Partnership HealthPlan of California

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

MPUD3001

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PROGRAM PURPOSE

Partnership HealthPlan of California is a County Organized Health System (COHS) contracted by the State of California to provide Medi-Cal Beneficiaries with a health care delivery system to meet their medical needs.

The mission of Partnership HealthPlan of California is "To help our Members, and the Communities we serve, be healthy." Our vision is to be "the most highly regarded health plan in California."

Partnership has program descriptions and policies to describe the structures needed to provide high quality health care while being stewards of taxpayer resources. In the Utilization Management Program Description, Partnership outlines the structure of our measurement and management of utilization of health care services within our system.

The Partnership Utilization Management (UM) program serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and to actively pursue identified opportunities for improvement.

The utilization program resides within the Health Services Department, which consists of seven (7) teams including:

- Utilization Management
- Behavioral Health
- Care Coordination
- Population Health
- Pharmacy
- Quality Improvement
- Health Equity

The Partnership UM program serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time
- Ensure that the setting in which the service is delivered is consistent with the medical care needs of the individual

The UM program provides a reliable mechanism to review, monitor, evaluate, recommend and implement actions on identification and correction of potential and actual utilization and resource allocation issues.

Partnership recognizes the potential for under-utilization and takes appropriate steps and actions to monitor for this. The processes for UM decision making are based solely on the appropriateness of care and services and existence of coverage. Partnership does not reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization and Partnership does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

PROGRAM OBJECTIVES

UM Program Objectives

The Partnership UM program serves to ensure that appropriate, high quality cost-effective utilization of health care resources is available to all members. This is accomplished through the systematic and consistent application of utilization management processes based on current, relevant medical review criteria and expert clinical opinion when needed. The utilization management process provides a system that ensures equitable access to high quality health care across the network of providers for all eligible members as follows:

- Ensures authorized medically necessary services are covered under contract with the State of California Department of Health Services (DHCS) California Code of Regulations (CCR) Title 22 - For Medi-Cal Members (Title 22)

- Coordinates thorough and timely investigations and responses to member and provider reconsideration and appeals associated with utilization issues
- Initiates needed operational revisions to prevent problematic issues from reoccurring
- Ensures that services which are delivered are medically necessary, which is defined as "reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury," and that those services are consistent with diagnosis and level of care required for each individual, taking into account any co-morbid condition that exists and the ability of the local delivery system to meet the need. Other examples of service-types requiring medical necessity review include (but are not limited to):
  - Services where continuing previously established care is necessary
  - Pharmaceuticals covered under Partnership's medical benefit
  - Out-of-network services that are only covered in clinically appropriate circumstances
- Educates members, practitioners, providers and internal staff about Partnership's goals for providing quality, cost-effective, managed health care
- Defines the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review
- Promotes and ensures the integration of utilization management with quality monitoring and improvement, risk management, and case management activities
- Ensures a process for critical review and assessment of the UM program and plan on, at minimum, an annual basis, with updates occurring more frequently if needed. The process incorporates provider, practitioner and member input along with any regulatory changes, changes to current standards of care, and technological advances
- Evaluates the ability of delegates to perform UM activities and to monitor performance

Program Structure

This section outlines the individual program staff and their assigned activities and responsibilities, including approval authority and the involvement of the designated physician.

Program Staff

Chief Medical Officer (CMO) – MD/DO

The Chief Medical Officer is responsible for the implementation, supervision, oversight and evaluation of the UM Program.

This position provides guidance and overall direction of UM activities and has the authority to make decisions based on medical necessity
which result in the approval or denial of coverage. The assigned activities for this position include but are not limited to:

- Assuring that the UM program fulfills its purpose, works towards measurable goals, and remains in regulatory compliance
- In collaboration with the Chief Health Services Officer, the Senior Director of Care Management, and the Director(s) and Associate Directors of Utilization Management; oversees UM program operations and assists in the development and coordination of UM policies and procedures.

- Reviews for the consistent application of UM decision criteria at least annually and implements corrective actions when needed
- In collaboration with the Health Equity Officer (HEO), oversees Quality Improvement and Health Equity Transformation Program (QIHETP) operations and serves as Co-Chair of the Quality Improvement and Health Equity Committee (QIHEC)
- Serves as the Committee Chair for the Quality/Utilization Advisory Committee (Q/UAC) and regularly attends the Physician Advisory Committee (PAC). CMO (or designee) also serves as the Pharmacy and Therapeutics (P&T) Committee Chair.
- Ensures timely medical necessity review and decisions are made by daily staffing physicians for medical review consultation
- Guides and assists in the development and revision of Partnership medical policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for Q/UAC review, adaptation and PAC approval
- As the chairman of the Q/UAC, presents UM activities on a regular basis to the Q/UAC and provides periodic updates on utilization management activities to the PAC and the Board of Commissioners
- Evaluates the overall effectiveness of the UM program
- Evaluates and uses provider and member experience data when evaluating the UM program in collaboration with the Chief Health Services Officer and appropriate committees

Medical Director – MD/DO

The Medical Director is a physician who oversees the appropriateness and quality of care delivered through Partnership and the cost-effective utilization of services. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

