Utilization Management Program Description 2021

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Subject:	**Utilization Management Program Description**
Applicability:	All Products; Nevada, Texas, Florida
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1. PURPOSE

Prominence Health Plan (PHP) Utilization Management Program (UM) is designed to maximize the effectiveness of services provided to plan members, by advocating access to appropriate, quality and cost-effective care.

This UM Program is applicable to all Prominence Health Plan products including Prominence Health Plan of Nevada, Prominence HealthFirst of Texas, and Prominence HealthFirst of Florida.

Utilization Management involves the evaluation and coordination of health care services for a culturally diverse population. The comprehensive UM Program promotes objective, systematic monitoring and evaluation of appropriate resources throughout the continuum of care. Prominence Health Plan's utilization management is an integral component of the Prominence Health Plans Quality Improvement (QI) Program. Utilization Management and Quality Improvement resources work in tandem in coordinating various aspects of the comprehensive Utilization Management/Quality Improvement functions. Utilization Management activities are supported by objective, evidence-based, nationally recognized medical policies, criteria, and clinical guidelines.

2. GOALS

It is the goal of PHP UM Program to coordinate the provision of high quality, safe, and cost-effective medical services by appropriate practitioners and providers, including delegated providers, utilizing available healthcare benefit resources. PHP is not a provider of care.

3. OBJECTIVES

3.1 Program Evaluation:

a. Prioritize and implement initiatives and measure effectiveness
b. Identify opportunities for improvement and implement action plans as needed
c. Develop a UM work plan yearly that employs the results of the previous year's program evaluation
d. Analyze utilization management, including, behavioral health indicators against performance goals and recognized thresholds and benchmarks
e. Conduct an annual UM program evaluation

3.2 Program Administration:

a. Promote fair, consistent, and timely utilization decisions in compliance with accreditation agencies, Department of Labor (DOL), and State or Federal regulations timeliness filing standards
b. Promote equitable and timely access to care/services across the network
c. Maintain processes that expedite prior authorization and specialist referrals as appropriate
d. Continue to provide clear explanation of denial reasons
e. Monitor prior-authorizations and denial turnaround times
f. Implement corrective action plan for deficient areas

3.3 Clinical Care:

a. Monitor compliance with Utilization Management clinical criteria
b. Increase health care service efficiencies and reduce avoidable expenses by implementing programs which encourage preventive health care and behaviors, improving quality of care by increasing patient engagement in health care management, promote wellness and compliance with treatment plans and improving the provider experience.

3.4 Program Effectiveness:

a. Monthly, Health Services Leadership Team reviews outcome metrics from the Health Services Division; including, the Utilization Management Department, Transition of Care Department, and Case Management Department against MCG well managed benchmarks and member outcomes.
b. Quarterly, the Health Services Director reports out on the above metrics to the MAC.
c. The MAC reviews each outcome metric report and conducts qualitative and quantitative analyses to determine the cause and effective performance data not within threshold.
    1. Under/Over Utilization: By practice site, MAC reviews and makes recommendation to address identified problems of under/over utilization as appropriate.
    2. Timeliness:
        i. Standard Prior Authorizations - Clinical Decision Making & Timeliness
        ii. Expedited Prior Authorizations - Clinical Decision Making & Timeliness
        iii. Authorization Appeals - Clinical Decision Making & Timeliness
        iv. Timely Decisions about Appeals
        v. Reviewing Appeals Decisions: Upheld and overturn rates of appeals
d. Annually, MAC receives, reviews, and makes recommendations concerning the outcomes on the following reports:
    1. Director, Performance Improvement reports out on Member Satisfaction and Experience.
        i. CAHPS & Mock Member Experience Survey: Access, accessibility, coordination, and continuity of care and services.
        ii. Evaluate member perception of Utilization Management related functions using survey data and other available data, develop, and initiate processes to improve when indicated.
    2. Director, Health Services reports out on the following:
        i. Inter-rater reliability testing conducted at least annually to ensure consistent application of Utilization Management criteria by the Utilization Management clinical staff and its delegates and acts upon opportunities, if applicable. Corrective action is implemented as needed.
        ii. Organization Determinations Letters
    3. Compliance: Meet requirements of regulatory and accrediting agencies to comply with applicable laws and regulations.

3.5 Delegation:

a. Maintain effective monitoring and oversight of delegated Utilization Management functions
b. Communicate results of oversight findings, including recommendations for improvement, to the PHP delegates
c. Refer to Delegation Section below.

d. **Vendor**	e. **Vendor Owner**	f. **Delegated Services**
g. **Liberty Dental**	h. **Operations**	i. **Credentialing, Customer Service, Griev & Appeals, Provider Network, Qu Improvement**
j. **MedImpact**	k. **Pharmacy**	l. **Customer service, Grievance, Pro Network, Prior Authoriztion, Request Payment/Direct Member Reimburser UM**

m. **National Vision Administrators (Vision)**	n. **Operations**	o. **Claims, Customer Service, Authorizations, Provider Netw Credentialing,& Grievances**
p. **Sinfonia Rx**	q. **Pharmacy**	r. **Medication Therapy Management**
s. **Teladoc**	t. **Health Services**	u. **Credentialing, Customer Service, Pro Network**
v. **Tethys Health Ventures**	w. **Health Services**	x. **Organ & Bone Marrow Transplant**
y. **CDMS**	z. **Sales**	aa. **Fulfillment Operations: Prior notification letters**
bb. **AaNeel Care**	cc. **IT**	dd. **Prior authorization, appeals/grievan member/provider portal source system**

4. ORGANIZATIONAL STRUCTURE

The organizational structure supporting the ongoing development and implementation of the comprehensive Utilization Management Program is defined through the Quality Improvement (QI) Committee Structure.

PHP Board of Directors is the governing body for Prominence Health Plans. The Board of Directors has ultimate authority, accountability, and responsibility for the quality of care and service delivered. The Board of Directors delegates the implementation and monitoring oversight of the day-to-day operational responsibilities to PHP Chief Executive Officer (CEO) and PHP Quality Improvement Committee. PHP Chief Medical Officer (CMO) or Medical Director(s), as applicable are responsible for reporting UM activities to the Board of Directors and providing feedback to the PHP as appropriate.

The Utilization Management Program functions under the direction of the PHP CMO or CMO delegate, and/or Medical Director who assures medical and behavioral health care decisions are based on appropriateness of care, State and Federal mandates, and consideration of unique needs of individuals as well as local communities. Services are also evaluated for consistency with benefit plan descriptions and medical necessity.

PHP Medical Director(s), PHP also ensures that a designated behavioral health practitioner, physician, psychiatrist, or clinical psychologist is involved in the implementation of behavioral health aspects of the Utilization Management Program, as applicable.

4.1 Quality Improvement Committee (QIC)

Is a multidisciplinary oversight committee that serves as a coordinating and advisory body and has final authority over other QI subcommittee's functions and activities. Identified quality and performance indicators are monitored to determine trends and or patterns and to select opportunities for improvement. The QIC meets at least quarterly per year and is chaired by the PHP CMO or delegate with the assistance of the PHP Medical Director(s), determine appropriate practitioner and staff resources in developing appropriate action plans for improvement. The QIC is responsible for providing direction and oversight of the comprehensive Utilization Management Program. It is the responsibility of the QIC to annually approve the PHP UM Program, UM Program Evaluation, UM activities, and monitoring the UM Program's effectiveness; including, measuring practitioner and member satisfaction to identify areas of dissatisfaction with PHP's processes specific to the comprehensive UM operational responsibilities.

4.2 Medical Advisory Committee (MAC)

Is a multi-dimensional advisory committee designed to assist in the development, implementation, monitoring, and analysis of identified clinical and service quality indicators and practice management of Plan Practitioners/Providers. The MAC is chaired by PHP Chief Medical Officer with assistance of the PHP Medical Director(s).

