminates, and annually updates clinical policies related to medical procedures, ~~behavioral health~~BH procedures, pharmaceuticals, and devices. The Clinical Policy Committee~~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. Providers are notified in writing through the provider newsletters and the provider web portal (as applicable) of new technology determinations made by the Plan. As with standard UM criteria, the treating provider may, at any time request the medical policy criteria pertinent to a specific authorization by contacting the UM Department or may discuss the UM decision with the Plan ~~m~~Medical ~~d~~Director.

Preventive and Clinical Practice Guidelines

While practice guidelines are not used as criteria for medical necessity determinations, the ~~m~~Medical ~~d~~Director and UM employees make UM decisions that are consistent with national evidence-based guidelines distributed to network providers. Such guidelines include, but not be limited to, adult and child preventive health, asthma, prenatal care, diabetes, lead screening, sickle cell, immunizations, American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry, and attention deficit hyperactivity disorder (ADHD/ADD) guidelines for both adults and children. As detailed in the associated policy LA.CP.CPC.03c 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 practice guidelines are listed on the Plan's public website. The Plan complies with the requirements specified in 42 C.F.R. §438.236~~.~~ (Model Contract 2.12.12.1).

Provider Access to Criteria

At any time, treating providers may request UM criteria, including internal clinical policy, pertinent to a specific authorization request by contacting the PHCO Department or they may discuss the UM decision with the Plan ~~m~~Medical ~~d~~Director. Each contracted provider receives a provider manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the department. The Provider ~~m~~Manual also outlines the Plan's policies and procedures.

Inter-rater Reliability (IRR)

At least annually the ~~CMO and~~ VP-PHCO and the and Vice President of Medical Affairs (VPMA), in conjunction with the Plan and the Clinical Criteria Team, initiates and conducts testing to assess the consistency with which medical directors and UM employees 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 VPPHCO or designee to compare how employees manage the same case, a forum in which the employees and physicians evaluate determinations, or periodic reviews/audits of cases against criteria. When an opportunity for improvement is identified through this process, the Plan's PHCO leadership takes corrective action. New UM employees are required to successfully complete ~~interrater reliability~~IRR testing prior to being released from training oversight.

Submission of Clinical Information

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

Prior Authorization

Prior authorization requires the provider to make a formal medical necessity determination request to the Plan prior to the service being rendered. An enrollee may also submit, verbally or in writing, for a service authorization request for the provision of services (Model Contract 2.12.3.6.6). 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 and any court-ordered requirements of LDH. Prior authorization is never required for emergency services, post-stabilization services, non-emergency inpatient hospital admissions for normal newborn deliveries ~~or~~and EPSDT screening services~~.~~ (Model Contract 2.12.3.1, 2.12.8.7).

Centene's Corporate PHCO Department reviews the Prior Authorization List routinely, in conjunction with the Plan's CMO and VPPHCO, to determine if any services should be added or removed from the list. The Provider Services, Enrollee Services and Network Management departments are also be consulted on proposed revisions to the Prior Authorization List. Such decisions are based on the Plan's program requirements, or to meet federal or state statutory or regulatory requirements. ~~Providers are appropriately notified when such modifications occur.~~

Clinical Information

For medical services that the Plan has determined require prior authorization and/or certification, only the minimally necessary information is obtained. The information required is not overly burdensome for the enrollee, the provider/~~staff~~employees, or the health care facility ~~staff~~employees. Clinical information received, as well as rationale for the medical necessity determination and/or leveling of care is documented and maintained in the clinical authorization system. Only information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services is collected. Information needed to perform the review may include, as applicable, but is not limited to the following information:

- Office and hospital records
- A history of the presenting problem
- Clinical or mental status exam notes
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history or assessments
- Information on consultations with the treating provider
- Evaluations from other healthcare practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitation evaluations
- Printed copy of criteria related to the request
- Information regarding benefits for service or procedure
- Information regarding local delivery system
- Patient characteristics and information
- Information from responsible family enrollees
- Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS), or other level of care assessment
- Physical or ~~behavioral health~~BH screenings and results

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 enrollee'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 enrollee's health care team, including the enrollee, or parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network provider or an out-of-network provider, if there is no in-network provider available. The second opinion is provided at no cost to the enrollee.