- Coordinates with the Directors, Associate Directors, and Managers of UM to provide daily support and appropriate direction to staff on issues pertaining to UM
- Serves on the Quality/Utilization Advisory Committee, Pharmacy & Therapeutics Committee, Credentials Committee and Internal Quality Improvement Committee as requested by the CMO/ may work with community provider committees and advisory boards on medical issues and policies
- Supervises and evaluates other Medical Directors as assigned (direct reports)

Medical Director for Quality - MD/DO

The Medical Director for Quality is a physician who provides clinical and operational guidance for Quality and Performance Improvement activities and is responsible for supervision and oversight of the Quality Assurance & Patient Safety, Clinical Quality & Patient Safety and Quality Measurement–HEDIS teams. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

The assigned activities for this position include but are not limited to:

- Serves as the Committee Vice Chair for the Quality/Utilization Advisory Committee (Q/UAC)
- Serves as the Chair for the Peer Review Committee
- Regularly attends the Credentials Committee
- Regularly attends the Physician Advisory Committee (PAC)
- Regularly attends the Internal Quality Improvement (IQI) Committee
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC)
- Evaluates the appropriateness and quality of medical care delivered through Partnership in all regions
- Participates in enterprise-wide projects that require physician involvement, especially as related to Quality and Performance Improvement activities
- Assists with coverage in the UM Department for medical necessity reviews, applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for Partnership members
- Other duties as assigned by the Senior Director of Quality or by the Chief Medical Officer

Medical Director of Medicare Services – MD/DO

The Medical Director of Medicare Services is a physician that oversees the appropriateness and quality of care delivered through Partnership and the cost-effective utilization of services. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

- Participates in Medicare Dual Special Needs Plan (D-SNP) policy, strategy and tactical activities, with the Medicare leads in other departments
- Providing medical leadership for Partnership's Medicare activities, including utilization management, quality, care coordination, pharmacy grievances, and compliance activities
- Assists with coverage in the UM Department for medical necessity reviews, applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for Partnership members
- Other duties, as assigned

Regional Medical Director - MD/DO

The Regional Medical Director is a physician with the authority to make decisions based on medical necessity which result in the approval or denial of coverage.

The assigned activities for this position include but are not limited to:

- Evaluates the appropriateness and quality of medical care delivered through Partnership in the designated regional area
- Participates in enterprise-wide projects that require Physician involvement
- Other duties as assigned by the Chief Medical Officer.

Associate Medical Director - MD/DO

This Physician has the authority to make decisions based on medical necessity that result in the approval or denial of coverage. The assigned activities for this position include:

- Coverage in the UM Department for medical necessity reviews applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for Partnership members
- Provides review of quality of care issues and serves on Q/UAC
- Other duties as assigned by the Chief Medical Officer

Behavioral Health Clinical Director - MD/DO/PhD/ PsyD

The Partnership Behavioral Health Clinical Director is an MD, DO, clinical PhD, or PsyD who is actively involved in the behavioral health aspects of the UM program. This Director provides clinical oversight of Partnership's behavioral health activities including substance use services and the activities of Partnership's delegated managed behavioral health organization(s). The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for behavioral health or substance use services. The assigned activities for this position include:

- Establishes UM policies and procedures in collaboration with Partnership's delegated managed behavioral health organization(s)
- Oversees and monitors quality improvement activities
- Facilitates network adequacy
- Participates in the peer review process
- Evaluates behavioral health care and substance use disorder (SUD) treatment services requests in collaboration with Partnership's delegated managed behavioral health organization(s)
- Oversees and monitors functions of Partnership's delegated managed behavioral health organization(s)
- Serves on Quality/Utilization Advisory Committee; Quality Improvement and Health Equity Committee (QIHEC); Pharmacy and Therapeutics Committee; Credentials Committee and Internal Quality Improvement Committee including the Substance Use Internal Quality Improvement Subcommittee.

Senior Director of Behavioral Health - MHA

This position is responsible for oversight and management of Partnership activities involving behavioral health (mental health and substance use) services and community projects which support access to and improvement of behavioral health.

- Responsible for the oversight activities involving the coordination of care for children and youth receiving child welfare services.
- Manages relationships with delegated entities and community stakeholders.
- Works with Partnership leadership, member counties, providers and the community to develop the Plan's approach to behavioral health services to the Medi-Cal population and the related projects focused on the range of social and community factors that affect Members' behavioral health.
- Participates in network development, contracting and outreach efforts within the Partnership network.

Pharmacy Services Director – Pharm.D.