The purpose of this committee includes, but is not limited to:

a. Creation and review of medical policies
b. Clinical criteria review annually
c. Care Management (CM) Program (Clinical practice and preventive health guideline development and review)
d. Over and/or under-utilization monitoring activities
e. Evaluation of new technology and new application of existing technologies
f. Annual review of UM Program Description, UM Work Plan, and UM Evaluation
g. Ongoing monitoring of UM performance data

The MAC includes appropriate practitioners with clinical expertise in identified fields of medicine including behavioral health. Expertise is sought through professional peer review organizations, delegates, or local practitioners as applicable. PHP gives practitioners, with clinical expertise in the area being reviewed, the opportunity to advise or comment on development and adoption of UM criteria, and on instructions for applying criteria. Currently, PHP utilizes evidence based nationally recognized criteria as a guide for making utilization decisions.

The MAC meets quarterly and is a subcommittee of the QI Committee. Medical Advisory activities are reported to QIC by the MAC chairperson.

4.3 Pharmacy and Therapeutics Committee (P&T)

The P&T is a multi-dimensional committee and is chaired by PHP Medical Director(s). P&T meets quarterly and is a subcommittee of the PHP QIC.

Members included but not limited to:

- Chief Medical Officer, Health Plan, who shall serve as Chairperson
- Medical Director, Health Plan, who shall serve as Chairperson if Chief Medical Officer is absent
- Director of Pharmacy, Health Plan, who shall serve as Vice Chairperson
- Five (5) external practicing physicians or practicing pharmacists. They may come from various clinical specialties that adequately represent the needs of members. At least two practicing physicians must be currently credentialed within Prominence Health Plan's provider network.

Standing Non-voting Members (standing invitees)

- Health Services Director, Health Plan
- Quality Improvement Director, Health Plan
- Clinical Pharmacist, Health Plan
- Pharmacy Liaison, Health Plan
- Clinical Pharmacist, Pharmacy Benefit Manager
- Clinical Pharmacist, Consultant
- The Chairperson may invite other Plan practitioners or other guests on an ad hoc basis for specialty review and/or input

The P&T annually reviews the pharmaceutical management procedures and updates procedures as new pharmaceutical information becomes available. The P&T recommends the adoption of, or assists in the formulation of policies regarding evaluation, selection, distribution, and therapeutic use of medications. This committee is responsible for evaluation of new technology, pharmaceutical technology, new application of existing pharmaceutical technologies, and for reviewing and recommending changes to PHP's Pharmacy Benefits Guide & Formulary Reference Guide. The P&T also provides advice on implementation of systems necessary to promote clinically appropriate use of pharmaceuticals and services to members through PHP Practitioners and Providers. Annually and when P&T Committee makes changes, PHP provides pharmaceutical management procedures to practitioners.

5. PROGRAM SCOPE AND ACTIVITIES

The scope of the UM Program is designed to evaluate and improve the quality and appropriateness of care and service provided to members objectively and systematically. Monitoring is designed to identify and pursue opportunities for improvement. Monitoring extends to both delegated and non-delegated functions. PHP or its delegated partners and Medical Groups, arrange for the provision of medical care to members through a network of contracted primary care and specialty practitioners, behavioral health clinicians, ancillary care providers, hospitals, and other facilities. Care that is provided is comprehensive in nature for both acute and chronic conditions. Behavioral Health Utilization Management is provided to health plan membership on a member self-referral basis. All care services are covered in the context of the member's defined benefit plan.

Utilization Management staff are available and receive inbound calls from members, practitioners, and providers during normal business hours 5:00am to 8:00pm Pacific Standard time including Mountain, Central, and Eastern time zones for members, practitioners, and providers seeking information about the Utilization Management process and the authorization of care. Inbound callers including members, practitioners and providers with UM questions may also contact PHP via the toll-free number. PHP Customer Service staff also answer member or practitioner questions regarding prior authorization requirements and benefits available. Customer Service triage all calls and forward any member who has questions regarding a specific case or UM decision to the appropriate clinical staff. All staff identifies themselves by name, title, and organization when initiating or returning calls regarding Utilization Management issues. Utilization Management has a confidential voicemail and fax that is available to members and practitioner/providers 24 hours a day/seven days a week. Communication received after normal business hours are responded to on the next business day.

Utilization Management staff send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon. PHP provides telecommunication services (TDD) and telephone typewriter or teletypewriter (TTY) services for deaf/hard of hearing and speech impaired members with questions about a specific case or questions regarding a UM decision. PHP offers language translation assistance to members free of charge in the requested language to discuss their UM issues**.** A well-publicized Customer Service dedicated phone number is available on the PHP website and published in the member quarterly newsletter and periodic mailings. The website and Member Newsletters contain information regarding benefits and services and how to access them.

Prior authorization/referral requirements are available on the PHP website. Delegated partners who provide UM services follow PHP's Utilization Management policies and procedures for administration of PHP's benefits.

5.1 Monitoring and Evaluation

The Utilization Management Program's scope includes, but is not limited to, monitoring and evaluation of PHP activity, delegated and non-delegated, for the following areas:

Services provided in inpatient hospitals, home care, skilled nursing facilities, and other treatment centers.

a. Appropriateness and medical necessity of pre-authorization decisions
b. Timeliness of UM decision making and notification processes
c. Assessing experience with the UM process of both member and practitioner and taking action to improve member and practitioner experience based on the assessment data collected from the member and practitioner survey
d. Utilization trends including under and over utilization
e. Utilization Management Delegation Oversight
f. Adequacy of member communications regarding denial decisions and the member's rights of appeal
g. Consistency of Utilization Management decisions in prior authorization and in concurrent review
h. Documentation and communication of denial decisions in easily understandable language, including a description of the appeal rights and process

i. Denial notices will include description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal, an explanation of the appeal process including appropriate practitioner reviewer availability to discuss any UM decision, including the right to member representation and time frames for deciding appeals, and a description of the expedited appeal process for urgent pre-service or urgent concurrent denials
j. Concurrent identification and documentation of potential quality of care issues
k. Referrals to QI of potential quality of care issues
l. Practitioner/provider and member appeals and complaints

i) The procedures for appealing an adverse determination provide that the adverse determination may be appealed orally or in writing by:
   1) an enrollee;
   2) a person acting on the enrollee's behalf; or
   3) the enrollee's physician or other health care provider

ii) A complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination. For complete complaint and appeal process, see Customer Service comprehensive policy on complaints and appeals.

6. ROLES AND RESPONSIBILITIES

The Utilization Management staff are comprised of licensed professional nurses, technical staff, physicians, and contracted behavioral health practitioners.

6.1 Chief Medical Officer

The Chief Medical Officer (CMO) reports to the PHP CEO. The CMO has a current unrestricted medical license and graduated, with completion of residency, from an accredited medical school.

Responsibilities for the CMO include, but are not limited to, the following:

a. Directs the development of goals and objectives for the UM Department and provides input in the development of goals in the activities related to achievement
b. Provides leadership for the Health Services Division which includes Utilization Management, Care Management, Performance Improvement, and Pharmacy Management
c. Participates in multi-disciplinary or cross functional task-oriented groups within PHP and as appropriate, participate in other internal and external projects

Performance accountabilities for the CMO include, but are not limited to, the following:

a. Provide executive level clinical leadership in implementing and monitoring the Utilization Management Program
b. Provide leadership and oversight supervision of the PHP Medical Director(s) and other clinical staff who perform utilization review
c. Provides clinical oversight of the Utilization Management Division
d. Evaluate PHP performance data and assist in the development of corrective action plans as necessary
e. Monitor implementation of the Utilization Management Program
f. Provide oversight of delegated UM Program functions, Complex Case Management, and Behavioral Health Care
g. Coordinate with Independent Physician Associations/Medical Group Medical Directors in Utilization Management activities

6.2 Medical Director(s)

The PHP's Medical Director(s) reports to the Chief Medical Officer (CMO) and is responsible for the implementation of clinical care activities and providing leadership within the Utilization Management Division. The Medical Director(s) will hold a current unrestricted medical license in the specific state they

are providing utilization review and will have graduated with completion of residency from an accredited Medical School. Only a Physician Medical Director may make denials of medical necessity decisions.