Extended Specialist Services

Established processes are in place by which an enrollee requiring ongoing care from a specialist may request a standing authorization. Additionally, the policies include guidance on how enrollees 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 an enrollee requires services that are not available from a qualified network provider, the Plan adequately and timely (according to the Plan's provider availability and accessibility standards) covers services out-of-network for ~~members~~enrollees. The decision to authorize use of an out-of-network provider is 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 an enrollee of the provider's family has a financial relationship.

Concurrent Review

The concurrent review process assesses the clinical status of the enrollee, verifies the need and level of continued hospitalization or ongoing ambulatory care, evaluates for alternative care options, facilitates the implementation of the provider's ~~plan of care~~care plan, promotes timely delivery of care, and engages in proactive discharge planning. The concurrent review ~~staff~~employees determine~~s~~ 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,
- ~~•~~
- Enrollee status, including any diagnosis change during stay, to determine special requirements to facilitate a safe discharge to another level of care,
- ~~•~~ ~~Member status, including any diagnosis change during stay, to determine special requirements to facilitate a safe discharge to another level of care,~~
- Additional days/service/procedures proposed, and
- Reasons for extension of the treatment or service.

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the ~~patient~~enrollee's condition on-site, telephonically, via fax, or other electronic means. ~~-~~The frequency of reviews is based on the severity/complexity of the enrollee's condition and/or necessary treatment and discharge planning activity and are not routinely conducted ~~on a~~ daily ~~basis~~. If, at any time, services cease to meet inpatient or ambulatory criteria, discharge criteria are met and/or alternative care options exist, the care manager contacts the provider 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 ~~m~~Medical ~~d~~Director or appropriate BH professional 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 employees become aware of potential quality of care issues, the concern is referred to the Plan QI Department for investigation and resolution.

The ~~P~~provision of an urgent inpatient hospital psychiatric screen, ~~:~~is that ~~A~~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 enrollee presents in a hospital, where they cannot 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 enrollee presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it is classified as an urgent screen. The referral from the Plan for an ~~U~~urgent ~~i~~inpatient ~~P~~psychiatric ~~H~~hospital ~~S~~screen is made within 24 hours after the referral and full medical information is received by Plan. The screen to determine appropriate treatment is 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.

Upon completion of the inpatient psychiatric hospital concurrent utilization review, if the inpatient admission is approved, the Plan notifies 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 notifies 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 includes whether or not an alternative community services plan is appropriate, the right of the enrollee to appeal and the process to do so.

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.

Discharge Planning

Discharge planning is a method of coordinating care, controlling costs, and arranging for the appropriate services upon discharge from the hospital. For enrollees who have not fully recovered or do not require the highly specialized and intensive services of acute hospital care, discharge planning assists the enrollee 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 an enrollee's hospital stay. The care management employees~~r~~ reviews~~s~~ the post-hospital needs of the enrollee with the enrollee, the enrollee's family, and the PCP. The care management employees~~r~~ works~~s~~ with the UM ~~staff~~employees of the hospital, PCP, and managing provider to arrange for services needed before the enrollee is discharged from the hospital. Community based agencies are included in the discharge planning as appropriate. For the ~~behavioral health~~BH population, provide aftercare planning for enrollees prior to discharge from a 24-hour facility.

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 coordinates benefits with other payors including Medicare, ~~W~~worker's ~~C~~compensation, and commercial insurance in order to maintain access to appropriate services.

