Medical Management Program
2023

The Cox HealthPlan (CHP) Medical Management Program is designed to partner with members to help them improve their health while utilizing appropriate medical services at the lowest cost. CHP and CoxHealth provide members with the knowledge and information needed to make informed care decisions that will maximize plan benefits and ultimately result in higher level of quality. Our program allows the combining of medical claims, pharmacy claims, health records and enrollment data with the health system's clinical resources, creating a comprehensive approach to identification, outreach and targeted care for our members.

Unlike other standard medical management programs that only use claims data, our program integrates and coordinates all health system resources for our members. All Cox HealthPlans members are eligible for medical management. Through data analytics and specific algorithms, members are uniquely identified, and the outreach process begins. Members will be contacted and engaged based on their specific needs. The CoxHealth care team performing the services consists of physicians, registered nurses, pharmacists, community health workers, case managers, social workers and dieticians. The care team collaborates with Cox HealthPlans' Medical Management Department to ensure complete care and service is provided.

Through **Population Health Management, Pharmacy Management, and Healthcare Utilization Management** techniques, our team identifies areas we can assist members, their families and providers. This ensures that our members receive timely, appropriate services to achieve our goals of:

- Promoting high-quality, cost-effective medical care
- Empowering members to take control of health care needs (self-management)
- Fostering higher-quality outcomes and better disease control
- Connecting members to In-Network providers
- Introducing members to a multitude of education and resources

Medical Management includes three components:

- Population Health Management (Case and Disease Management)
- Pharmacy Management
- Utilization Management

Each of these three areas is described below.

POPULATION HEALTH MANAGEMENT

Population Health Management is the process in which member and patient data of an entire population is pulled together from multiple resources and analyzed so that care delivery can be provided in a way that improves member experiences, as well as clinical and financial outcomes. The services and programs offered by Cox HealthPlans through the CoxHealth Population Health Services department help facilitate the right care, at the right time, through well-coordinated, supportive efforts.

Personal **A**pproach **T**o **H**ealth (**PATH**)
Living healthy is a lifelong journey and Cox HealthPlans is committed to supporting members at every step of their health care experience. Everyone has their own PATH, and Population Health Services Care Advising is a service created to help members during their journey.

Providing Personalized Support
Depending on the individual needs of the member, Care Advisors bring a team of health care professionals to support the member on their PATH, including a pharmacist, dietitian, and social worker. Participants work one-on-one with personal Care Advisors, who also work closely with each member's primary care provider to help them follow their PATH to a healthier life. Care Advising offers educational materials to assist in understanding and managing medications, managing symptoms, and planning physician visits. Social determinants of health are taken into account for each patient and they are supported in navigating roadblocks to care.

TRANSITION CARE — This service helps members safely transition out of the hospital and avoid complications that could cause a readmission. Many members and their families need and want extra support in this time surrounding a hospital stay. Transition Care includes access to a team of health care professionals who help members navigate health decisions and make the next steps on their PATH a little easier.

COMPLEX CARE — Many members living with chronic health conditions have difficulty managing the complexity of the health care system and often lack the skills to effectively self-manage their conditions. Complex Care Management is a service that helps members:

- communicate their current health issues
- address physical, social, and emotional well-being
- discuss personal health goals
- create a care plan with specific actions to help meet those goals

ADVANCED ILLNESS CARE — Living with a serious or advancing illness can be difficult and stressful for members and their loved ones or caregivers. As an extension of care received from their physician, an advanced illness nurse Care Advisor is available to help members make important decisions about their health and future.

Members can work with Care Advisors to learn ways to better manage current symptoms, identify personal goals for care, address emotional and spiritual concerns, reduce unwanted or unnecessary care, and improve quality of life whenever possible.

CHRONIC CARE IMPROVEMENT PROGRAM – The chronic care improvement program (CCIP) is a clinically focused health initiative that meets CMS requirements. The CCIP document describes the opportunity for a chronic condition's improvement, the goal or target, the specific interventions that will be introduced to achieve the goal, the members targeted, and the expected results. See the CCIP document for more information on CHP's current CCIP.

Population Health Management Overview

	TRANSITION CARE	COMPLEX CARE	ADVANCED ILLNESS CARE
Goals:	*Member will be independent and have no readmissions within 30 days*	*Reduce Emergency Room (ER) visits and hospital admissions*	*Promote self-management and hospice/palliative care utilization as appropriate*
Identify	• All inpatient admissions are reviewed by the Transitions Coordinator, who confirms the member is appropriate for the program	• Members are identified by claims submitted by care provider or by referral from a Transitions Coordinator • Candidates are reviewed for program appropriateness by a Nurse Case Manager (NCM) and care provider	• Members are identified through provider claims history, prior enrollment in other programs such as Transition or Complex Care Management, and/or provider referral • NCM collaborates with PCP to ensure program appropriateness
Enroll	• Transitions Coordinator meets with the member/family in the hospital to introduce and explain the program • Voluntary enrollment	• NCM contacts eligible members to explain and discuss the program • Voluntary enrollment	• NCM contacts eligible members to explain and discuss the program • Voluntary enrollment
Assess	• A needs-based assessment is performed and discharge planning developed	• NCM completes a full assessment of member needs and establishes a personalized care plan with self-management goals	• NCM completes a full assessment of member needs and establishes a personalized care plan with self-management goals
Action	• Transitions Coordinator collaborates with hospital staff to create a smooth transition to the next level of care (Home, Skilled Nursing Facility, Long Term Care, etc.) • Post-discharge assessment is performed within two days of the discharge date	• NCM connects member with the appropriate resources (pharmacist, social worker, behavioral health specialist, etc.) • Care coordination with Primary Care Provider (PCP) and/or specialist(s)	• NCM works with member and family to understand goals, develop a symptom response plan and complete advance directives • NCM collaborates with PCP and/or specialist(s) for referrals and discuss need for palliative or hospice care
Follow-Up	• Transitions Coordinator follows up weekly (more often if needed) to ensure stability after discharge and that physician follow-up appointments are completed • Transitions Coordinator advocates for member through communication with care providers regarding barriers and/or progress • Assesses readiness for program graduation or need for further treatment (Complex Care Management or Advanced Illness Care)	• NCM follows up every two weeks (more often if needed) • NCM advocates for member through communication with care providers regarding barriers and/or progress • Evaluates progress toward goals and assesses readiness for program graduation	• NCM follows up every 1-2 weeks (more often if needed) • NCM re-evaluates for appropriate level of care at three months • If no level of care modification needed, the NCM will continue to monitor member for changes in status and/or end-of-life preferences