Performance accountabilities for the Medical Director(s) include, but are not limited to, the following:

a. Provide clinical oversight of the Utilization Management function
b. Supervise clinical decisions
c. Perform individual clinical care review (including complaints and appeals) and makes recommendations as appropriate
d. Determine status of technologies, e.g., experimental, investigational, accepted for clinical use accessing nationally recognized technology assessment reviews, to include but not limited to: Hayes Medical Technology, Agency for Healthcare and Quality, and a review of information from appropriate government regulatory bodies
e. Review and evaluate out-of-network referrals as appropriate and make final determination regarding payment
f. Assist UM delegates in review of medical necessity, benefit denials, and assists delegates in making final determination regarding coverage for services
g. Available by phone to discuss proposed and/or denial determinations with the requesting practitioner
h. Utilize the expertise of board-certified consultants to assist in making medical necessity determinations when needed
i. Review and approve Utilization Management policies and procedures
j. Provide oversight of and participate in Utilization Management inter-rater reliability process to evaluate consistency of applying UM decision criteria and implement corrective actions when needed

6.3 Utilization Management Staff

Utilization Management operates in a clearly defined organizational structure. PHP ensures that there are adequate staff and resources to effectively perform this function and support Utilization Management processes. The UM staff is comprised of the following:

6.3.1 Director of Health Services Functions:

a. Director of Health Services holds a current Nevada Registered Nurses license
b. Will have a BSN or BS degree in a related health science field, Masters preferred
c. Will have a minimum of 5 years of clinical, utilization, and management experience
d. Provides day-to-day supervision of assigned UM staff and supervises all medical necessity decisions
e. Is the contract owner for the UM delegates including Medicare administration
f. Is the Medicare UM expert and will develop ongoing programs to meet UM requirements
g. Integrate the UM/Health Services division with other departments within the Health Plan departmental operations to promote a well-functioning managed care plan

6.3.2 Manager of Utilization Management:

a. Manager of Utilization Management holds a current Nevada Registered Nurses license
b. Will have a BSN or BS degree in a related health science field, Masters preferred
c. Will have a minimum of 5 years of clinical, utilization, management experience
d. Provides day-to-day supervision of assigned UM staff and supervises all medical necessity decisions
e. Participates in staff training
f. Monitors for consistent application of UM criteria by UM staff, for each level and type of UM decision
g. Monitors documentation for completeness and adequacy
h. Is available to UM staff on site or by telephone

6.3.3 Clinical Nursing Staff:

a. Registered Nurses (RN) hold a current Nevada, Texas, or Florida Registered Nurses license
b. Will have a minimum of 3 to 5 years of clinical and utilization experience
c. Will provide onsite UM reviews for hospitalized PHP patients
d. Will assist the hospital transition of care and discharge planners with discharge plans for PHP members
e. Will act as a liaison between the PHP member and the facilities
f. UM staff review proposed inpatient, outpatient, and ancillary services for medical appropriateness, using nationally recognized clinical criteria. UM staff may only approve requested services based on criteria. All denials must be issued by the Medical Director.

6.3.4 Clerical Staff:

a. Non-licensed personnel provide clerical support
b. Are not involved in any clinical aspects of the Utilization Management function

6.4 Pharmacy Staff

The pharmacy staff reports to the Pharmacy Director and is responsible for the implementation of clinical care activities and providing leadership within the Utilization Management Division in regard to provider-administered drugs. The pharmacy department has a clearly defined organizational structure. PHP ensures that there are adequate staff and resources to effectively perform this function and support Utilization Management processes within the pharmacy department.

6.4.1 Director of Pharmacy Functions:

a. Director of Pharmacy holds a current Registered Pharmacist license in any US state or territory
b. Will have at least 5 years of clinical, utilization, and management experience
c. Provides day-to-day supervision of UM pharmacy staff and supervises all medical necessity decisions
d. Provides accountabilities for policies and processes related to pharmacy department activities
e. Is the contact and relationship owner for all delegates related to pharmacy benefit management and provider-administered drug management

6.4.2 Clinical Pharmacist/Manager of Clinical Pharmacy Functions:

a. Clinical Pharmacists must hold a current Registered Pharmacist license
b. Will have a minimum of 3 to 5 years of clinical and utilization management experience
c. Will create, review, revise, and update clinical criteria for provider administered drugs as approved by the P&T committee.
d. Will create, review, revise, and update any relevant policies that impact the UM Division (e.g., step therapy policy, site of care policy, etc.)
e. Will update the list of CPT codes for which pharmacy manages that do/do not require prior authorization
f. Will review requested provider-administered drugs that require prior authorization, using nationally recognized clinical criteria and/or P&T approved criteria. Pharmacists may approve and deny initial requests for provider-administered drugs for Medicare-related requests. For commercial, pharmacists may approve any requests but may only deny requests if they have a Registered Pharmacist license in the state from which the request came.

6.4.3 Prior Authorization Specialist

a. Prior Authorization Specialists must hold a current Certified Pharmacy Technician (CPhT) license.
b. Will have a minimum of 3 to 5 years of clinical experience as a pharmacy technician.
c. Will receive and triage prior authorization requests for review by a clinical staff member (MD, PharmD, or RN).
d. Will perform outreach to providers and provider offices to obtain the relevant clinical information required to make coverage determinations.
e. Will receive and triage appeal requests.

f. Will help write and deliver notification letters following coverage determinations.

A comprehensive orientation is provided for staff. This includes a mentoring program for the first month of employment. Staff participates in in-service education and are encouraged to attend internal and external education conferences to maintain their competency on an ongoing basis.

7. UTILIZATION MANAGEMENT FUNCTIONS

PHP Utilization Management Department maintains and annually updates their program description and policies and procedures, which are consistent with State, Federal, and accrediting agencies standards, regulations, and guidelines.

PHP will not restrict or interfere with any communication between a healthcare provider and a patient regarding any information that the provider determines is relevant to the health care of the patient.

Delegated entities are required to maintain applicable policies and procedures that are consistent with Prominence Health Plan and update them at least annually.

PHP views the Utilization Management function as directed toward comprehensive care of a patient rather than fragmented care, delivered, and managed at different entry points into the health care delivery system. This system encourages and supports the development of cost-effective alternatives to traditional modes of medical practice without compromising the quality of care rendered to members.

Key components of Utilization Management that have been outlined include prospective, concurrent, and retrospective review, including Transitional Care.

It is PHPs expectation that the administration and requirements of this Utilization Management Program will be met through:

a. PHPs coordinated effort on an on-going basis; and/or
b. Delegation of key Utilization Management program components to established medical groups or UM companies as appropriate

PHP or its delegated partners will perform the following Utilization Management processes to include but not limited to:

7.1 Pre-Service Review (Prior Authorization)

Pre-service review (prior authorization) provides a “before the fact” opportunity to evaluate medical appropriateness, cost-effectiveness, and payment determination recommended in the following setting:

a. Inpatient-Acute, Rehabilitation, Psychiatric, Skilled Nursing facilities (SNF)
b. Outpatient-hospitals, ambulatory surgery centers, rehabilitation, physician offices, and other provider services (i.e., prosthetics, durable medical equipment (DME), etc.)

The basic elements of pre-service review (prior authorization) include eligibility verification, coverage determination, benefit interpretation, and medical necessity review for approval of in and outpatient services as well as medication review. Utilization Management Nurses authorize procedures and services such as surgery and other services such as DME and help coordinate visits to practitioners and providers as needed.

Pre-service review (prior authorization) is performed by licensed registered nurses (RNs) under the direction of the Plan’s Medical Director(s) or by a Clinical Pharmacist in accordance with Utilization Management Policies and Procedures, accepted national medical evidence-based criteria, and Medicare DME guidelines. Each decision considers the individual needs of the patient and the availability of services in the local delivery system. PHP does provide pharmaceutical exception review based on medical necessity information from prescribing practitioners. Handling of these requests is subject to the same communication and turnaround times as any other pre-service (prior authorization) request.

Pre-service review staff follows State, Federal, accrediting agencies, and health plan guidelines for process, documentation requirements, timelines, and notification of decisions to providers and members.