Out-of-Network Services

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

Provider Termination

Enrollees are notified of a PCP termination from the Plan's network or of specialist termination for those enrollees in active treatment with that provider. In order to ensure appropriate continuity and transition of care, the Plan allows continuation of such services for up to ~~ninety (~~90~~)~~ calendar days or until the enrollee is reasonably transferred to a in-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 an enrollee changes physicians due to termination from network or by enrollee choice, the Plan assists with transfer of the medical records to the new provider as needed.

Retrospective Review

Retrospective review is an initial review of services that have already been rendered (LA.UM.05.01 Retrospective Review for Services Requiring Authorization). This process encompasses services performed by a participating or non-participating provider without ~~P~~plan notification and/or authorization and when there was no opportunity for concurrent review. The director or designee reviews the request for retrospective authorization. If supporting documentation satisfies the administrative waiver of notification, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the director or designee requests a medical director review. A determination is made within ~~thirty (~~30~~)~~ calendar days of obtaining the results of any appropriate medical information that may be required, but in no instance later than 180 calendar days from the date of receipt of request for service authorization~~.~~ (Model Contract 2.12.6.3.1).

Post-service authorization requests are reviewed to determine if any of the following circumstances exist:

- The provider was not able to determine the ~~member~~enrollee's eligibility.
- The service was urgent in nature and there was not time to submit a request prior to service delivery.
- The service is part of an ongoing plan of treatment for a newly eligible ~~member~~enrollee.
- Extenuating circumstances existed that precluded the provider from submitting a timely pre-service or concurrent review authorization request.

Significant Lack of Agreement

When there is significant lack of agreement between the Plan's employees and the health care provider regarding the appropriateness of certification during the initial review or appeal process, additional information may be requested.

~~"~~Significant lack of agreement~~"~~ means the UM reviewer has:

- Tentatively determined a service cannot be certified,
- Referred the case to the ~~m~~Medical ~~d~~Director for review; and
- Spoken to or attempted to speak to the provider regarding additional information.

Timeliness of Utilization Management~~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 providers to notify the Plan of a service request and for the Plan to make UM decisions and subsequent notifications to the enrollee and provider. The Plan regularly monitors and reports on timeliness of UM decision making.

For all pre-scheduled services requiring prior authorization, the provider must notify the Plan within seven (7) calendar days prior to the requested service date or as soon as the need for service is identified. Facilities are required to notify the Plan of all inpatient admissions, residential admissions, and long-term care facility admissions within one (1) business day following

the admission. Prior authorization is never required for emergency services~~.~~ (Model Contract 2.13.6.2.11.2). Once the enrollee's emergency medical condition is stabilized, notification of hospital admission or authorization for follow-up care is required as stated above. All decisions and notifications are provided within the timeframes as noted in LA.UM.05 Timeliness of UM Decisions and Notifications.

Denial Notices

A denial of services, also called an adverse determination, is a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations (LA.UM.07 Adverse Determination (Denial) Notices). The ~~m~~Medical ~~d~~Director or reviewer may approve an alternative to the service being requested. If the requesting provider and/or enrollee do not agree to the alternative, the originally requested service may be denied. However, if the requesting provider and/or enrollee agree with the alterative and the care is authorized, the requesting provider has essentially withdrawn his or her initial request and this is not to be considered a denial. The Plan does not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval unless the approval was based upon a material omission or misrepresentation about the enrollee's health condition made by the provider~~.~~ (Model Contract 2.12.6.3.2).

Upon any adverse determination made by the Plan ~~m~~Medical ~~d~~Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, is communicated to the requesting provider and the enrollee. Verbal notification of any adverse determination is also be provided when applicable. All notifications are provided within the timeframes as noted in LA.UM.05 Timeliness of UM Decisions and Notifications. The written notification is easily understandable and includes the enrollee 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~~.~~ (La R.S. §46:460.74).

Providers are provided with the opportunity to discuss any UM denial decisions with a physician or other appropriate reviewer. The Plan ~~m~~Medical ~~d~~Director or appropriate provider reviewer (BH provider, dentist, pharmacist, etc.) serves as the point of contact for the informal reconsideration/peer to peer discussion. This is communicated to the provider 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) calendar days of the date of the adverse decision letter. It is not a prerequisite, nor does it supersede the enrollee's right to file an appeal.