This position is responsible for overseeing all HealthPlan activities related to medication benefit and pharmacy services and supervising the Partnership Pharmacy management team, Partnership Clinical Pharmacists, and support staff. The assigned activities for this position include but are not limited to:

- Medication coverage management
- Development of applicable policies and guidelines
- Serves on the Pharmacy and Therapeutics (P&T) Committee (serving as Chair when designated by the CMO), the Global Medi-Cal Drug Utilization Review (DUR) Board and the Pediatric Quality Committee (PQC)
- Drug utilization review
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC)
- Drug prior authorization for medications covered under the medical benefit
- Implementation of cost effective utilization management measures for medications covered under the medical benefit
- Participation in provider education initiatives such as academic detailing with plan physicians
- Medical education meetings
- Assisting with development of Clinical Practice Guidelines
- Other duties as assigned by the Chief Medical Officer

Chief Health Services Officer - RN

Provides executive leadership on current and new Health Services programs, operations, projects, policies and procedures to ensure high quality results across the continuum. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Provides oversight and guidance for the UM program across all regions including daily support and appropriate direction to staff on issues pertaining to UM.
- Provides after-hours clinical coverage for providers requesting authorization for services pursuant to health plan policies and procedures.
- Reports to the Q/UAC on Health Services activities
- Coordinates departmental UM and Quality Improvement efforts
- Oversees the design and implementation of Quality Improvement and UM programs in order to meet Medicare Model of Care standards as well as National Commission on Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) accreditation for both Medi-Cal and future Medicare lines of business (D-SNP).
- Has a lead role in regulatory audits (DHCS, DMHC, CMS, NCQA)
- Collaborates with providers and facilities
- Monitors and analyzes UM data to inform decision making
- Develops recommendations based on data analysis and strategic planning
- Collaborates with the Chief Medical Officer and the Q/UAC on UM activities
- Evaluates and uses provider and member experience data when evaluating the UM program in collaboration with the Chief Medical Officer
- Serves as Chairperson of the Benefit Review Evaluation Workgroup (BREW)

Director of Health Equity – MD/DO/PharmD/RN

The Director of Health Equity serves as the Health Equity Officer (HEO) and is responsible for the co-implementation, co-supervision, co-oversight and evaluation of the Quality Improvement and Health Equity Transformation Program (QIHETP). This position provides guidance and overall direction of QIHETP activities and has the authority to make decisions based on the health equity annual plan. The assigned activities for this position include but are not limited to:

- Assuring that the QIHETP program fulfills its purpose, works towards measurable goals, and remains in compliance with regulatory requirements.
- In collaboration with the Chief Medical Officer (CMO); oversees QIHETP program operations and assists in the development and coordination of QIHETP policies and procedures.
- Serves as a Co-Chair for the Quality Improvement, Health Equity Committee (QIHEC) and the Population Needs Assessment (PNA) committee and regularly attends the Quality/Utilization Advisory Committee (Q/UAC) as a standing member
- Guides and assists in the development and revision of QIHETP medical policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for QIHEC review
- Other duties as assigned the Chief Executive Officer (CEO)
- Provides guidance to in staff trainings and on-site continuing education regarding diversity, equity, and inclusion and health equity
- Provides support for obtaining recommended accreditations that support diversity, equity, inclusion, and health equity (e.g. NCQA Health Equity Accreditation)

Senior Director of Care Management- RN

Under the direction of the Chief Health Services Officer, this position is responsible for setting and carrying out the overarching strategic direction and goals of the Utilization Management and Care Coordination Departments. This position maintains and oversees proper delivery, coordination and execution of all related services and activities to improve the health outcomes of members and has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Oversees and manages a large team of clinical and non-clinical staff while working in cross collaboration with both Medical Directors and other senior departmental leaders
- Responsible for overseeing the operations, programming and alignment of Utilization Management and Care Coordination department programs and activities
- Proactively works with key internal and external stakeholders to implement policies, procedures and/or initiatives that fulfill the organization's goals, strategic priorities and mission
- Provides clinical leadership in the design and implementation of programs and procedures for all lines of business; demonstrates decisiveness and communicates decisions and rationale clearly
- Stays abreast of health care policies, regulations and changes as they relate to those issued by CMS, DHCS, NCQA and/or other associated agencies
- Utilizes data to analyze and support quality patient outcomes and ongoing evaluation of the organization's Care Coordination and Utilization Management programs; ensuring effective and efficient health and quality outcomes, improving care coordination and meeting requirements of contracts

Director of Utilization Management - RN

Under the direction of the Senior Director of Care Management, this position is responsible for the day-to-day implementation of Partnership's UM Program and ensuring consistent development, implementation, and maintenance of health services programs. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Implements the UM program
- Provides day to day direction to UM Associate Directors, Managers and Supervisors to meet department goals and objectives and is available to staff on-site or by telephone
- Conducts annual performance evaluations for assigned UM staff

- Conducts monitoring activities
- Participates in staff trainings and on-site continuing education
- Participates in clinical audits of health services programs and services; oversees the nursing component of the audits and assists with development of corrective action plans when necessary
- Reports to the Q/UAC on UM activity
- Collaborates with providers and facilities
- Develops recommendations for program improvements
- Coordinates activities with Quality Improvement, Care Coordination, Population Health, Health Equity, Enhanced Health Services, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care outcomes and trends
- Participates in establishing and maintaining reports which relay the efficacy of UM activities and summarizes, at least annually, the UM activity, quality improvement activities and utilization outcomes, with supporting statistical data at IQI and Q/UAC