Authorization decisions are supported by relevant clinical information particular to each case (such as medical records, consultations with treating practitioners, and peer-to-peer discussions). Request for clinical information is limited to only information relevant to the review process. PHP does not routinely request medical records to make UR decisions. Board-certified physicians from appropriate specialty areas are utilized to assist in making determinations, including denials of medical necessity as indicated. Member confidentiality is strictly protected, and confidentiality requirements pertain to both information received by the PHP and information exchanged between PHP and third parties.

7.2 Out-of-Area/Out-of-Plan Review

Out-of-Area/Out-of-Plan is defined as any care or service rendered outside of the Health Plan's geographical service area, or care that is rendered by non-contracted providers.

Upon identification or notification of out-of-plan/out-of-area request for service, PHP Utilization Management Nurses refer the request to PHP Medical Director(s) for review, recommendation, and determination. PHP Medical Director(s) will contact the referring practitioner to discuss the referral as appropriate. Attempts will be made to keep the referral in-network. PHP UM Nurses work closely, via telephone, with the facility Case Managers and Transition of Care Discharge Planners to meet the member's needs beyond the inpatient setting.

7.3 Concurrent Review

Concurrent review is performed for known admissions to health care facilities including but not limited to, acute (inpatient), rehab, SNF, and out of network home care services. Concurrent review is an assessment of ongoing medical and behavioral utilization management to determine continued medical necessity and appropriateness of care. Concurrent review is performed by licensed professional nurses under the direction of a PHP Medical Director.

Appropriateness is determined by level of care, intensity of service, and severity of symptoms using nationally recognized medical review criteria such as MCG guidelines (formerly Milliman Care Guidelines), as a guide. PHP UM Nurses issue concurrent authorization in accordance with accepted medical criteria, taking into account the needs of the individual patient and the local delivery system such as availability of skilled nursing facilities or home care in the service area to support the patient after hospital discharge. Decisions are supported by relevant clinical information particular to each case (such as medical records, consultations with treating practitioners, and peer-to-peer discussions). Cases that do not meet screening criteria for the member's condition or setting of care are referred to PHP Medical Director(s) or designee for review, recommendation, and determination. Adverse determinations of Texas members enrolled in the Commercial HMO product must be referred to and may only be determined by an appropriate physician or other health care provider with appropriate credentials (as per 19.1706 of Texas Title relating to Requirements and Prohibitions Relating to Personnel) to determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services. Telephonic review is performed for most facility services needing review by the UM Nurses; however, the UM nurses work in conjunction with the Transition of Care Nurses who are onsite at the specific facilities.

7.4 Onsite Review, Discharge Planning, and Transitions of Care

Refer to PHP Transition of Care Program Description and PHP Post Discharge Follow Up Program Description.

7.5 Complex Case Management

Refer to PHP Complex Case Management Program Description.

7.6 Post-Service Review (Retrospective)

The PHP clinical staff conducts post-service review as appropriate (retrospective) only as directed by the Director of Health Services. Review is based on the same established review guidelines described above. The review process includes reviewing medical care after the service has been provided, reviewing for eligibility and coverage determination, level of care, medical necessity, practitioner notification, emergency admission status, etc.

7.7 Medical Claims Review

Claims processors may request a medical review of claims and codes that have been submitted for payment. The process includes reviewing medical care after the service has been provided, components of eligibility and coverage determination, medical necessity, level of care, appropriateness, and presenting symptoms. Any questionable claim as identified by the Claims Manager will be sent to the PHP Medical Director(s) for review and determination.

8. EMERGENCY SERVICES

Care that is needed on an urgent or emergency basis is not subject to pre-service or prior authorization, regardless of the time of day, day of the week, or place of service.

PHP covers emergency services to screen and stabilize the member without prior approval, where prudent layperson acting reasonably, would have believed that an emergency medical condition existed, and if an authorized representative acting for the organization, authorized the provision of emergency services. PHP defines emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
b. Serious impairment to bodily functions; or
c. Serious dysfunction of any bodily organ or part
d. A condition, sickness, or injury that could result in serious disfigurement due to failure to get immediate medical care for a condition, sickness, or injury

Post-service (retrospective) emergency services claim review will be performed as requested but emergency service claims are not routinely reviewed. Claim evaluation as requested will include review of presenting symptoms and not base payment solely on discharge diagnosis.

9. BEHAVIORAL HEALTH-MANAGEMENT

PHP's behavioral utilization management processes are designed to promote the appropriate referral, diagnosis, and treatment of behavioral health disorders commonly seen in primary care and to evaluate the appropriate use of psychopharmacological medications. PHP does not provide a centralized triage and referral process for behavioral health care. In conjunction with the PHP Medical Director(s), PHP also ensures that a designated behavioral health practitioner physician or clinical PhD or Psychologist is involved in the implementation of behavioral health aspects of the Utilization Management Program, as applicable. PHP has the support of a designated Behavioral Health Psychiatrist/Medical Director from one of the parent companies (Universal Health Networks behavioral health facilities.) The psychiatrist from one of the Universal Health Network facilities participates on the PHPs Medical Advisory Committee. PHP also has support from the delegate who is providing Behavioral Utilization Management and through PHPs contractual agreements. There is no prior-authorization requirement for outpatient Behavioral Health/Chemical Dependency services. Behavioral Health therapy notes are never requested. All care services are offered in the context of the member's defined benefit plan. In patient services require prior authorization. In-patient care is assessed by the appropriate behavioral healthcare professional.

To ensure appropriate access to behavioral health care, PHP monitors performance against an accreditation agency's Managed Behavioral Healthcare Organization appointment accessibility

standards for hours of operation and service availability for behavioral health care for the following aspects as follows:

a. Life-threatening emergency
b. Non-life-threatening emergency
c. Urgent Care
d. Initial visit for routine care
e. Follow-up routine care
f. Centralized screening and Triage as applicable (not currently applicable)

In addition, PHP also monitors meaningful clinical issues that reflect demographic and epidemiological characteristics of Plan membership. PHP collaborates with contracted behavioral health practitioners through joint operating meetings and quarterly Quality Improvement and Medical Advisory meetings. The behavioral health practitioner participates in the annual review and approval of behavioral health UM, policies, and review criteria. The PHP Medical Director(s) collaborates with the behavioral health practitioner on an as needed basis.

Through joint participation on various QI committees and subcommittees, and through ongoing communication with behavioral health practitioners and providers, the following Behavioral Health indicators are monitored and analyzed utilizing the steps of the QI process:

a. Collaboration with behavioral health practitioners and providers in developing appropriate clinical practice guidelines
b. Enhance continuity and coordination of care by promoting exchange of patient information between medical practitioners and behavioral health practitioners and providers
c. Monitoring performance of behavioral health follow-up visits within seven (7) days after discharge or within thirty (30) days after discharge for all inpatient admissions
d. Monitoring and evaluating the use of psychopharmacological medications to increase the appropriate use of medications and reduce the incidence of adverse drug reactions
e. Review of complaint and appeal data to assess member satisfaction and access to behavioral Utilization Management
f. Evaluation of new technology as indicated

PHP ensures that any contracted behavioral health care organization has a comprehensive Utilization Management program that outlines the scope and process.

10. AUTHORIZATION DECISIONS

PHP uses all information relevant to a member's care when making UM decisions. When making a determination of coverage based on medical necessity, authorization decisions are supported by relevant clinical information appropriate to each case including, but are not limited to: medical records, consultation with the treating practitioner, diagnostic testing results, photos, operative reports, etc. Special circumstances, such as disability, acute illness, or life-threatening condition, are considered with each request. When criteria and or guidelines are not appropriate to make a decision the Medical Director/Directors will consult with additional criteria or medical references. Clinical coverage decisions are based on the eligibility of the member, the member's evidence of coverage or summary of benefit description, certificate of coverage, medical policy, and for Medicare products CMS, NCDs and LCDs and other evidence-based clinical literature.

Board certified physicians, with an unrestricted license to practice medicine from appropriate specialty areas, are also utilized to assist in making determinations of medical necessity as indicated.