Appeal of Utilization Management~~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 State Fair Hearing rights. A denial of these services is not considered an action for purposes of grievances and appeals. Enrollees, authorized representatives (with written consent from the enrollee as dictated by State contract), or legal representatives of a deceased enrollee's estate may appeal adverse determinations regarding care. A healthcare provider with knowledge of the enrollee's medical condition, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. Expedited appeals are available to enrollees for any urgent care requests and do not require written enrollee consent for a healthcare provider to act on the enrollee's behalf. Punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal~~.~~ (Model Contract 2.15.4.11).

Enrollees are provided a reasonable timeframe to file an appeal. The content of an appeal including all clinical care aspects involved are fully investigated and documented. Enrollees, or their authorized representatives, have the right to submit comments, records, documentation, and other information relevant to the appeal in person or in writing. A physician or other appropriate clinical peer of a same-or-similar specialty, not supervised by the individual, nor involved in the original determination, evaluates medical necessity decisions for adverse appeal decisions. The Plan receives, reviews, resolves, and provides the ~~member~~enrollee with written or electronic notification of the decision as noted in LA.UM.08 Appeal of UM Decisions.

The Plan provides an explanation of the appeals process and the right to a State Fair Hearing of adverse determination to all enrollees upon enrollment and annually thereafter. This process is also explained in the Enrollee Handbook, enrollee newsletters, enrollee educational flyers, adverse determination notifications, and may be posted at network provider offices. All materials are produced in ~~E~~english and are available in additional languages upon request. ~~-~~Enrollees and providers,

who appeal on behalf of enrollees, 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.

Experience with Utilization Management~~UM~~ Process

Annually, the Plan evaluates both enrollees' and providers' satisfaction with the UM process (LA.UM.11 Experience with the UM Process). Mechanisms of information gathering may include, but are not limited to, enrollee satisfaction survey results (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS)), enrollee/provider grievances/complaints and appeals that relate specifically to UM, provider satisfaction surveys with specific questions about the UM process and soliciting feedback from enrollees/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, the Plan develops an action plan and interventions to improve on the areas of concern which may include ~~staff~~employees retraining and enrollee/provider education.

Communication

Enrollees and providers can access UM ~~staff~~employees 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. TTD/TTY services for deaf, hard of hearing, or speech-impaired enrollees are available. The phone numbers are included in the Enrollee Handbook, on the web and in all enrollee letters. Additionally, language assistance for enrollees to discuss UM issues is provided either by bilingual ~~staf~~employees~~f~~ or through language line services.

Inbound and outbound communications may include directly speaking with providers and enrollees; or fax, electronic or telephone communications (e.g., sending email messages or leaving voicemail messages). Employees identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues. After normal business hours and on declared State holidays, calls to the UM department are automatically routed to the 24-hour nurse advice line. The 24-hour nurse advice line is not a delegated UM entity and therefore does not make authorization decisions. The 24-hour nurse advice line employees take authorization information for next business day response by the Plan or notify the Plan on-call ~~staff~~employees in cases requiring immediate response.

The Plan's PHCO Department is available to coordinate services for enrollees 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~~employees may direct the enrollee, as appropriate, to their PCP or emergency department. Under no circumstances does the PHCO ~~staff~~employees offer medical advice. At any time, enrollees may also contact 24-hour nurse advice line, 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 UM Department by phone, facsimile, or web portal (as available) from the servicing/managing provider or facility. Although a health care provider may designate one or more individuals as the contact for the UM ~~staff~~employees, in no event does this preclude a medical advisor from contacting a health care provider or others in ~~his or her~~their employment when there is unreasonable delay or when the designated individual is unable to provide the necessary information or data requested.