Director of Enhanced Health Services

Under the direction of the Chief Health Services Officer, plans, monitors and evaluates utilization management activities to identify strategic initiatives to enhance the efficacy of the UM program, while improving health outcomes, in a cost effective manner. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Serves as Director of CalAIM program
- Responsible for oversight of housing and incentive payment programs
- Responsible for connecting with Street Medicine programs
- Collaborates with the provider relations contracting team to identify strategic opportunities and develops recommendations
- Participates in contract review and negotiations
- In collaboration with the Chief Health Services Officer and Senior Director of Provider Relations, reviews and processes provider grievances in accordance with appropriate regulatory requirements and participates in provider grievance meetings
- Works with county agencies and community-based organizations to facilitate the DHCS CalAIM initiative related to Enhanced Care Management (ECM) and Community Support (CS) Services with focus on improving medical health outcomes and healthcare costs
- Works collaboratively with claims and configuration department leaders and team members to identify systematic issues or opportunities for staff and/or provider education
- Attends claims configuration meetings and Benefit Review Evaluation Workgroup (BREW) as well as IQI, Q/UAC and PAC
- Works with providers and/or vendors to facilitate issue resolution and ensure a consistent UM process
- Develops, reviews, and/or revises Partnership UM policies and procedures in collaboration with the Chief Health Services Officer as appropriate.
- Develops expertise in housing services funded through the Medi-Cal program including 1915(c) Home and Community Based Services Waivers and other Medicaid housing related opportunities such as Assisted Living Waivers.
- Leads Partnership discussions regarding state and federal housing/homeless policy, legislative, and regulatory strategy and implementation, and oversee and support regional and local policy initiatives, with a strong economic equity lens.
- Works with local agencies, state networks, and community organizations to identify issues and develop consensus positions on policy issues.
- Carries out research and policy analyses on issues and opportunities related to state housing policy and low-income housing programs, gathers member input, and establishes policy priorities and a legislative and regulatory agenda on an annual and ongoing basis.
- Interacts with housing advocacy groups and other organizations to identify emerging issues and opportunities.

Associate Director of Utilization Management - RN

Under the direction of the Director of Utilization Management, manages and provides direction to the Utilization Management department Managers, Supervisors and staff for all product lines ensuring consistent development, implementation, and maintenance of health services programs. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Implements the UM program
- Provides day to day direction to UM Managers and Supervisors to meet department goals and objectives and is available to staff on-site or by telephone
- Conducts annual performance evaluations for assigned UM staff
- Conducts monitoring activities
- Participates in staff trainings and on-site continuing education
- Audits medical records as appropriate and monitors for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Collaborates with providers and facilities
- Develops recommendations for program improvements
- Coordinates activities with Care Coordination, Population Health, Quality Improvement, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care outcomes and trends
- Participates in establishing and maintaining reports which relay the efficacy of UM.

Associate Director of Enhanced Health Services

Under the direction of the Director of Enhanced Health Services, is responsible for managing the CalAIM program. Provides strategic support and management/supervisory support for the CS and ECM staff, including but not limited to, strategic goal setting, program planning, budget/account management, and supervision of team members.

- Participates in internal and external meetings, providing input and guidance to community stakeholders and partners regarding the CalAIM program
- Fosters cross-departmental collaboration in shared operational activities related to the ECM benefit and CS services (ex: Provider Relations, Care Coordination, Claims, etc.)
- In collaboration with Provider Relations, prepares and reviews provider and member education materials related to CalAIM
- Ensures timely monitoring and oversight of Partnership-contracted ECM and CS providers, pursuant to DHCS regulations and Partnership policies and procedures
- Identifies trends, patterns and/or opportunities for enhancements to workflows, tools and/or systems to promote efficiency, cost, and quality of ECM and CS services
- As directed, prepares or provides updates on DHCS deliverables and reports associated with CalAIM, including but not limited to the DHCS Model of Care template, DHCS ECM Exception Request(s), and/or DHCS ECM and CS reporting guidelines
- Maintains knowledge of CalAIM requirements and shares updates with appropriate internal/external stakeholders, as necessary

Associate Director of Utilization Management Regulations

Under the direction of the Director of Utilization Management, provides oversight of the UM Program to ensure compliance with regulatory requirements including, but not limited to, requirements of DHCS, CMS, and the National Committee for Quality Assurance (NCQA) . Assigned activities include:

- Coordinates activities with External and Regulatory Affairs Compliance, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care issues and trends related to UM Department processes
- Prepares reports on departmental activities according to established schedules and format. Identifies patterns and trends, conducts retrospective review as needed and works with UM Leadership to develop corrective action plans.
- Prepares and presents the annual evaluation, program description to IQI and Q/UAC
- Participates in the grievance process
- Acts as primary contact and support to each UM Delegate, providing training and support as necessary

- Conducts delegation oversight through regular auditing of each UM Delegate, prepares audit reports for review by the Director of Utilization Management, and prepares information for the Delegation Oversight Review Sub-Committee (DORS) and NCQA Steering Committee.
- Collaborates with Department leaders to ensure that all policies and procedures related to regulatory requirements are updated at least annually, or as needed, and presented to appropriate committees for review. Assists Partnership staff and providers with the interpretation of Partnership policies, procedures, and regulatory requirements.
- Works with UM Leadership and UM Trainer to develop standardized training content and materials for new staff and ongoing education for existing staff
- Participates in the planning and development of new/ enhanced Health Services plan benefits or product lines as needed. Attends Benefits Review and Evaluation Workgroup meetings
- Participates in audits by various regulatory agencies as necessary