PHARMACY MANAGEMENT

Managing pharmacy benefits and utilization is another key area in maintaining great service and a successful health plan. Programs and initiatives consist of:

- Evaluating member needs regarding their health conditions and corresponding prescriptions
- Providing them with additional resources to manage these needs and save money
- Coordinating efforts between members, their families and physicians
- Educating members on how to use the formulary to their advantage to get the most out of their benefit
- Employing multiple strategies designed to appropriately steer utilization to the lowest cost
- Promoting member safety in medication management

Specialty Medication and Disease Management Program

In collaboration with CoxHealth and CoxHealth Pharmacy, we are pleased to offer the Specialty Medication and Disease Management Program exclusively to CHP members. This program is designed to help improve the health of our members with specific diagnoses, reduce their cost for expensive specialty medications, and provide them with additional resources to manage their disease.

WHO IS ELIGIBLE: Cox HealthPlans determines who is eligible to participate in the Specialty Medication and Disease Management Program based on:

- Enrollment in a CHP Individual or Employer group health plan
- Members diagnosed with one of the health conditions listed below
- Members taking at least one of the prescription medications listed below

Specific Diagnoses:	Target Membership – Anyone Currently Taking:
Crohn's, Multiple Sclerosis (MS), Psoriasis, Psoriatic Arthritis, Rheumatoid Arthritis (RA), Ulcerative Colitis	Acitretin, Actemra, Avonex, Betaseron, Budesonide, Cimzia, Copaxone, Enbrel, Gilenya, Glatiramer, Glatopa, Humira, Iluma, Kevzara, Kineret, Olumiant, Orencia, Otezla, Rasuvo, Rebif, Rinvoq, Simponi, Skyrizi, Stelara, Tremfya, Uceris, Xeljanz

What Program eligible members can expect:

- Detailed letter introducing the program
- Calls offering to schedule first appointment
- Members must have at least one appointment with the program's dedicated physician per year to participate
- Upon program start, the above prescriptions currently being filled through specific specialty pharmacies will be transferred to CoxHealth Pharmacy

- In addition to the current physicians being seen for the diagnoses, members will have full access (both in-person and by phone) to a dedicated program physician, as well as a specialty pharmacist and chronic disease management education specialists through CoxHealth Population Health Services

Benefits of the program:

- No pharmacy co-pay or deductible for qualified specialty medications
- No co-pay, coinsurance, or deductible for office visits with the program physician
- Convenience of getting medication at our local pharmacy or having it delivered
- Closer one-on-one care with unlimited access to the program physician, pharmacist, and dietician in-person or on the phone
- Higher quality outcomes and better disease control
- Free select classes at CoxHealth Center for Health Improvement (CHI)
- Access to support groups

Pharmacy Management Initiatives

Prescription Savings Program
Many "lifestyle medications" are not covered under health insurance policies. The Rx Personal Savings Program allows members and their dependents an added prescription benefit for such medications at no additional cost. The program allows your members to receive an immediate discount (outside of their existing prescription plan) on many of the most frequently prescribed lifestyle medications.

There are no enrollment forms or opt-ins, no claims to send in or discount cards to carry. Members simply use their existing CHP identification card to get the savings —as much as 65% off retail price— at the point of sale.

Maximum Dollar Review
All prescriptions costing $5,000 or more at retail and $2,500 or more through mail order are submitted for review and approval of appropriateness and accuracy in pricing.

New Client 60-Day Moratorium
At CHP, customer service is just as important as risk management. This transitional program allows for a 60-day grace period where plan limitations (such as quantity limit, excluded drugs, prior authorization, step therapy, etc.) are suspended on specific prescription medications. During those 60 days, new members can contact CHP Medical Management Department for assistance with the prior authorization process or to find another therapeutic equivalent medication that is on their new formulary.

Because formularies differ among carriers, the intent of the program is to allow for continuity of certain care and reduce member disruption when a member is switching to CHP from another insurance company. If our representatives or our agents have the opportunity to meet with new members during the enrollment process, the program is also reviewed at that time.

Medication Therapy Management (MTM) - Medicare Advantage

The Medication Therapy Management (MTM) program is available to eligible Medicare Advantage plan beneficiaries. This CMS-required program helps to ensure proper use of medications and to identify and reduce possible medication problems. To qualify, beneficiaries must meet all of the following criteria:

- Have at least 3 of the following conditions or diseases: Chronic Heart Failure (CHF), Diabetes, Dyslipidemia, Hypertension, Bone Disease-Arthritis-Osteoporosis, or End-Stage Renal Disease (ESRD), and
- Take at least 8 covered Part D medications, and
- Are likely to have medication costs of covered Part D medications greater than $4,935 per year.

The MTM program offers two types of clinical medication review: Targeted Medication Review (TMR), a quarterly review, and Comprehensive Medication Review (CMR), an annual discussion and review of medications after which the beneficiary will receive a summary of the review and a Medication Action Plan (MAP) and Personal Medication List (PSL), to assist beneficiaries with medication management.