The PHP Chief Medical Officer or Medical Director/Directors reviews and makes the final denial determination regardless of the reason for the denial. Clinical Pharmacists or Pharmacy Director reviews and may make denial determinations for provider-administered drugs. The physician making the final determination is prohibited from having any disqualifying associations with the physician who made the initial adverse determination. In addition, the physician conducting the utilization review is prohibited

from having any association with the enrollee or health care provider who is requesting the utilization review or appeal.
Denials for pharmaceutical services are reviewed and determination made by the PHP Medical Director(s) with input from the PHP's Clinical Pharmacist. Only the PHP Chief Medical Officer and, Medical Director(s), may decide based on medical necessity that will result in a denial of coverage.

Decisions are made in a timely manner to accommodate the clinical urgency of the situation. PHP dictates timeliness standards in accordance with The Department of Labor, accreditation agencies, and State specific UM Review Procedures, or other state or federal guidelines as appropriate. PHP monitors timeliness through monthly pre-service (prior authorization) reports, monthly and periodic audits, and denial turnaround time reports (refer to Turnaround Time requirements for each State below).

Utilization Management decision-making is based only on appropriateness of care and service. PHP and its delegated groups do not provide bonuses or other incentives for denial of medically necessary services. PHP and its delegated groups do not offer incentives to encourage inappropriate underutilization. PHP does not perform Emergency Department pre-service or concurrent review.
Authorization and denial notifications are mailed, faxed, electronically transmitted, and/or telephonic follow-up as indicated.

10.1 Nevada, Texas, Florida Decision-Making Turnaround Time Requirements-Medicare

Requirements	Decision Type	Approval Decision	Approval Notification	Notification Type	Denial Decision	Denial Notification	Notification Type
CMS URAC 19	**Non-urgent Pre-service**	14 Calendar Days of request	14 Calendar Days of request	Oral or written, telephonic	14 Calendar Days of request	14 Calendar Days of request	Written, telephonic
Medicare	• Extension: 14 calendar day extension – Documented in the utilization management electronic platform, in the patient record, at the time of extension. • For non-urgent cases, a onetime extension may be applied for up to 14 calendar days provided that the organization determines that an extension is necessary because of matters beyond the control of the organization • The organization notifies the patient, prior to the expiration of the initial 14 calendar day period of the circumstances requiring the extension and the date when the plan expects to make a decision.						
CMS NCQA UM 5 URAC 19	**Urgent Pre-service**	72 Hours of request	72 Hours of request	Oral, written, telephonic	72 Hours of request	72 Hours of request	Written, telephonic
Medicare	Extension: 14 calendar days when certain conditions are met						
CMS NCQA UM 5 URAC 19	**Urgent Concurrent**	72 Hours of request	72 Hours of request	Oral or written, telephonic	72 Hours of request	72 Hours of request	Oral, followed by written
Medicare	• Extension: One request within the first 24 hours for information and before the end of that time the Plan may implement an extension for 72 hours • Urgent concurrent extension: authorization expiring less than twenty-four (24) hours of receipt of request. Request for extension will be completed within 24 hours of receipt of request						
CMS	**Urgent Part B**	24 Hours of request	24 Hours of request	Oral or written, telephonic	24 Hours of request	24 Hours of request	Oral, followed by written
Medicare	Extension: No extensions allowed						
CMS	**Standard Part B**	72 Hours of request	72 Hours of request	Oral or written, telephonic	72 Hours of request	72 Hours of request	Oral, followed by written
Medicare	Extension: No extension allowed						

	Post services: Written, telephonic	30 Calendar Days of Request	30 Calendar Days of Request	Oral, written, telephonic	30 Calendar Days of Request	30 Calendar Days of Request

10.2 Nevada and Florida State Specific Decision-Making Turnaround Time Requirements-Commercial

Requirements	Decision Type	Approval Decision	Approval Notification	Notification Type	Denial Decision	Denial Notification	Notification Type
Nevada & Florida: DOL/ NCQA/ URAC	**Non-urgent Pre-service**	15 Calendar Days of request	15 Calendar Days of request	Oral, written, telephonic	15 Calendar Days of request	15 Calendar Days of request	Written, telephonic
	Extension: 15 calendar day extension after allowing up to 45 days for information to be received						
Nevada & Florida: DOL/ NCQA/ URAC	**Urgent Pre-service**	72 Hours of request	72 Hours of request	Oral, written, telephonic	72 Hours of request	72 Hours of request	Written, telephonic
	Extension: One attempt will be made to obtain information in the first 24 hours, then extension for up to 48 hours						
Nevada & Florida: DOL/ NCQA/ URAC	**Urgent Concurrent**	24 Hours of request	24 Hours of request	Oral, written, telephonic	24 Hours of request	24 Hours of request	Written, telephonic
	Extension: One request within the first 24 hours for information and before the end of that time the Plan may implement an extension for 72 hours						
	Post services: Written, telephonic	30 Calendar Days of Request	30 Calendar Days of Request	Oral, written, telephonic	30 Calendar Days of Request	30 Calendar Days of Request	

10.3 Texas State Specific Decision-Making Turnaround Time Requirements-Commercial

Requirements	Decision Type	Approval Decision	Approval Notification	Notification Type	Denial Decision	Denial Notification	Notification Type
Texas: DOL/ NCQA/ URAC	**Non-urgent Pre-service**	15 Calendar Days of request	15 Calendar Days of request	Oral, written, telephonic	15 Calendar Days of request	15 Calendar Days of request	Written, telephonic
	Extension: 15 calendar day extension after allowing up to 45 days for information to be received UM process clearly documents that there are at least two (2) documented attempts at consultation between the medical reviewer and the treating physician prior to issuing an adverse determination Non-urgent pre-service requests: Treating physician must be given 24 hours to contact medical reviewer prior to denial						
Texas: DOL/ NCQA/ URAC	**Urgent Pre-service**	72 Hours of request	72 Hours of request	Oral, written, telephonic	72 Hours of request	72 Hours of request	Written, telephonic
	Extension: One attempt will be made to obtain information in the first 24 hours, then extension for up to 48 hours						
Texas: DOL/ NCQA/ URAC	**Urgent Concurrent**	24 Hours of request	24 Hours of request	Oral, written, telephonic	24 Hours of request	24 Hours of request	Written, telephonic

	Extension: One request within the first 24 hours for information and before the end of that time the Plan may implement an extension for 72 hours For those prospective and concurrent review subject to Texas Code 28 TAC Section 19.1709 (d)(3) • Within one hour after the time of the request for post-stabilization care subsequent to emergency treatment, with written notification within three working days of the telephone or electronic transmission. • Within twenty-four hours of the request for services to be provided in the inpatient setting at the time of the decision, which is considered urgent.				
	Post services: 30 Calendar Days of Request	30 Calendar Days of Request	Oral, written, telephonic	30 Calendar Days of Request	30 Calendar Days of Written, telephonic Request

UM records will be retained for a minimum of 7 years. The records will be stored securely with easy access for cases that need to be reopened.

11. DENIALS

Utilization Management denials regardless of the reason, require review, and final determination by the PHP Medical Director(s). A Psychiatrist, or certified addiction medicine specialist reviews any denial of behavioral health care that is based on medical necessity. Board certified physicians, with current unrestricted license to practice medicine from appropriate specialty areas, are utilized to assist making determinations of medical necessity as indicated.

Denial decisions are communicated via telephone or fax to the requesting practitioner/provider and in writing to the member and requesting practitioner/provider. The denial letters contain the reason for the denial, in easily understood language, and information on the member and practitioner/provider appeal process. The requesting practitioner/provider is given the opportunity to discuss any denial decision prior to issuing an adverse determination with the PHP Medical Director(s) or Clinical Pharmacist. The denial letter contains, for the requesting practitioner/provider, the phone number to contact the PHP Medical Director(s) or Clinical Pharmacist to discuss the decision. The requesting practitioner/provider is notified of the Medical Director(s) availability and call back phone numbers, via the fax cover sheet and the denial letter. Within the denial letter, members and practitioners are informed that they may request copies of, at no charge, the actual benefit provisions, guidelines and/or protocol on which the denial decision was based.