Senior Manager of Justice Involved Programs – RN

Under the direction of the Director of Enhanced Health Services, is responsible for working directly with justice-involved agencies and providers who serve justice-involved members in Partnership HealthPlan of California's county network. The assigned activities include:

- Serves as the Justice Liaison for the HealthPlan
- Facilitates communication with external stakeholders including: network providers, county staff, state prison system, probation offices, police/sheriff departments and other stakeholders as appropriate
- Oversees and develops a system for care coordination for this designated population on behalf of the HealthPlan, ensuring providers and staff are capable of serving this member population.
- Serves as the HealthPlan lead for oversight of any applicable MOUs between the HealthPlan and other entities as directed by DHCS and supports MOU activities and requirements to ensure HealthPlan compliance.
- Establishes systems to ensure connections with county behavioral health plans for the delivery of specialty mental health services on behalf of this specific population.
- Serves as a point of escalation for care managers if they face operational obstacles when working with County and/or community partners.

Manager of Utilization Management - RN

Responsible for the implementation, management and evaluation of an effective and systematic UM Program. Provides day-to-day guidance to UM staff and manages all aspects of utilization review activities and is available to staff on-site or by telephone. Working with the Chief Medical Officer, Chief Health Services Officer, Directors of UM, Associate Directors of UM, utilization committees, and Health Plan Directors, promotes efficient resource utilization throughout the organization, providing leadership, teambuilding and direction needed to ensure attainment of UM goals. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Coordinates completion of activities
- Monitors for consistent application of UM criteria by UM staff for each level and type of UM decision
- Participates in staff trainings and on-site continuing education
- Provides recommendations for interventions designed to improve utilization management issues
- Coordinates implementation of interventions
- Develops UM policy and procedures for Q/UAC approval
- Develops, or coordinates development of, documentation of UM activities
- Conducts annual performance evaluations for assigned UM staff

Manager of Long Term Support Services (LTSS) – RN

Provides leadership and clinical oversight for operational aspects of Utilization Management for Long Term Support Services (LTSS); including the responsibility for providing daily oversight, leadership, support and management of assigned staff. Collaborates with departmental and Health Services leadership to oversee and monitor the provision of LTSS benefits and services; coordinating with Partnership providers and/or

community stakeholders as necessary. This position has the authority to make decisions on coverage not relating to medical necessity.

- Provides day-to day direction to licensed clinical staff regarding utilization review, care coordination, discharge planning, and other services across the continuum of care for members in need of LTSS
- Ensures compliance with regulatory/accreditation requirements related to UM by collaborating with other departments and maintaining survey and audit readiness
- Leads, develops and operationalizes evidence-based best practices and activities to address LTSS benefits and/or services (ex: Transitional Care Services, facility placements, care coordination, etc.)
- Identifies and incorporates quality-monitoring activities to improve the quality of care, outcomes, and/or costs for members receiving one or more LTSS (ex: Skilled Nursing, Community Based Adult Services, In-Home Support Services, etc.)

Clinical Manager, Enhanced Health Services - RN

Assists the Director and Associate Director of Enhanced Health Services (EHS) in the development, implementation, management and evaluation of an effective and systematic CalAIM Program. Provides day-to-day guidance to nursing staff and manages all aspects of utilization review activities and is available to staff on-site or by telephone. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Monitors for consistent application of UM criteria by EHS staff for each level and type of EHS decision
- Participates in staff trainings and on-site continuing education
- Provides recommendations for interventions designed to improve utilization management issues
- Coordinates implementation of interventions
- Oversees auditing and oversight of CalAIM providers
- Collaborates with departmental leadership to oversee and maintain a cohesive team with a high level of productivity, accuracy and quality to achieve goals and objective
- Maintains updated policies and procedures, workflows, documentation, desktops, reports, etc.
- Fosters cross-departmental leadership in shared operational activities related to the CalAIM initiatives. (ex: Provider Relations, Utilization Management, Claims, etc.)
- Maintains knowledge of the CalAIM initiatives and shares updates with appropriate internal /external stakeholders when necessary

Manager of Utilization Management Operations

Responsible for the operational aspects of Utilization Management, including responsibility for providing daily oversight, leadership, support, and management of assigned staff. Ensures compliance with established criteria, regulations, standards, best practices and Health Plan benefits. The assigned activities include:

- Provides daily operations oversight and direction to the team Supervisor(s) and Data Coordinators
- Manages day to day functions including coordination of assignments, monitoring of call volume and adherence to Partnership workplace policy and is available to staff on-site or by telephone
- Assists in the refinement/improvement of the HS programs
- Provides performance feedback to the Data Coordinator staff and conducts staff trainings as needed.
- Monitors UM Data Coordinator activity for consistent application of desktop processes and procedures by UM Data Coordinator staff
- Provides leadership, direction, training, and support to the assigned staff
- Participates in staff trainings and on-site continuing education
- Conducts annual performance evaluations for assigned UM staff

Senior Programmer Analyst

This position supports the design, development, and documentation of Partnership's core claims processing, TAR processing, and claims processing platforms. Provides technical support and problem resolution to UM Department end users.