Access to Physician Reviewer

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

Requesting Copies of Medical Records

PHCO ~~staff~~employees does not routinely request copies of medical records on all patients reviewed. During prospective and concurrent review, copies of medical records are only required when difficulty develops in certifying the medical

necessity or appropriateness of the admission or extension of stay. In those cases, only the necessary or pertinent sections of the record are required. Medical records may also be requested to complete an investigation of an enrollee complaint/grievance/appeal or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities are maintained at all times. Confidentiality of information necessary to conduct UM activities is always maintained. ~~Unless modified by state statute and/ or federal regulations, health care providers are not reimbursed for the reasonable costs for providing medical information in writing including copying and transmitting any requested patient records or other documents. Enrollees requesting a copy of the Plan's designated record set are not charged for the copy.~~

Sharing Information

The Plan's PHCO ~~staff~~ employees share~~s~~ 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 enrollees or providers.

Provider – Enrollee Communication

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

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

Emergency Services

Emergency department services are available 24 hours/day 7 days/week. Prior authorization is not required for emergency services and coverage for such is based on the severity of the symptoms at the time of presentation (LA.UM.12 Emergency and Post-Stabilization Services). Emergency services are covered services furnished by a qualified practitioner that are needed to evaluate or stabilize an emergency medical condition. The Plan covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

An emergency medical condition is a medical, mental health, or substance use related 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 providers, and is covered until the enrollee is stabilized. The Plan also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a Plan network provider, or ~~P~~plan representative, instructs an enrollee to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the enrollee'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 does not refuse to cover an emergency service based on the provider'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. Enrollees who have an emergency medical condition are not required to pay for subsequent screening and treatment needed to diagnose the specific condition or stabilize the enrollee.

~~**Pharmaceutical Management**~~

~~The Pharmacy Management Program is overseen by the Plan Pharmacist. All policies and procedures utilized by the Plan related to pharmaceutical management include the criteria used to adopt the procedure as well as a process that includes pharmacists and appropriate providers and uses clinical evidence from appropriate external organizations in the development of such policies and procedures. The program is reviewed at least annually and updated as new pharmaceutical information becomes available. Pharmacy policies and procedures are made available, annually and after updates, to enrollees and prescribing practitioners via newsletter or another mailer and/or the Plan website.~~

~~**Preferred Drug List**~~

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

~~**Pharmacy Benefit Manager**~~

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

~~The pharmacy prior authorization (PA) process promotes the most appropriate utilization of selected high risk and/or high-cost medications, and those with a high potential for abuse. This process is delegated to the PBM and administered in accordance with applicable state and federal requirements, accreditation standards, and recognized high quality practice standards. The PA criteria for approval of drug coverage are developed, reviewed, and approved by the State Medicaid Pharmacy staff due to the Single Preferred Drug List (PDL).~~

Behavioral Health Management

The Plan is responsible for providing basic and specialized ~~behavioral health~~BH benefits and services to all enrollees as provided in a medical provider's office. The Plan strongly supports the integration of both physical and ~~behavioral health~~BH 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; enrollees accessing care with contracted providers do not require a referral from their PCP nor an assessment. The Plan assists enrollees with locating a network ~~behavioral health~~BH provider to schedule referred services with appropriate urgency to the applicable care setting and exchange appropriate information with those providers to ensure coordination and continuity of care.

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

Behavioral Health Levels of Care

The Plan ensures enrollees receive high quality ~~behavioral health~~BH care services and that all placements are a the most appropriate, least restrictive, and medically necessary level to treat the specialty needs of the enrollee (Model Contract 2.9.25.22). 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 enrollee's ~~behavioral health~~BH (i.e., mental health and/or substance abuse) needs. Levels of care may be available as a covered benefit; covered benefits vary by ~~P~~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 healthBH specialists. This level of care also includes observation 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 healthBH specialists at facilities which are not licensed as hospitals.