Practitioners are notified of availability of UM criteria annually and when UM denial notifications are sent. Actual benefit provisions, guidelines, or protocol on which the denial decision was based are made available at no charge to practitioner/providers and members upon request. Copies of criteria can be mailed, faxed, discussed by phone, or made available to the practitioner office, upon request.

12. AFFIRMATIVE STATEMENT ABOUT INCENTIVES

PHP distributes a statement annually to members, practitioners, providers, and employees, via the Plans mailed Newsletter, website posting or mailing to Practitioners, providers and employees who make UM decisions affirming the following:

a. UM decision making is based only on appropriateness of care and service and existence of coverage
b. The Plan does not specifically reward practitioners or other individuals for issuing denials of coverage
c. Financial incentives for UM decision makers do not encourage decisions that result in underutilization

13. APPEALS

Appeals are processed through the Customer Service Department. Requests for appeal may be initiated by members or by individuals advocating on behalf of members, including practitioners. A member or practitioner, benefit or medical necessity appeal may be filed orally or in writing within 180 calendar days after receipt of the denial notice. The PHP Appeals Specialist can assist those members who need help

filing an appeal. Appeals for urgent or emergent care may be submitted to the Customer Service Department orally as an expedited appeal. PHP must give a decision within 24-72 hours after receipt of the appeal. For pre-service appeals (before services are received) PHP must give a written decision no later than 30 calendar days after receipt of the appeal. For post-service appeals (after services are received). PHP must give a written decision no later than 60 calendar days after receipt of the appeal. Clinical input into the appeal process is provided by Medical Directors in the Appeals and Grievance functional area.

Texas specific: A standard appeal must be resolved as soon as practical, but, under Insurance Code §4201.359 and §1352.006, in no case later than 30 calendar days after the date PHP receives the appeal from the appealing party. If a retrospective utilization review is conducted, PHP shall provide notice of an adverse determination under the retrospective utilization review in writing to the provider of record and the patient within a reasonable period, but not later than 30 days after the date on which the claim is received. This may be extended once by PHP for a period not to exceed 15 days, if PHP:

a. Determines that an extension is necessary due to matters beyond PHP's control; and
b. Notifies the provider of record and the patient before the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which PHP expects to make a determination.

If the appeals process has been exhausted for an appeal based on a medical necessity denial, a request for Independent Review may be requested at no cost to the member. This Independent Review will be conducted by an external review organization certified and appointed by the State of Nevada, State of Florida, Office of Consumer Health Assistance, or the State of Texas Department of Insurance. Appeal reviews are conducted by health care professionals who were not involved in the initial determination of non-certification. Reviewers are from the same or similar specialty that manages the condition. Any additional information or documents may be provided with the appeal. PHP delegate's appeals to contracted Imaging Review Company, an NCQA/URAC accredited UM company for high tech imaging, chemo, radiations, musculoskeletal, genetic labs, and sleep services.

A complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination. PHP Customer Services Department processes all complaints.

14. CRITERIA

PHP has adopted nationally recognized Utilization Management review criteria that are objective, and evidence based, to make impartial, fair, and consistent decisions. PHP uses the most current guidelines and criteria sets to assist in making UM decisions. Use of the screening criteria guidelines should not preempt sound clinical judgment. PHP applies these guidelines and criteria to the list of CPT codes that they have designated as requiring prior authorization. PHP shall use written medically acceptable screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, and other health care providers as applicable. Screening criteria also recognizes that if evidence-based medicine is not available for a particular health care service provided, PHP will utilize generally accepted standards of medical practice recognized in the medical community.

Criteria PHP uses include, but are not limited to:

a. NCD/LCD: National and local coverage determinations published by CMS
b. MCG
c. Hayes Technology Review
d. P&T approved guidelines
e. National Cancer Care Network (NCCN) Guidelines
f. American Diabetes Association (ADA)
g. Medicare DME criteria as appropriate
h. Behavioral Health Criteria (e.g., ASAM, Diagnostic and Statistical Manual of Mental Disorders, Clinical Practice Guidelines).

i. Pharmaceutical criteria
j. National Institute of Health (NIH)
k. Up to date: criteria and technology resource

Screening criteria shall be:

a. Objective
b. Clinically valid
c. Compatible with established principles of health care
d. Flexible enough to allow a deviation from the norm when justified on a case-by-case basis

Screening criteria will be used to determine only whether to approve the requested treatment. A potential denial of requested treatment will be referred to the appropriate physician, or other health care provider to determine medical necessity.

When applying the criteria, the Utilization Management staff will consider the following factors: age, comorbidities, and complications, progress of treatment, individual needs, psychosocial situation, and home environment, as applicable. The guidelines are intended to be used as screening tools to determine medical necessity, and appropriate care for requested treatment. In addition, decision makers will consider characteristics of the local delivery system available to the patient including coverage of benefits for and availability of skilled nursing facilities, sub-acute care facilities, or home care when needed in the service area to support the patient after discharge, and local hospitals' ability to provide all recommended services within the estimated length of stay. Utilization Management clinical staff collaborate with PHP Medical Director(s) when needed to explore alternative coverage or services when UM guidelines are not appropriate.

All practitioners and members are notified of availability of UM criteria annually in the Member and Provider Newsletters and when UM denial notifications are issued. PHP annually reviews the UM criteria and the procedures for applying them and updates the criteria when appropriate. The Medical Advisory Committee reviews and approves Utilization Management criteria on an annual basis. PHP does not currently develop their own review criteria. PHP utilizes nationally recognized review criteria as a guide in making medical necessity review decisions. Expertise will be validated through professional peer review organizations as needed.

Screening criteria also recognizes that if evidence-based medicine is not available for a particular health care service provided, PHP will utilize generally accepted standards of medical practice recognized in the medical community.

PHP will involve appropriate practitioners in developing, adopting, and reviewing criteria applicability as appropriate. Utilization Management Nurses will refer to the Medical Director(s) when criteria and guidelines are not appropriate to make a decision. The Medical Director(s) is supported in his/her decision through a variety of sources, including additional criteria and medical literature, consultation with board certified specialists, and practitioners available through committees. Board certified physicians, with an unrestricted license to practice medicine from appropriate specialty areas, are utilized in making determinations of medical necessity as indicated. The criteria used by PHP and/or delegated groups to assess medical necessity must be based on sound clinical evidence e.g., MCG, etc.

The review criteria along with the Independent Physician Associations/Medical Groups or the UM delegate's Utilization Management Program will be reviewed prior to delegating the Utilization Management function. The Independent Physician Associations/Medical Groups or delegated UM Company's Utilization Management Program and review criteria must be updated annually and submitted to PHP for review.

PHP and its delegates conduct inter-rater reliability audits annually for all clinical staff that directly perform utilization review and utilization management including the PHP CMO and Medical Director(s) using

PHPs approved review criteria, to ensure consistent and fair application of Utilization Management criteria in the review process. Corrective action is implemented as needed. Independent Physician Associations /Medical Groups with delegated functions are responsible for assessing the consistency of the application of the criteria across reviewers and implementing corrective action as needed. The results of these audits shall be forwarded to PHP on an annual basis.

Specific review criteria, actual benefit provisions, guidelines, or protocols are made available at no cost to practitioner/providers and members upon request. Copies of criteria can be mailed, faxed, or discussed by phone.

15. PATIENT SAFETY

PHP's patient safety vision demonstrates its commitment to patient safety through contracted practitioners and providers. Contracted practitioners and providers are encouraged to adopt quality improvement programs and projects that address errors and opportunities in the health care delivery system. The QI Committee structure supports patient safety through the evaluation of safety issues through the QI Committee and/or appropriate subcommittees. Quality Improvement Committee, Medical Advisory Committee, Credentialing Committee, and the Pharmacy and Therapeutics Committee all review and provide input regarding issues related to quality of care and patient safety.