- Maintains in-depth knowledge of various Partnership systems
- Tests, schedules, and implements new releases and upgrades of software

- Tests, schedules, and implements interface changes to systems, when needed
- Supports development of business requirements for various system implementations
- Uses sound technical judgment and makes appropriate systems decisions
- Assists in development and maintenance of policies and procedures to document new and changed elements of UM Operations

Inpatient/Outpatient/LTSS Nurse Supervisor UM - RN

This position is responsible for the daily mentorship and oversight of the staff assigned to inpatient, outpatient or LTSS services. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Works collaboratively with all levels of leadership within the department to efficiently coordinate workflow and individual staff assignments
- Provides day to day supervision to the assigned team, overseeing daily operations of the inpatient, outpatient or LTSS review process
- Participates in staff trainings and on-site continuing education. With UM Leadership, conducts annual performance evaluations for assigned UM staff
- Audits medical records as appropriate and monitors for consistent application of UM Criteria by UM staff, for each level and type of UM decision.
- This position, in addition to his/her own case load, may be assigned cases in the area of oversight as deemed necessary to provide coverage

Clinical Supervisor of Enhanced Health Services - RN

Provides daily supervision and program support to designated staff. Assists departmental leadership in developing and maintaining a cohesive team with a high level of productivity, accuracy and quality to achieve goals and objectives

- Provides daily leadership, direction, resources, training, evaluation, coverage, and program support to assigned staff
- Performs supervisory functions such as timecard management, directing work activities, conducting annual reviews and training to staff
- Maintains active participation with inbound and outbound provider reporting and other related duties, adjusting assignments as necessary to meet business needs and/or regulations
- Facilitates meetings with Partnership providers and/or external community partners as necessary
- Supports organizational collaboration and communication regarding CalAIM initiatives through active collaboration

Inpatient/Outpatient Nurse Lead UM - RN/ LVN

This position is responsible for assisting with oversight of daily operations of the inpatient or outpatient review process (as assigned). This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Provides direction and support, to staff concerning daily assignments.
- Participates in interview process and provides training in inpatient or outpatient review for new hires.
- Evaluates appropriateness of care through interpretation of benefits as outlined in Title 22, Medi-Cal Provider Manual using Partnership policies and procedures, and InterQual criteria.
- Documents and maintains patient-specific records in the data collection software system.
- Assists in the refinement/improvement of the Health Services programs. Participates in continuous process improvement endeavors.
- Works with other Partnership departments to resolve issues relating to authorization of medical services.
- Participates in Inter-rater Reliability studies, reviewing medical records as assigned.
- Communicates regularly with the UM Team Manager and works collaboratively to resolve issues.

Nurse Auditor - RN

Under the direction of the UM Manager of Training & Education, this position conducts audits of assigned areas, assists in department audit initiatives and performs audits in accordance with the department audit plan. As an integral member of the Training and Education Team, this position helps the audit function keep pace with the audit needs of the UM Department.

Nurse Coordinator/ UM II - RN/ LVN

Work collaboratively with all levels of UM leadership and other Partnership staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Assist in training and orientation of new staff to the department upon request
- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines
- Review and authorization of Long Term Care TARs based on established guidelines
- Review and authorization of inpatient Hospital TARs based on established guidelines
- Review and authorization of Enhanced Care Management (ECM) and Community Supports TARs based on established guidelines
- Reviews residential placement authorization requests for substance use disorder (SUD) treatment services according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements for Medi-Cal eligible beneficiaries. Licensed staff who operate in the capacity of behavioral health authorizations are required to complete specialized ASAM[1] training annually.
- Retrospective review of services to determine medical necessity
- Refer cases to the Chief Medical Officer for requests that may not appear to meet evidence- based medical necessity criteria
- Determines if requested services are part of the member's benefit package
- Work collaboratively with the Care Coordination, Population Health, Pharmacy and Quality Improvement staff on UM issues

Nurse Coordinator/ UM I - RN/ LVN

Work collaboratively with all levels of UM leadership and other Partnership staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care. This position has the authority to make decisions on coverage not relating to medical necessity. Activities assigned include:

- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines.
- Review and authorization of Long Term Care TARs based on established guidelines.
- Review and authorization of inpatient Hospital TARs based on established guidelines.
- Review and authorization of Enhanced Care Management (ECM) and Community Supports TARs based on established guidelines
- Reviews residential placement authorization requests for SUD treatment services according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements for Medi-Cal eligible beneficiaries. Licensed staff who operate in the capacity of behavioral health authorizations are required to complete specialized ASAM[1] training annually.
- Retrospective review of services to determine medical necessity
- Refer cases to the Chief Medical Officer for requests that may not meet medical necessity criteria
- Determine if requested services are part of the member's benefit plan
- Work collaboratively with the Care Coordination, Population Health, Pharmacy, and Quality Improvement staff on UM issues

[1] American Society of Addiction Medicine (ASAM) Criteria - As defined in the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Intergovernmental Agreement, pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient.