Opioid Information - Medicare Advantage

The Drug Management Program (DMP) is available to beneficiaries of the Medicare Advantage plan to help ensure the safe and effective use of prescription opioids, benzodiazepines, and other frequently abused medications. For beneficiaries affected by opioid and/or benzodiazepine addiction, opioid treatment services are available, which include substance abuse counseling, individual and group therapy, toxicology testing, and certain FDA-approved opioid agonist and antagonist treatment medications. CMS requires continued monitoring of prescription opioid and benzodiazepine use; therefore, the following safety edits are applied at the beneficiary's pharmacy:

- Care Coordination Edit – an alert sent to the pharmacy when an opioid or benzodiazepine prescription is submitted, and CoxHealth's records show that a beneficiary has filled other opioid-containing prescriptions written by two or more different prescribers.
- Opioid Naïve Edit - A limitation on the amount an opioid prescription can be filled for at the pharmacy when it is determined that a beneficiary has not filled an opioid claim within the last 120 days, in which case the beneficiary will be considered opioid naïve, and CMS requires CoxHealth to limit the initial prescription amount to 7 days, even if the prescription is written for more. After the initial prescription is filled for 7 days, subsequent opioid prescriptions can be filled for up to 30 days as long as the claims history shows a prior opioid claim within the previous 120 days.
- Drug Utilization Review (DUR) Edit - specific opioid and benzodiazepine utilization edits are programmed to ensure safe quantities are being dispensed. Additionally, edits are in place to ensure there is monitoring for potential drug to drug interactions that could be harmful.

UTILIZATION MANAGEMENT

Utilization Management (UM) is a process that encourages members to seek the most cost-effective and appropriate quality care possible. CHP's team of registered nurses, medical resource specialists, and certified case managers carry out a variety of UM techniques. Medical management staff performs continuous prospective, concurrent, and retrospective reviews using the latest guidelines supported by evidence-based literature and ensures alignment with industry standards. Under the Healthcare Utilization Management reviews, Member Outreach provides guidance for members to resources such as self-care instruction, coordinating health care education, and assistance in locating providers. These reviews are ongoing throughout the year to evaluate the use of appropriate procedures, setting (place of service), and resources through Care management and Preauthorization review requirements. By reviewing the utilization of specific health care services and collaborating with members, focus is placed on areas where the most beneficial change and savings can be realized.

CHP's UM program applies to all members and is approved and monitored by the UM Committee and Quality Improvement Committee (QIC).

UM PROGRAM OBJECTIVES

- Ensure services are medically necessary and delivered at appropriate levels of care.
- Ensure that the Medical Management Department utilizes standardized criteria and informational resources as decision support tools to evaluate medical necessity of health care services (e.g., MCG, evidence-based research database and internally developed criteria).
- Ensure consistent application of UM criteria by medical management staff.
- Identify chronic diseases and encourage services to decrease morbidity & mortality.
- Identify potential members for placement into CoxHealth Population Health Services programs.
- Monitor the potential for under/over-utilization of services and the potential for fraud and abuse.
- Integrate the UM program with the QI program to ensure quality of care and service and continuous quality improvement.

SCOPE

The UM program has been developed to provide assurance that physician, institutional, ancillary and therapeutic services are properly utilized and to assure that these services are available, accessible, medically appropriate and cost effective. Mechanisms used to achieve these goals are:

- Prospective review of elective services (including inpatient, outpatient surgical and diagnostic services/procedures, pharmaceuticals, hospice, home health, durable medical equipment, out of network services, and new technologies)
- Initial (urgent admissions) and concurrent review of inpatient care
- Discharge planning and coordination

- Prior authorization for high-risk medical services and medications
- Coordination with vendors for delegated services such as Pharmacy Benefit Management services
- Retrospective review of non-authorized admissions, ambulance, pharmacy and other services
- Community-based coordination services for high-risk members
- Involvement in the QIC and UM Committee to assure consistency and quality of care
- Review of High Dollar claims to ensure medical necessity and appropriate billing
- Quarterly and Ad Hoc review of new technologies/codes including determination of pay or deny status.

PROGRAM STRUCTURE

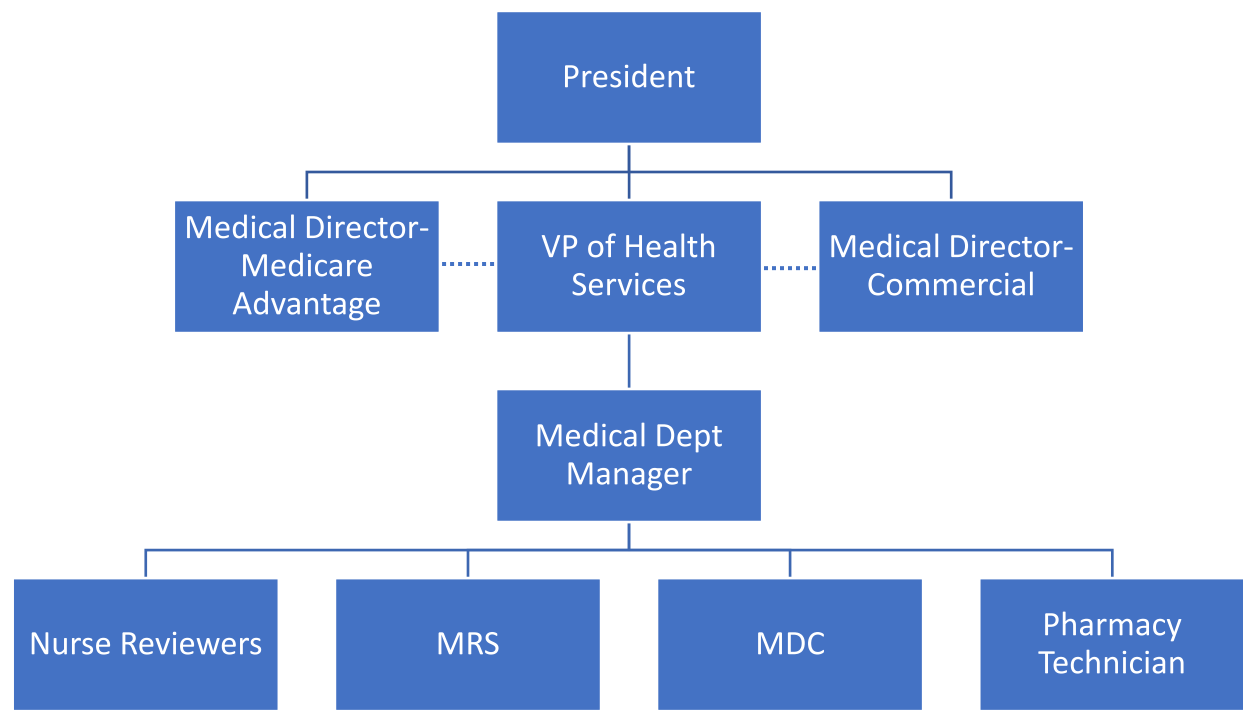
Quality Improvement Committee (QIC)
The QIC reviews all the UM Committee minutes and determines final approval of the UM program and evaluation and the UM Committee recommendations. The QIC includes the Medical Directors and other physicians, including a BH practitioner. The QIC coordinates functions related to medical services and quality improvement.