Residential Treatment

Residential treatment describes a 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 healthBH services that cannot be provided by a combination of outpatient or community-based services. Each enrollee's treatment plan should address their specific mental health and/or substance abuse needs, set discharge criteria, identify barriers to discharge, and ensure the treatment is the least restrictive option. Family therapy should occur two (2) to three (3) times a week to ensure the enrollee can successfully reintegrate back to their home and community, unless there is an identified valid reason why this is not clinically appropriate or feasible.

Partial Hospitalization

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

Day Treatment

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

Intensive Outpatient

Intensive outpatient programs must provide an integrated program of rehabilitation, counseling, education, therapeutic, and/or family services preferably nine (9) hours in a week (minimum of six (6) hours a week) to address an individual's behavioral healthBH 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 an enrollee 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 healthBH 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~~BH 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~~SUD 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. MHPAEA does not preempt State law, unless such law limits application of the act. The Plan ensures ~~non-quantitative treatment limitations (~~NQTLS~~)~~ are applied with a fair and equitable approach that takes into account recognized clinically appropriate standards of care. If an enrollee is provided mental health or SUD~~substance use disorder~~ benefits in any classification of benefits, mental health and ~~substance use disorder~~SUD benefits must be provided to the enrollee in every classification in which medical/surgical benefits are provided~~.~~ (Model Contract 2.2.7.2 & 2.2.7.2.1, 2.2.7.2.2).

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 reports fraud and abuse information identified through the UM Program to LDH's ~~P~~program ~~I~~integrity ~~U~~unit in accordance with 42 CRF §455.1(a)(1)~~.~~ (Model Contract 2.12.1.2.3).

Predictive Modeling

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. Enrollees may be identified for CM through additional sources, including, but not limited to: inpatient census reports, health risk screening, data from UM/CM processes, new enrollee welcome calls, enrollee self-referral, and physician referral.

Care Transition

The Plan provides active assistance to enrollees when transitioning into or out of the Plan, including transition to another MCO or other programs. In the event an enrollee entering the Plan is receiving medically necessary covered services at the time of enrollment, the Plan honors a transition period for continuation/coordination of such services up to ~~ninety (~~90~~)~~ calendar days or until the enrollee may be reasonably transferred without disruption, whichever is less (Model Contract 2.8.1.4.9). The Plan may require prior authorization for continuation of select services as noted on the Prior Authorization List beyond ~~thirty (~~30~~)~~ calendar days~~.~~ (Model Contract 2.12.7.1.1). The Plan allows 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 first ~~thirty (~~30~~)~~ calendar days of enrollment (Model Contract 2.12.7.1.2). During the transition period, the Care Manager notifies the new PCP of enrollee's selection, initiate a request of transfer for the enrollee's medical files, transition medically necessary services to a network provider (if applicable) and all other requirements for new enrollees. Providers are required to send a copy of the enrollee's medical record and supporting documentation, at no charge to the enrollee, to the new PCP within ten (10) business days of receiving the PCP's request. For enrollees in active care transitioning out of the Plan, the Care Manager communicates active services and coordinate with the receiving entity to ensure a smooth transition without interruption of care.

Pregnant Women

In the event a new enrollee entering the Plan is receiving medically necessary covered services other than prenatal services at the time of enrollment, the Plan is responsible for the costs of continuation of such medically necessary services, without any form of authorization needed and without regard to whether such services are being provided by network or non-network providers. The Plan provides continuation of such services up to ~~ninety (~~90~~)~~ calendar days or until the enrollee may be reasonably transferred to an in-network provider 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~~.~~ (Model Contract 2.12.7.2.3).

In the event a new enrollee entering the Plan is in her first trimester of pregnancy and is actively receiving medically necessary covered prenatal care services at the time of enrollment, the Plan is responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of authorization needed and without regard to whether such services are being provided by a network or non-network provider until such time as the Plan can reasonably transfer the enrollee to a network provider without impeding service delivery that might be harmful to the enrollee's health~~.~~ (Model Contract 2.12.7.2.1).