Clinical Pharmacist – Pharm.D., RPh

Work collaboratively with all levels of Pharmacy leadership to review medication Treatment Authorization Requests (TARs) to promote safe, appropriate, and cost-effective drug therapy. Pharmacists have the authority to make decisions based on medical necessity that result in the approval or denial of coverage of medications.

- Communicates and educates prescribers on TAR processes, TAR determination, and Partnership medication coverage policies
- Provides oversight to the pharmacy technician staff in the daily TAR review process
- Participates in P&T meetings and conduct drug utilization reviews to identify treatment gaps and optimize medication therapy outcomes based on national treatment guidelines and evidence-based medicine
- Participates in the development of technician drug review guidelines and creation of authorization criteria for medical benefit medications
- Participates and works with other departments on cross-departmental initiatives that require Clinical Pharmacy input/participation
- Support HEDIS and other clinical quality improvement work through provider academic detailing and member engagement activities
- Ensures compliance with regulatory and quality standards/requirements including, but not limited to, the standards of the National Committee for Quality Assurance (NCQA) and the requirements for the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS)
- Other duties as assigned by the Pharmacy Services Director

Pharmacy Technician – CPhT, RPhT

Work collaboratively with all levels of Pharmacy leadership to review medication Treatment Authorization Requests to promote safe, appropriate, and cost effective drug therapy.

- Reviews and approves TARs based on established internal pharmacy technician review guidelines &/or Partnership drug TAR requirements (prior authorization criteria for use). If a TAR cannot be approved based on guidelines/criteria, the pharmacy technician will refer the TAR to the Clinical Pharmacist for an escalated review.
- Educates prescribers on TAR processes, TAR determination, and Partnership medication coverage policies.
- Supports HEDIS and other clinical quality improvement work through provider academic detailing and member engagement activities.

Data Coordinator/ Supervisor UM – Administrative

Works closely with UM Leadership to establish consistent evaluation of Data Coordinators' work performance. Responsible for oversight of Data Coordinators.

- Monitors day to day functions including coordination of assignments, monitoring of call volume and adherence to Partnership workplace policy and is available to staff on-site or by telephone
- Assists in the refinement/improvement of the HS programs
- Provides performance feedback to the Data Coordinator staff and conducts staff trainings as needed.
- Monitors UM Data Coordinator activity for consistent application of desktop processes and procedures by UM Data Coordinator staff
- Provides leadership, direction, training, and support to the assigned staff
- Participates in staff trainings and on-site continuing education
- Conducts annual performance evaluations for assigned UM staff

Policy Analyst

This position is responsible for drafting, editing, reviewing, auditing, tracking, monitoring and maintaining utilization management policies and procedures for Partnership. Under the supervision of the Associate Director of Utilization Management Regulations, ensures compliance with governing rules, regulations, and/or accreditation standards.

- Prepares UM policies and/or related materials for appropriate committees' review and attends meetings of the Internal Quality Improvement Committee and Quality/Utilization Advisory Committee.
- Performs policy research to analyze current and/or new regulations by applicable Partnership regulators and/or accrediting agencies (ex: DHCS, DMHC, CMS, NCQA, etc.)
- Reviews both draft and final All Plan Letters (APLs) and/or regulatory changes and supports leaders with the research, planning, implementation and/or operational readiness submissions across the organization.
- Participates in audits with Partnership's regulatory and/or accreditation bodies by preparing policies, documents and/or reports as needed.
- Conducts analysis, collects information, and evaluates impact of regulatory and compliance issues to inform auditing and monitoring activities.
- Analyzes the impact of new programs/benefits and efficacy of existing processes, policies, procedures and trainings.

Program Manager I – (Regulatory/Delegation)

Under the direction of the Associate Director of UM Regulations, assigned activities include:

- Responsible for day to day duties associated with oversight of UM delegated entities
- Responsible for successful implementation of new activities and processes with delegated entities
- Identifies and resolves issues and concerns with UM delegation to ensure risk is mitigated in a timely manner and recommends solutions to Leadership for final decision, as necessary
- Responsible for collecting and tracking required document submissions from delegated entities
- Coordinates and participates in both desktop and onsite audits of delegated entities
- Ensures efficient and appropriate collaboration between the Utilization Management staff and UM delegated entities

Program Manager I – (EHS)

Under the direction of an Associate Director of Enhanced Health Services, develops, implements, improves, and manages assigned programs related to CalAIM. Participates in the design, implementation, and/or expansion of strategic programs and departmental initiatives. Supports the development and execution of program goals, outcome measures, and program reporting.

- Creates and delivers CalAIM program information and reports to both internal and external stakeholders
- Supports the development and execution of strategies to engage stakeholders.
- Responsible for program evaluation and continuous improvement activities
- Responsible for successful implementation of CalAIM activities.
- Reviews program data accuracy, completeness, and required submissions.