Utilization Management Committee
The UM Committee meets on a regular basis and includes the Medical Directors, other physicians, and Medical Management staff. The responsibilities of the committee are to:

- Review and approve the UM Program and evaluation annually;
- Review and approve the clinical criteria used to make UM decisions no less than annually;
- Review new medical technology and make determinations for individual consideration or inclusion in the benefit program;
- Evaluate reports related to members in care management and authorize interventions;
- Evaluate the use and cost of services provided to members through utilization reports, and direct the development of specific programs or projects related to identified trends;
- Review annual inter-rater reliability testing and direct action to correct any issues identified;
- Review reports on potential fraud and abuse and determine actions; and
- Evaluate practitioner and member satisfaction with the UM process, and authorize interventions to improve satisfaction.

The UM Committee reports to the QIC.

DEPARTMENT STAFF



Medical Director - Commercial

The Commercial Medical Director is responsible for oversight and annual evaluation of the UM and Medical Management program, including oversight of activities within Care Management, development of UM policies and procedures, and ensuring consistent application of UM decision criteria. The Commercial Medical Director is licensed to practice medicine in the state of Missouri. The Commercial Medical Director works closely with the Director and Manager of Medical Management and with MLS physicians to evaluate care and make determinations based on the benefit structure and medical necessity, as defined by the approved criteria. The Commercial Medical Director is a critical member of the UM and Quality Improvement Committees. The Commercial Medical Director will provide input into pharmacy management as needed. He/she also reviews determination of new CPT/HCPCS/Dx code setting (pay/pend/deny). This role also serves as a conduit between CHP and system facility and ancillary providers.

Medical Director - Medicare Advantage (MA)
The MA Medical Director is responsible for oversight of the Medical Management program for MA beneficiaries to ensure consistent application of CMS requirements for the medical management of MA plans. The MA Medical Director is licensed to practice medicine in the state of Missouri. The MA Medical Director is a member of CHP's Compliance, Utilization Management and Quality Improvement Committees. This role will also serve as a conduit between CHP and system facility and ancillary providers.

Behavioral Health Practitioner
The Behavioral Health Practitioner will review and give input on behavioral health and substance abuse access standards as well as be involved in the development and adoption of behavioral health components of the utilization management program. The Behavioral Health Practitioner will also sit on the CHP Utilization Management and Quality Improvement Committees.

Vice President (VP) of Health Services
The VP of Health Services has the overall responsibility for Medical Management and Population Health Management. This role works closely with the Medical Directors and the Medical Department Manager to ensure that the strategic direction of the UM program is fulfilled. The VP of Health Services facilitates supports Population Health Management to ensure compliance, effectiveness and integrity of the program. This role is also responsible for making sure that tools, resources and education are available to the Medical Management team and interacts with vendors and delegated entities on a regular basis.

Medical Department Manager
The Medical Department Manager is responsible for oversight of daily activities within the Medical Management Department, assuring that policies are followed by staff and managing the operations of the area. This role reports to the VP of Health Services. The Manager ensures that all potential denials are sent to MLS or the appropriate Medical Director for review. The Manager facilitates medical appeals with external physician reviewer for input on the cases, when necessary. The Manager may also coordinate and refer members to the CoxHealth's Population Health Services for case and disease management services.

Medical Department Coordinator (MDC)
The MDC is responsible for support of all Medical Department functions for CHP. This individual has primary oversight of the utilization review intake for authorizations, department policy and procedure management, and direct support to the department manager and VP. Other chief duties include: independent development of member/provider correspondence; data collection and entry; report generation utilizing various software programs; and assists nursing staff with the utilization and care management process. Direct assistance with the development and implementation of new programs designed for cost savings and quality care. The Department Representative will perform various clinical duties which include supply ordering, photocopying, scanning, electronic faxing/filing, appointment scheduling, and transcription.

Medical Resources Specialist (MRS)
The MRS is responsible for performing administrative duties associated with services required by the Nurse Reviewer for the utilization process and other department procedures. This position serves as a liaison between CHP, providers, MLS physician reviewers, and members to ensure that requests have been processed in an accurate and timely manner. The role functions to promote effective utilization of product lines in accordance with plan provisions and department guidelines.

Nurse Reviewers
The Nurse Reviewers are registered nurses in the State of Missouri who perform UM functions for the health plan. The Nurse Reviewers are responsible for review of all cases requiring prior approval, concurrent, and retrospective review to identify appropriate level of care and whether the cases meets standard coverage criteria. The nurses refer any case not meeting criteria to MLS physician reviewers or the appropriate Medical Director for verification. The Nurse Reviewers are also certified in care management (CM) so they may also assist in identifying and performing discharge planning and care management as needed. The nurses may refer cases for disease or care management when identified or perform basic CM functions. If a quality of care issue is identified, the nurses refer the case to the Medical Department Manager for investigation and determination of subsequent actions.

Pharmacy Technician
The Pharmacy Technician is responsible for performing duties that support pharmacy utilization management activities for the health plan. This role functions to promote effective utilization of pharmacy benefits and will work closely with CHP's pharmacy benefit manager (PBM), Elixir. The Pharmacy Technician will also serve as a member of the Utilization Management Committee and other CHP committees as needed.

MLS Physician Reviewers
CHP delegates physician review to MLS, an independent review organization, for medical necessity review, determination, and physician peer review. All medical necessity and denial cases are referred to MLS. MLS supports all areas of CHP UM review, ensuring appropriate case review by a licensed physician with appropriate specialty, and behavioral health practitioner involvement depending on the type of review.