Additional Quality Improvement monitoring activities that proactively address patient safety include but are not limited to, the following processes:

a. Periodic practitioner/provider office site visits
b. Member and Practitioner/Provider education of patient safety issues through articles published in the PHP newsletters and/or publications
c. Monitoring important aspects of practitioner compliance with Clinical Practice Guidelines and Preventive Health Guidelines, including monitoring activities when appropriate
d. Monitoring of member complaint data and selected quality of care or service performance monitoring issues to identify practitioner/provider-specific trends or patterns for opportunities for improvement
e. Ambulatory medical record reviews practitioner records to monitor continuity and coordination of care between primary care practitioner/provider and specialists, including behavioral health practitioners
f. Monitor continuity and coordination of care between providers such as hospitals, skilled nursing facilities, and home care agencies to assure the timely and accurate communication of member information
g. Total Population/Disease Management and health management programs and activities
h. Ongoing evaluation of new technology and assessment of medical and behavioral health procedures, pharmaceuticals, and/or medical devices, including implementation of appropriate technologies that promote clinical efficacy and safety such as opioid utilization in the PHP population
i. Annually assessment of the PHP's organizational providers (i.e. contracted hospitals) activities to improve patient safety (i.e. The Joint Commission National Patient Safety Goals).

16. CONFIDENTIALITY/PRIVACY

Employees and agents of PHP will maintain the confidentiality of member information, medical records, peer review, and quality improvement records. All employees and agents of PHP sign a confidentiality Statement during the hiring process. Any breach in confidentiality may result in disciplinary action. It is each employee's responsibility to ensure that such information and records are not improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner. Member concerns regarding confidentiality are specifically identified and reviewed by PHPs Compliance Department and QI staff as appropriate. Member specific medical information is used solely for the purpose of utilization management and is shared with those entities that have authority to receive such information. Data shared between PHP, its providers, and delegated entities are considered private and are governed by

the contractual relationship between the parties. This data is not released to the public. Release of any information to other healthcare practitioners and providers is limited to only that information necessary for continuation of care and service and will be in accordance with State and Federal laws. Confidentiality policies and procedures are communicated to members, practitioners, providers, and employees as applicable.

17. KEY CLINICAL AND SERVICE INDICATORS

The Utilization Management Program's monitoring and evaluation methods are based on the use of both clinical and service indicators. On an annual basis PHP monitors and quantitatively and qualitatively analyzes utilization indicators including behavior health indicators, against established thresholds to detect over/under utilization trends.

The analysis is conducted to determine the cause and effect of all data not within threshold by practice site and take action to address identified problems of under/over utilization from which select opportunities for improvement are identified. Data input from key PHP department specific reports is evaluated and analyzed for determining opportunities for improvement, implementation of corrective action if needed and effectiveness of interventions. Data is presented at various PHP committees for recommendations for improvement opportunities.

Specific utilization indicators, include but are not limited to:

a. Timeliness of decision-making
b. Notification of determinations
c. Discharges/Bed Days/1000
d. Inpatient Admit Rates
e. Average Length of Stay
f. Behavioral Health Indicators
g. Readmission Rates
h. Denial Data
i. Member Complaints

18. EVALUATION of NEW TECHNOLOGY

Pharmaceutical Patient Safety and Technology Assessment and Guidelines Review evaluate new technologies or new application to existing technologies that include medical technology, behavioral health procedures, pharmaceuticals, and devices. The Medical Advisory Committee (MAC) and/or the Pharmacy and Therapeutics Committee (P&T) are responsible for this function. MAC and/or P&T will develop recommendations based on a rational, published scientific, and clinical evidence-based approach to the use of technology and pharmaceuticals to assist in benefit coverage determinations. PHP will seek input from relevant government regulatory bodies, specialists, and professionals who have expertise in the technology and will be utilized as appropriate. PHP collaborates with any contracted Pharmacy Benefit Manager to review, recommend, and establish patient safety guidelines and protocols related to pharmaceuticals. The contracted Pharmacy Benefit Managers policies, procedures, protocols, and Preferred Drug list are reviewed and approved at P&T on an annual basis. Updates are provided at least annually, or as new pharmaceutical information become available.

18.1 Formulary

Members and practitioners are informed about the availability of the online formulary and updates through the quarterly newsletters. Other modes of notification of formulary updates and pharmaceutical management include but are not limited to:

a. Direct mailing to practitioners
b. Provider manual
c. Member and Practitioner Quarterly Newsletters
d. Online pharmaceutical information available to the prescribing practitioner.

18.2 Performance Responsibilities

Include, but are not limited to, the following:

a. Evaluate pharmacoeconomic studies and effectiveness data for drug therapies and other interventions
b. Analyze outcome data as it relates to short- and long-term effectiveness, efficacy, and patient safety
c. Evaluate new technologies and the new application of existing technologies
d. Determine status of technologies, e.g., experimental, investigational, accepted for clinical use accessing nationally recognized technology assessment reviews, to include but not limited to: Hayes Medical Technology review, Agency for Healthcare Quality, BlueCross/ BlueShield Consumer Technology Center, and a review of information from appropriate government regulatory bodies such as Medicare
e. Prepare recommendations regarding new technology and new applications of existing technologies

Technology review and assessment is never delegated. MAC and P&T will provide reports to the QIC quarterly as appropriate.

19. PHARMACEUTICAL MANAGEMENT

The Prominence Health Plan Pharmacy and Therapeutics (P&T) Committee is the committee responsible for formulating and recommending policies and all matters related to the prescription drug benefit, formulary composition, the therapeutic use of patient self-administered medications, and use of provider-administered infusions under the medical benefit applicable all members for all lines of business. The P&T Committee may delegate select P&T functions to the contracted pharmacy benefit manager for select Prominence product lines. For example, for the development of the Part D formulary and coverage policies, P&T functions is delegated to the PBM's P&T Committee. The P&T Committee recommendations are submitted to Prominence HealthFirst, Prominence HealthFirst of Texas, Prominence HealthFirst of Florida, and Preferred Health Insurance Company, Inc.; Plan Administration; and network practitioners and providers.

PHP collaborates with a contracted Pharmacy Benefit Manager (PBM) who is licensed in the State of Nevada, Texas, and/or Florida, to review, recommend and establish patient safety guidelines and protocols related to pharmaceuticals. PHPs Pharmacy and Therapeutics Committee (P&T) reviews and approves on an annual basis the adoption of the PBMs policies and procedures for pharmaceutical benefit administration. PHP ensures that all policies and procedures include a process that uses clinical evidence from appropriate external organizations and criteria used to adopt the pharmaceutical management procedure. Pharmaceutical management procedures and preferred drug lists are provided to members and PHP practitioners via PHP web site, at least annually, and/or as new pharmaceutical information become available.

This pharmaceutical information includes but is not limited to:

a. Lists of preferred pharmaceuticals and restrictions
b. Prior authorization criteria with instructions on how to use the pharmaceutical management procedures
c. Explanation on how a practitioner must provide information to support a prior authorization
d. Co-payment and coinsurance requirements and the pharmaceutical classes to which they apply
e. Explanation of limits or quotas

Members can complete the following actions in one attempt or contact on the PHP website or by calling the PHP Customer Service Department:

a. Determine financial responsibility for a drug, based on the pharmacy benefit
b. Initiate the exceptions process
c. Order a refill for an existing, unexpired, mail-order prescription
d. Find the location of an in-network pharmacy
e. Conduct a pharmacy proximity search based on zip code
f. Determine potential drug-drug interactions

g. Determine a drug's common side effects and significant risks
h. Determine the availability of generic substitutes

Members can also complete the following actions via telephone in one attempt or contact either by calling PHP Customer Services Department or by calling PHP contracted PBM's customer service desk: Appropriate phone numbers are listed on the back of the members ID card:

a. Determine financial responsibility for a drug, based on the pharmacy benefit
b. Initiate the exceptions process
c. Order a refill for an existing, unexpired, mail order prescription
d. Find the location of an in-network pharmacy
e. Conduct a proximity search based on zip code
f. Determine potential drug-drug interactions
g. Determine a drug's common side effects
h. Determine the availability of generic substitutes

Pharmaceutical management and preferred drug lists are available on the PHP website as well as a hard copy is distributed to Prominence Health Plan practitioners at least annually and to members upon request. PHP has a Clinical Pharmacist on staff that can also help with member/provider questions or concerns.