In the event a new enrollee entering the Plan is in her second or third trimester of pregnancy and is actively receiving ~~medically necessary~~medically necessary covered prenatal care services at the time of enrollment, the Plan is responsible for providing continued access to the prenatal care provider (whether network or non- network provider) for ~~sixty (~~60~~)~~calendar days post-partum, provided the enrollee remains covered through the Plan, or referral to a safety net provider if the enrollee's eligibility terminates before the end of the post-partum period~~.~~ (Model Contract 2.12.7.2.2).

The Plan ensures that the enrollee is held harmless by the provider for the costs of the above medically necessary MCO covered services~~.~~ (Model Contract 2.12.7.2.4).

Continuity for DME, Prosthetics, Orthotics, and Supplies

In the event an enrollee who is newly enrolled with the Plan is actively receiving Medicaid covered DME, prosthetics, orthotics, and certain supplies and services at the time of enrollment, whether such services were provided by another MCO or Medicaid fee-for-service, the Plan is responsible for the costs of continuation of these services, without any form of authorization and without regard to whether such services are being provided by network or non-network providers. The Plan provides continuation of such services for up to ~~ninety (~~90~~)~~ calendar days or until the enrollee may be reasonably transferred to a network provider (within the timeframe specified in the State Contract) without disruption, whichever is less. The Plan also honors any prior authorization for DME, prosthetics, orthotics and certain supplies and services issued while the enrollee was enrolled in another MCO or the Medicaid fee-for-service program for a period of ~~ninety (~~90~~)~~ calendar days after the enrollee's enrollment in the Plan~~.~~ (Model Contract 2.12.7.5.1, 2.12.7.5.2).

Measuring Effectiveness

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

- Utilization data, such as frequency of ~~ED~~ emergency department visits or inpatient admissions
- Self-reported enrollee and provider information such as satisfaction (CAHPS) with the program, level of understanding of the communication process with providers.
- Turn ~~A~~around ~~T~~times for ~~D~~decision/~~D~~determination ~~N~~notification
- Denial ~~O~~overturn ~~R~~rate (~~%~~percentage of denials overturned on appeal)

This measurement and analysis are documented as part of the annual UM Program ~~E~~evaluation.

Care Management and Disease Management

Disease management is a multidisciplinary, continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for, chronic medical conditions. ~~Care management~~CM or care coordination is a collaborative process of assessment, planning, coordinating, monitoring, and evaluating the services required to meet an individual's needs. Both programs are described in detail in LA.CM.01 Care Management Program Description.

Program Evaluation

The UM Program is evaluated at least annually, and modifications made as necessary. The CMO and VP~~-~~PHCO evaluates the impact of the UM Program by using:

- Enrollee complaint, grievance, and appeal data

- The results of enrollee satisfaction surveys
- Provider complaint and provider satisfaction surveys
- Relevant UM data
- Provider profiles
- Drug ~~U~~utilization ~~R~~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 PHCOC for review, action, and follow-up. The final document is then submitted to the BOD/governing body through the QAPIC for approval.

Reports
The plan submits UM reports as specified by LDH. LDH reserves the right to request additional reports. LDH notifies the plan of additional required reports no less than ~~sixty (~~60~~)~~ days prior to the due date of those reports~~.~~ (Model Contract 2.12.1.4).

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. Delegation is dependent upon the following factors:

- A pre-delegation review is necessary to determine the ability to perform the delegated function(s) ~~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 specifies the standards of performance to which the contracted group has agreed.~~ The relationship manager for the delegate prepares contract and delegation agreement with the delegate to include applicable SLAs and performance guarantees, as well as reporting requirements
- 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, including turn-around time, inter-rater reliability, program description, annual workplan and evaluation~~to include monthly utilization summaries, days, and quality assurance/improvement issues, as applicable~~.

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

- Annual review and 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 the Plan's Delegated Vendor Oversight Department and the PHCOC.
- 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. In the instance where the delegate is the National Committee for Quality Assurance (NCQA) accredited, the Plan may assume that the delegate is carrying out responsibilities in accordance with NCQA

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