AllMed Physician Reviewers (secondary)
CHP also delegates physician review to AllMed Healthcare Management, another independent review organization that CHP chose as a secondary organization for medical necessity review, determination, and physician peer review to be used if needed.

UTILIZATION ACTIVITIES

Clinical Review Criteria and Policies

Licensed clinical staff use evidence-based clinical guidelines from nationally recognized authorities in conjunction with the terms of the member's benefits plan to guide UM decisions involving precertification, concurrent review, discharge planning, and retrospective review. Medical management staff utilizes guidelines from the following sources:

- MCG guidelines;
- Internally developed criteria;
- Industry standard (other payer published guidelines);
- Federal and state guidelines when applicable;
- CMS guidelines when applicable.

The relevant guidelines used in making coverage decisions for medical benefit related services are available, upon request, to members and are readily accessible in the provider portal to treating practitioners. Pharmacy benefit clinical management is available on our website via the formulary lookup tool and other resource documents.

The purpose of the clinical coverage guidelines is to assist in the interpretation of medical necessity and determine if standard of care is to low, being met, or unnecessarily being exceeded. These guidelines do not replace the professional judgment exercised by properly trained, licensed and experienced clinicians and professionals who evaluate the provision of services in accordance with accepted standards of care. Staff considers the individual needs of the member when applying clinical criteria and making coverage determinations.

Information Sources

Inpatient and outpatient care (ambulatory) coverage determinations are based on **information from sources** such as:

- Clinical Office and hospital records that include documentation of the following as applicable:
    - History of the presenting problem;
    - Clinical exams;
    - Diagnostic testing results;
    - Treatment plans and progress notes;
    - Patient psychosocial history;
    - Clinical evaluations and findings from treating practitioner(s);
    - Evaluations from other health care practitioners and providers;
    - Photographs;
    - Rehabilitation evaluations.
- Information concerning the local delivery system;
- Patient characteristics;

- Pharmacy claim history;
- Information from responsible family members.

Authorization for Hospitalizations/Inpatient Care
In order to assure appropriate and efficient utilization of services and facilities, the Nurse Reviewer reviews all requests for hospitalization. The requests include emergent, urgent, routine, and elective admissions. Requests for emergent admissions occur after the completion of a medical screening examination and, where appropriate, when stabilizing treatment is under way. Prior authorization for emergent services in the emergency department is not required. All cases that do not meet MCG criteria based on severity of illness and intensity of service are forwarded to MLS physician reviewers or the appropriate Medical Director for review and recommendation.

Monitoring for Over- and Under- Utilization
CHP collaborates with CoxHealth Population Health Services to monitor and act on over- and under-utilization. Some of the items monitored for over-utilization are ER visits and inpatient stays. If a member is marked as over-utilizing these services, Population Health Services will reach out and work to help them figure out more appropriate avenues for their health care needs. The Center for Health Improvement will also monitor under-utilization of preventive services, such as yearly primary care physician appointments and adult vaccines. When members are found to be under-utilizing preventive services, Population Health Services will perform outreach to encourage and engage members into utilizing these services. CHP gets reporting on these numbers and can conduct follow up as necessary. CHP also uses HEDIS and HEDIS-like measures to monitor over- and under-utilization, with Quality Improvement Initiatives, outreach, or follow ups with providers occurring based on measure outcomes.

Concurrent Review
Concurrent review is a process where we review member’s ongoing services for care. Concurrent review is most commonly done for inpatient services where the need for continued stay is appropriate for that specific level of care and that the care being delivered meets the standards previously discussed. The Nurse Reviewer obtains all relevant clinical information and coordinates/collaborates with the care team that is delivering care. The Nurse Reviewer is performing care management and care coordination duties throughout the time the member is under the care of the provider.

The Nurse Reviewer uses clinical expertise to apply MCG criteria to review each case. The Nurse Reviewer also takes into consideration, but not limited to, the member’s current clinical status, laboratory values, radiology results, pathology reports, treatment plan, and progress of treatment, member’s age, any complications/co-morbidities, psychosocial factors, and home environment as part of the review process.

Throughout the concurrent review process, the Nurse Reviewer may identify quality of care issues and report these incidences as they arise to the appropriate individuals so that it may go to the CHP Quality Improvement Department for review and investigation if necessary. CHP’s Quality Improvement

Committee and/or the appropriate Medical Director review cases of substantial quality of care concerns, and take action as indicated by the review.

Discharge Planning
The Nurse Reviewer, working directly with the Hospital care management/social worker staff, assists with discharge planning, recovery facility care, and home health care management in order to ensure continuity of care and safe transition of the member to the home setting, from acute and post-acute inpatient areas. The Nurse Reviewer is involved in coordinating any or all of the following services or activities as part of discharge planning: network options, alternative services, durable medical equipment, pharmacy, rehabilitation services (inpatient or outpatient), skilled nursing needs, transportation, home preparation, family teaching, home health agency coordination, respiratory care services, referral for outpatient mental health services, and community services, if appropriate.

Retrospective Review
The Nurse Reviewer performs review for cases in which CHP was not notified of an admission. CHP is typically made aware of this after a claim has been received. The process includes requesting those records dealing with the case. The Nurse Reviewer conduct retrospective review of inpatient services rendered during the member's admission as if they were still inpatient. If appropriate, the Nurse Reviewer may assign/delay days for services that were delayed by the actions or inactions of the practitioner or provider or both, resulting in prolonged hospitalization for the member. When a delay of this nature occurs, the member is held harmless; any denial of payment is related to the contract between CHP and the provider and not a benefit or medical necessity denial for the member.

Medical Outpatient Activities

Prior Authorization for Outpatient Diagnostic and Surgical Procedures and Referrals
The Nurse Reviewer conducts prospective review for selected outpatient diagnostic and surgical procedures. Treating practitioners may telephone, fax or write a request for services requiring prior authorization. The Nurse Reviewer uses MCG criteria and/or other criteria previously noted to help determine whether coverage criteria are met. All cases where there is a recommendation for denial or uncertainty of whether the request meets criteria, the Nurse Reviewer obtains MLS physician or Medical Director review (as applicable) and recommendation/determination.