20. DELEGATION GUIDELINES

Prominence Health Plan's Utilization Management may delegate selected components of the comprehensive Utilization Management process to Independent Physician Associations/Medical Groups, or accredited UM companies who meet Prominence Health Plans standards for delegation.

Health Services Delegated Vendors:

Vendor	Vendor Owner	Delegated Services
Liberty Dental	**Operations**	**Credentialing, Customer Service, Grievance & Appeals, Provider Network, Quality Improvement**
MedImpact	**Pharmacy**	**Customer service, Grievance, Provider Network, Prior Authorization, Request for Payment/Direct Member Reimbursement, UM**
National Vision Administrators (Vision)	**Operations**	**Claims, Customer Service, Prior Authorizations, Provider Network, Credentialing, & Grievances**
Sinfonia Rx	**Pharmacy**	**Medication Therapy Management**
Teladoc	**Health Services**	**Credentialing, Customer Service, Provider Network**
Tethys Health Ventures	**Health Services**	**Organ & Bone Marrow Transplant**
CDMS	**Sales**	**Fulfillment Operations: Prior auth notification letters**
AaNeel Care	**IT**	**Prior authorization, appeals/grievances, member/provider portal source system**

20.1 Delegated Activities

Prominence Health Plan may delegate selected Utilization Management functions to established medical groups and/or Independent Physician Associations or accredited UM companies when key Utilization Management components are in place and conform to Prominence Health Plan requirements. Prominence Health Plan's interest is in assuring that systems and resources of the group can adequately meet the quality of medical care and the service demands of our members in the most cost-effective manner. Although, specific Utilization Management function components may be delegated to a practitioner/provider group, or delegated other UM company entity, Prominence Health Plan is a resource to the Group or delegate UM company in ensuring compliance with regulatory and accreditation standards, as well as Prominence Health Plan's UM program requirements which include appropriate data collection and reporting to meet the needs through periodic updates and audits of their systems.

Prominence Health Plan views the Utilization Management function as directed toward comprehensive care of the patient rather than fragmented care, delivered, and managed at different entry points into the health care delivery system. This system encourages and supports the development of cost-effective alternatives to traditional modes of medical practice without compromising the quality of care rendered to members.

Key components of Utilization Management that have been outlined include prospective, concurrent, and retrospective review, including Care Management and Case Management.

It is Prominence Health Plan's expectation that the administration and requirements of this Utilization Management Program will be met through:

a. Prominence Health Plans coordinated effort on an on-going basis

All delegation activities are based on a pre-delegation assessment and ongoing annual monitoring and oversight to ensure that the entity delegate meets Prominence Health Plan's policies, procedures, UM program requirements, and goals of continuous quality improvement. The delegation does not relieve Prominence Health Plan of full responsibility for compliance with subchapter and Insurance Code Chapter 4201 of Texas code, including the conduct of those to whom utilization review has been delegated. For specific details of delegated activities in UM, refer to the individual delegation agreements for behavioral health, pharmacy, and case management. In addition, refer to Independent Physician Associations and their delegation agreements as applicable. An annual review of delegation responsibilities and contractual agreements will be performed. Opportunities for improvement will be identified and an action plan will be developed as needed.

20.1.1 Delegation Oversight

A written delegation document exists that includes but is not limited to the following:

a. Is mutually agreed upon
b. Describes the responsibilities of the organization and the delegated entity
c. Describes the delegated activities
d. Requires at least semiannual reporting to the organization
e. Describes the process by which the organization evaluates the delegated entity's performance
f. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement

20.1.2 Provisions for protected health information (PHI) include:

a. A list of the allowed uses of PHI
b. A description of delegate safeguards to protect the information from inappropriate use or further disclosure
c. A stipulation that the delegate will ensure that sub-delegates have similar safeguards
d. A stipulation that the delegate will provide individuals with access to their PHI
e. A stipulation that the delegate will inform the organization if inappropriate uses of the information occur
f. A stipulation that the delegate will ensure that PHI is returned, destroyed or protected if the delegation agreement ends

20.1.3 Delegation Accountability

Prominence Health Plan retains accountability for the functions delegated and performs oversight of these activities in the following manner:

a. Analysis of monthly and/or quarterly and/or semiannual reports from the delegated UM company or Independent Physician Associations/Medical Group
b. Annual evaluation of delegated functions, including their UM Program description and policies and procedures
c. Identification and follow-up on opportunities for improvement if applicable

d. Evaluation of member and provider satisfaction survey results

21. DELEGATED GROUPS STRUCTURAL REQUIREMENTS

A Joint Operating Committee (JOC) which includes Utilization Management exists for each delegated group. The committee includes key departmental representatives from Prominence Health Plan and from the delegated groups. The committee meets at regularly scheduled intervals, no less than quarterly. Routine operating issues are discussed and resolved by this committee. Prominence Health Plan will receive designated reports from the delegate at least semiannually and more often as mutually agreed upon.

While Prominence Health Plan does not delegate Quality Improvement, delegated groups are expected to be proactive in their approach to quality management. It is expected that a mechanism shall be in place for reporting quality/risk management issues to Prominence Health Plan on a concurrent basis.

22. UTILIZATION MANAGEMENT PROGRAM EVALUATION

Prominence Health Plans Utilization Management Program description along with those of the Prominence Health Plan delegated partners, is formally reviewed on an annual basis and revised as needed. The Utilization Management Program evaluation is incorporated into the Annual QAPI Program Evaluation and is presented to the QAPI Committee for review and approval.

The program is reviewed against the performance metrics, goals, baselines, and annual outcome. Refer to Section Program Effectiveness above.

a. Compare current and prior year's results against current program's goals
b. Evaluate the effectiveness of program goals
c. Identify variable factors affecting goals
d. Add or modify activities as appropriate
e. Improve the efficiency and effectiveness of the processes
f. Set new goals and targets for the following year's program

Example of the PHP's Program Evaluation Template:

[2021] Quality Metrics

Metric	Mechanism to Monitor	Responsible Party	Monitoring Frequency
Enter each metric			

TEAM MEMBERS
Identify quality team members, include titles

Quality Meeting Dates
Enter quality meeting dates:

General Summary
The MAC committee is happy to report that in [YEAR] [COMPANY NAME] has met [xxx]% of the metrics goals adopted by the committee this year. Prominence Health Plan contributes our success to our team members and the dedication found in each employee; consultant used to meet our client's needs.

This evaluation will look at each metric individually and provide the baseline measurement, the goal, explore any barrier on why the goal was not met, if applicable, and if an action plan is needed. In addition, an evaluation of the available resources and whether the right individuals were involved in the metric will be completed.

ENTER METRIC(S)
Baseline Measurement: [IDENTIFY [YEAR] BASELINE]

Goal: [IDENTIFY [YEAR] GOAL]
[YEAR] Aggregate results: [IDENTIFY AGGREGATE RESULTS FOR [YEAR]]

Was Goal Met: [YES OR NO]

If yes: [ENTER WHAT FACTORS ENTERED INTO OUR SUCCESS]

If no: [ENTER WHAT BARRIERS WERE IDENTIFIED FOR THE FAILURE TO MEET THE GOAL]

Resources: [Identify whether the resources were adequate and appropriate]

Right People Involved: [Identify whether the right people were involved in the monitoring and analysis of the metric]

SUMMARY AND [UPCOMING YEAR] PLANS BASED ON THE EVALUATION
As demonstrated from the information provided, Prominence Health Plan is dedicated to ensuring that our services meet the needs of our patients and our clients and continue to meet our mission. In [YEAR] the MAC Committee and Oversight authority plan to [ENTER UPCOMING YEARS PLANS, METRICS, ADDITIONAL RESOURCES ETC.]

Prominence Health Plan will conduct at a minimum, an annual evaluation of all delegated entities functions, program materials, policies, and procedures, to ensure that the delegates continue to meet Prominence Health Plan's standards. Results of these annual evaluations of the delegated oversight responsibilities and activities will be incorporated into Prominence Health Plan's annual evaluation and work plan. In addition, Prominence Health Plan will inform the enrollee population serviced and network providers of the results of the evaluation of the utilization services via the member and provider newsletters.