Referrals to or exception requests for any out-of-network specialist or practitioner require review. Cases in which there is a question regarding benefits, the Nurse Reviewer contacts the Medical Department Manager for a benefit determination. These are reviewed on a case by case basis and if appropriate, a member may be referred out of network if an appropriately qualified specialist is not available in network.

Outpatient behavioral health management does not require prior authorization. Emergency behavioral health or substance abuse services do not require prior authorization and/or referrals.

Retrospective Review

The Nurse Reviewer may request selected medical records for retrospective review including those records dealing with cases in which CHP was not notified prior to services being rendered for services requiring prior authorization.

Recovery Care Facility

Recovery Care Facility Management ensures that members admitted to a recovery care facility such as rehabilitation facility or skilled nursing facility are assessed prior to admission to determine the scope of their clinical needs, the level of care required, the appropriate provider, and the anticipated outcome. The Nurse Reviewer reviews the member's care and progress in the facility on a regular basis to ascertain continued eligibility and the necessity of care in a skilled level facility.

Home Health Care

The Nurse Reviewer reviews requests for home health care to ensure that members meet coverage criteria and receive continuity of care with a safe transition to the home setting. The Nurse Reviewer reviews the member's care and continued progress while receiving home care on a regular basis to determine continued appropriateness and necessity for services in the home setting.

Hospice Care

The Nurse Reviewer reviews requests for inpatient, extended care facility and/or in-home hospice to ensure that members meet requirements for admission.

Durable Medical Equipment

CHP reviews requests for durable medical equipment (DME) against coverage criteria and verifies member benefits. When the request does not meet guidelines, the Nurse Reviewer refers the request to the appropriate Medical Director or MLS Physicians for review and recommendation/determination.

Pharmacy Benefit Management

CHP delegates pharmacy UM services to its pharmacy benefit manager (PBM), Elixir. Elixir conducts prior authorizations and overall clinical management techniques. Elixir reports on utilization trends, fraud and abuse, and network management metrics. Elixir will issue adverse determinations for requests that do not suffice clinical management criteria or conform to the formulary allowances. Adverse determinations are issued electronically to the pharmacy and in writing to the member and prescriber. First and second level appeals for an adverse determination are handled by Elixir. Elixir maintains the CHP formulary composition.

Elixir is accredited by URAC for PBM and Drug Therapy Management. Elixir maintains a number of pharmacy and prescription safety programs and has a Clinical Care and Member Engagement programs available to support medication adherence and safety.

The Vice President of Health Services reviews monthly, quarterly, and annual reports from the PBM for unexpected utilization patterns of pharmacy benefits and unexpected utilization patterns of non-formulary by providers, as well as potential fraud, waste and abuse.

CHP reviews exception requests for non-formulary and/or non-covered drugs for medical necessity on a case by case basis. There is a specific form that is utilized for this process and is available online. CHP also reviews exception requests when the requesting practitioner has not attempted or completed step therapy or requests a brand name when a generic is covered on the formulary. If the request is denied, the member and practitioner are notified with information on initiating an appeal.

CRITERIA

The Medical Management department primarily uses MCG criteria for utilization review. In some instances MCG may not have criteria/guidelines available. In cases like this, CHP will use other national evidence based resources and/or MLS. Please see also the Utilization Activities section on page 12 of this document for other sources. All criteria are reviewed annually by the UM Committee for new, revised, replacement, or continued use.

Practitioners and providers may request copies of specific criteria by contacting the Medical Management department by phone, fax, or letter. Criteria/Determination Guidelines may also be found in the provider portal.

DECISION MAKING PROCESS

Any decision regarding a request for health services, whether approved or denied, is called a determination. In order to make appropriate utilization management decisions, licensed health professionals, such as the Nurse Reviewers, collect information that includes member demographics, member eligibility and benefit coverage, and all relevant clinical data regarding severity of illness and intensity of service. This may include, but not limited to the member’s signs and symptoms, clinical status, co-morbidities, complications, laboratory values, radiology results, pathology reports, primary care physician notes, or treating practitioner’s notes or opinion of the case. The Nurse Reviewer also takes into consideration the individual needs of the member, including socioeconomic status and home environment, and the characteristics of the local delivery system. The Nurse Reviewer utilizes criteria to determine whether the health service request meets clinical criteria and, if not, obtains additional information as indicated, and refers the case to a Medical Director or MLS physician for review and determination if uncertainty is present. The Nurse Reviewer may consult the appropriate Medical Director or MLS physician on any case when assessment indicates that UM guidelines are not appropriate.

CHP has a contract with MLS to review and evaluate medical determinations. MLS has an extensive panel of board-certified primary and specialty care practitioners. The CHP Medical Directors are licensed physicians who may also review denials that are based on medical necessity and may consult with board-certified physicians from appropriate specialty areas in the community to assist in making determinations of medical necessity.

The physician reviewer is available by telephone to discuss adverse organization determinations based on medical necessity with the treating practitioner.

There may be requests for care or services that could be considered to be either a covered or non-covered benefit depending on the circumstances. The Medical Department Manager or Director(s) may review requests based on facts of the case. If needed, the appropriate Medical Director may be needed to consult with board-certified specialists to reach a determination. UM decision making is based only on appropriateness of care and service and existence of coverage. The organization does not reward practitioners or other individuals for denial, limitation, or discontinuation of authorized services.

The UM Program is structured in a manner to ensure that providers are not prohibited from advocating on behalf of members. CHP does not allow any financial incentives or monetary gains for any denial, limitation, or discontinuation of authorized services and furthermore does not encourage decisions that result in underutilization.

TIMELINESS OF UTILIZATION MANAGEMENT DECISIONS

Initial Determinations

For initial determinations, the Plan will make the determination within 36 hours, which shall include one working day, of obtaining all necessary information regarding a proposed admission, procedure, or service requiring a review determination. For purposes of this section, “necessary information” includes the results of any face-to-face clinical evaluation or Second Opinion that may be required.
(1) In the case of a determination to certify/approve (authorize) an admission, procedure or service, CHP will notify the Provider rendering the service by telephone within 24 hours of making the initial certification, and provide written or electronic confirmation of the telephone notification to the Member and the Provider within two working days of making the initial certification.
(2) In the case of an Adverse Determination, the Plan will notify the Provider rendering the service by telephone within 24 hours of making the Adverse Determination; and shall provide written or electronic confirmation of the telephone notification to the Member and the Provider within one working day of making the Adverse Determination.

Concurrent Review Determinations

For concurrent review determinations, CHP will make the determination within one working day of obtaining all necessary information.
(1) In the case of determination to certify/approve (authorize) an extended stay or additional services, the Plan will notify by telephone the Provider rendering the service within one working day of making

the certification, and provide written or electronic confirmation to the Member and the Provider within one working day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.
(2) In the case of Adverse Determination, CHP will notify by telephone the Provider rendering the service within 24 hours of making the Adverse Determination, and provide written or electronic notification to the Member and the Provider within one working day of the telephone notification. The service shall be continued without liability to the Member until the Member has been notified of the determination.

Retrospective Review

For retrospective review determinations, CHP will make the determination within 30 working days of receiving all necessary information. CHP will provide notice in writing of our determination to a Member within 10 working days of making the determination.

ADVERSE DETERMINATIONS (DENIALS)

Denials fall into two categories: Administrative and Clinical.

Administrative denials may be based on contractual (Certificate of Coverage/Summary of Benefit) facts or state/federal regulatory rules. Examples of administrative denials may be, but not limited to, direct plan or summary of benefit exclusions, failure to notify CHP of an admission within one business day of the admission, etc. The Nurse Reviewer makes administrative denials under the supervision of the Manager of Medical Management.

Clinical denials are based on medical necessity and are supported by licensed physicians as previously discussed, along with consultation of board-certified specialists, including behavioral health specialists, as necessary. The initial electronic notification and written confirmation of denial contains the telephone number that the requesting practitioner may call to speak with a physician and/or designee regarding denials based on medical necessity. Denial letters are sent to the treating practitioner and the member.

Denial letters contain the reason, specific utilization review criteria or benefits provision used, that the member may obtain a copy of the criteria or benefit provision and information about the appeal process. CHP also has policy and procedure for reconsideration requests for initially denied services. Additionally, the member, a representative of the member, or the physician acting on behalf of a member may initiate in writing or electronically a standard or expedited appeal by contacting CHP’s Member Services, Medical Department Manager or submission directly to the Grievance and Appeal department.

Complaints and Grievances

Definitions

A complaint is any expression of concern about a condition in the Plan's operation. A complaint may be initiated in person, in writing, or by telephone to the Member Services Department.

A Grievance is a written complaint submitted by or on behalf of a Member regarding the following:

- Availability, delivery or quality of health care services, including a complaint regarding an Adverse
- Determination made pursuant to Utilization Review;
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between a Member and a health carrier.

A complaint is only considered a Grievance when it is in writing as a Grievance letter submitted to CHP. A Covered Person may file a Grievance when he feels CHP has not adequately responded to his/her needs.

Procedures for Complaints

Covered Persons with complaints or problems regarding any aspect of services rendered by CHP Provider, or relationships with that Provider should contact the Provider with whom the problem occurred. If the matter is not satisfactorily resolved, the Covered Person may make an informal complaint by contacting CHP. If the informal complaint is not with a particular Provider, but is with the administrative operations of CHP itself, the Member Services Department should be contacted directly. The Covered Person has the right to contact the Director of the Missouri Department of Commerce and Insurance at any time for assistance by mail at P.O. Box 690, Jefferson City, MO 65101; or by phone at (800) 726-7390 or (573) 751-2640.

Procedures for Formal Grievances

CHP has a first-level and second-level Grievance review. A Covered Person, a Covered Person's representative, or a Provider acting on behalf of a Covered Person, may submit a Grievance. CHP encourages Providers to advocate on behalf of their members.

First Level Grievance

First-level Grievance reviews must be submitted within 180 days from the date of written notice from the Plan to the enrollee of a processed Claim or response to Preauthorization request.
Upon receipt of a request for first-level Grievance review, the Plan will:

- Acknowledge receipt in writing of the Grievance within 10 working days;
- Conduct a complete investigation of the Grievance within 20 working days after receipt of a Grievance, unless the investigation cannot be completed within this time. If the investigation cannot be completed within 20 working days after receipt of a Grievance, the Covered Person shall be notified in writing on or before the 20th working day and the investigation shall be

completed within 30 working days thereafter. The notice shall set forth with specificity the reasons for which additional time is needed for the investigation;

- Within 5 working days after the investigation is completed, someone not involved in the circumstances giving rise to the Grievance or its investigation will decide upon the appropriate resolution of the Grievance and notify you in writing of the Plan's decision regarding the Grievance and of the right to file for a second level review. The notice shall explain the resolution of the Grievance and the right to file for a second-level review in terms which are clear and specific;
- Within 15 working days after the investigation is completed the Covered Person and/or the person who submitted the Grievance will be notified in writing of the Plan's decision regarding the Grievance. The notice of the Plan's decision will include the Covered Person's or the Plan's rights to file a request for review with the Missouri Department of Commerce and Insurance.
- The Covered Person has the right to contact the Director of the Missouri Department of Commerce and Insurance at any time regarding a Grievance: P.O. Box 690, Jefferson City, MO 65101, (800) 726-7390 or (573) 751-2640. If the Grievance is unresolved by the Missouri Department of Commerce and Insurance, then it shall be resolved by referral to an independent review organization.

Second Level Grievance

Second-level Grievance reviews must be submitted within 180 days from the date of written notice from the Plan to the person who submitted the First-level Grievance.

- Upon receipt of a request for second-level review, the Plan will submit the Grievance to a
- Grievance/Appeal Committee consisting of:
- Other Members; and
- Representatives of Cox HealthPlans who were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance. Review by the Grievance/Appeal Committee shall be conducted within 20 working days of receipt of the request for second-level review unless expedited review is applicable. The Covered Person will receive a written notice 10 working days in advance of the Grievance/Appeal Committee hearing. The Covered Person's presence during the hearing is not mandatory. The Committee's decision will be sent to the Covered Person in writing within 5 working days of the hearing. The notice of the Committee's decision will include the Covered Person's or the Plan's right to file a request for review with the Missouri Department of Commerce and Insurance.
- Where the second level review involves an Adverse Determination, a majority of persons serving on the committee will be appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstance giving rise to the Grievance or in any subsequent determination of the Grievance.
- The Covered Person has the right to contact the Director of the Missouri Department of Commerce and Insurance at any time regarding a Grievance: P.O. Box 690, Jefferson City, MO 65101, (800) 726-7390 or (573) 751-2640. If the Grievance is unresolved by the Missouri Department of Commerce and Insurance, then it shall be resolved by referral to an independent review organization.

Expedited Review of Grievances

CHP has written procedures for the expedited review of a Grievance involving a situation where the time frame of the standard Grievance procedures would seriously jeopardize the life or health of a Covered Person or would jeopardize the Covered Person's ability to regain maximum function. A request for an expedited review may be submitted orally or in writing. However, for purposes of the Grievance register requirements, the request shall not be considered a Grievance unless the request is submitted in writing. Expedited review procedures shall be available to a Covered Person, the representative of a Covered Person and to the Provider acting on behalf of a Covered Person. The member can call the phone number on the back of their ID card to submit an oral request for an expedited review and for instruction on how to submit the request in writing. The Plan will notify the Covered Person orally within 72 hours after receiving a request for an expedited review of the Plan's determination, and shall provide written confirmation of

EMERGENCY SERVICES

The Emergency Medical Treatment and Active Labor Act (EMTALA) defines an emergency medical condition as "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs." CHP covers emergency services as necessary to screen and stabilize members without pre-certification in cases in which a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

Through our partnership with CoxHealth Population Health team as wells as internal data we can identify members that utilize ER/UC services more frequently than three visits per six-month period. Members that are shown to routinely use the ER for non-emergent medical issues (colds, cough, etc.), may be contacted by the Medical Management Team. Following review by a RN Case Manager, an ER/UC utilization letter may be sent, when appropriate. Any barriers to care (such as lack of a Primary Care Physician, financial hardship, medication non-compliance, etc.) will be identified and the RN case manager/Nurse Coordinator will guide the member to access appropriate assistance. This process can help our members receive the right care when they need it.

OUT-OF-NETWORK UTILIZATION

Members are not limited to using an In-Network provider, but when an Out-of-Network (OON) provider is utilized, plan expenses are higher which result in higher costs to the policyholder. Internal reporting and analytics show members that are utilizing OON providers, and data on those facilities is reviewed. Contact may be made during authorization review and/or if a member has been consistently utilizing an OON provider when In-Network options are readily available. If appropriate, after review by an RN Case Manager, member may be called or a letter may be sent. This outreach ensures members are aware that they have been seeing an OON provider, how that affects their out-of-pocket expenses, and offers them assistance with transitioning their care to an In-Network provider.

Weekly Case Conference

Each week the medical management team reviews its complex inpatient cases. The cases are assessed for level of care, appropriateness of care, network status, care management needs, discharge planning, etc.

HIGH DOLLAR CLAIMS

High dollar claims are reviewed weekly to ensure appropriateness/reasonableness of services provided, coding/ billing submitted, site of care used, and for potential care management opportunities.

DELEGATION AND OVERSIGHT

CHP has delegated arrangements for certain utilization activities under the medical and pharmacy benefits. These arrangements include the use of physician reviewers from MLS as well as formulary, UM of commercial transplant cases by Optum, and UM of prescription drug by the PBM, Elixir.

All clinical denials are based on medical necessity and are supported by licensed physicians as previously outlined. UM by board-certified specialists is performed as necessary. The Medical Director/physician reviewer renders a determination recommendation as discussed above.

All delegates are required to abide by guidelines set forth by CHP, the State of Missouri, the Accreditation Association for Ambulatory Heath Care (AAAHC), and CMS as applicable. Delegation oversight assessments are conducted at least annually, and delegates are required to develop and implement performance improvement and corrective action plans for deficiencies discovered during the assessments. Assessments include a review of compliance to contractual terms, performance guarantees, policies and procedures, with reports and file audits as applicable. All oversight assessment results, and follow-up activities are reviewed by the UM Committee.

SATISFACTION WITH THE UM PROCESS

CHP will conduct an annual member and provider satisfaction survey. The Medical Management Department evaluates member and provider satisfaction with the UM process. A variety of resources are used to assess member and provider satisfaction. Resources include the CAHPS survey, an internal provider specific survey, as well as information gleaned from member/provider complaints, grievances and appeals. Results are analyzed and sent to the UM Committee for review. The UM Committee determines whether any changes need to be made in the administration of the UM program that would not jeopardize cost, quality or efficiency, but would enhance satisfaction on the part of members and/or providers.

INTER-RATER RELIABILITY (IRR)

The Medical Department Manager or a designee and the Commercial Medical Director perform IRR for nurse and physician reviews at least annually. A behavioral health practitioner also performs IRR for behavioral health reviews at least annually. The purpose of the IRR is to ensure the consistent, appropriate use of criteria, and a high quality of review is being met. Results are reviewed and steps are

taken to improve if needed. The analysis is sent to the UM Committee for review and action, if necessary. If corrective actions need to be made, the manager assures that these are implemented.

CONFIDENTIALITY

As required by state/federal laws and regulations, Health Insurance Portability and Accountability Act of 1996 (HIPAA), utilization management activities are conducted in a manner to ensure the confidentiality of the member and the practitioner when applicable. Medical Management staff is required to have passwords to access the computer system with confidential information. Confidential documents are destroyed using the shredder. Staff is required to keep conversations regarding confidential information confidential. Information is only shared with those with a "need to know" basis of the information to perform a necessary activity. Documents including minutes of all committee proceedings that are developed, created, delivered, or reviewed as part of the utilization management process, are confidential and are maintained in accordance with federal and state laws which protect the integrity and confidentiality of the professional review function and exempt those records from public disclosure or subpoena or both. The Privacy Officer is on-site to address compliance issues with annual training to the Nurse Reviewers.

Approved:

UMC: 4/11/2023
QIC: 4/11/2023
BOD: Delegated to QIC