Program Manager I – (LTSS)

Under the direction of the Manager of Long Term Support Services (LTSS), supports operational aspects of Utilization Management related to LTSS including monitoring and reporting of the provision of LTSS benefits and services. Assigned activities include:

- Serves as the In-Home Supportive Services (IHSS) Specialist
- Serves as the Community Provider Advisory Council (CPAC) Coordinator
- Facilitates Point Click Care discharge reporting
- Monitors and tracks Letters of Agreement (LOAs)
- Coordinates with Health Analytics for Dashboard reporting
- Coordinates Critical Incident Review
- Creates specialized documents (Desktops, Info sharing with facilities and other departments, etc)
- Acts as a point of contact for the team for additional reporting needs

Project Coordinator II - (EHS)
Under the direction of an Associate Director of Enhance Health Services, provides coordination and implementation support of defined tasks for CalAIM programs. Conducts business analysis to evaluate programs, exercises independent judgement in leading assigned projects, tracks and reports data to a higher complexity level, coordinates daily activities, communicates program status to stakeholders.

- Coordinates, facilitates, and leads both internal and external meetings for CalAIM Providers.
- Supports the successful implementation of CalAIM projects.
- Customarily and regularly compiles, reviews and analyzes project data and results.
- Develops expertise in program focus areas and stays informed of key developments and training/development opportunities within our network and across the healthcare industry, maintains accurate provider listing for CalAIM Providers.

Project Coordinator I - (EHS)
Under the direction of an Associate Director of Enhanced Health Services, provide coordination and implementation support of defined tasks for CalAIM program.

- Coordinates and facilitates both internal and external meetings for CalAIM Providers.
- Develops and publishes agendas, meeting minutes, and necessary documentation
- Attends project meetings, follows up on assigned tasks, and communicates the status of projects to the supervisor
- Manages, tracks, and processes CS or ECM referrals

Health Services Analyst I
Performs routine and ad-hoc reporting and data management for internal and external users; assists in maintaining reporting systems within the department. Prepares, analyzes, reports, and manages data used for both plan-wide and regional decision making for evaluating performance in key quality measures and the effective use of health plan resources on a routine and ad hoc basis. Works collaboratively with departments company-wide to identify data needs, develop and maintain data queries and tools, and complete accurate reporting to support performance and process improvements.

Continuing Education Program Coordinator - Administrative
Provides administrative support to the Chief Medical Officer. Responsible for coordinating the Continuing Education program, including planning meetings and trainings. Audits each CME/CE activity to ensure all elements required by organizations overseeing Partnership's educational programs are documented. Maintains organized electronic versions of all continuing education records.

Executive Assistant to CMO - Administrative
Provides administrative support to the Chief Medical Officer. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

Executive Assistant to the Chief Health Services Officer - Administrative
Provides administrative support to the Chief Health Services Officer. Manages appointment calendar, develops agendas, organizes meetings and executes minutes for designated meetings.

Health Services Administrative Assistant II – UM, EHS - Administrative
Provides administrative support to the Utilization Management Director and/or other UM Leadership. Manages appointment calendars, coordinates setup and executes minutes for designated meetings.

Health Services Administrative Assistant I – UM - Administrative
Provides administrative support to UM Leadership. Manages appointment calendars and works closely with the Information Technology Department to ensure appropriate electronic functioning for the Utilization Management Department.

Health Services Administrative Assistant I – CMO - Administrative

Responsible for administrative support to the Associate and Regional Medical Directors. Responsible for managing appointment calendars, scheduling daily UM and pharmacy workload coverage for the MDs, developing weekly and monthly schedules for distribution to other departments, and coordinating Peer-to-Peer requests from providers. Coordinates setup and executes minutes for designated meetings.

Authorization Specialist/ UM Trainer – Administrative

Responsible for providing training on all appropriate software platforms for new hires. Creates and maintains current training materials for the UM department. In conjunction with UM leadership team, prepares and delivers retraining of identified topics as deemed necessary.

- Facilitates independent DME consultant evaluation visits to members for specialty equipment needs as needed or directed by UM Leadership.
- Acts as a resource regarding UM department software programs and special projects upon request and is available to staff on-site or by telephone
- Coordinates with Member Services Call Center system to place members into appropriate Direct Member status related to their care.

Data Coordinator/ UM Lead - Administrative

Under the direction of the Data Coordinator Supervisor and UM Leadership:

- Monitors Data Coordinator documentation for accuracy
- Ensures Data Coordinator staff have the resources required for completing TAR entry and using good judgment and is available to staff on-site or by telephone
- Enters both manual and electronic submitted data into Partnership systems for RAF and TAR authorizations
- Monitors UM Data Coordinator staff for consistent application of desktop processes and procedures
- Responsible for assisting with ongoing staff education in proper use of systems and Partnership UM Departmental policies and procedures
- Participates in staff trainings and on-site continuing education

Coordinator II - Administrative

Under the direction of applicable UM/ EHS leadership:

- Serves as a resource to other departments who have inquiries into the UM/ CalAIM process
- Responsible for the input of data and information concerning UM/ CalAIM Referrals and Authorizations
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated
- Responsible for clerical processing of appeals (as applicable) in accordance with policy, procedures, timeframes and requirements of various regulatory bodies for all lines of business
- Acts as liaison to Claims Department in coordinating timely response to all claims inquiries
- Participates in special projects, tasks and assignments as directed

Coordinator I - Administrative

Under the direction of applicable UM/ EHS leadership - responsible for the input of data and information concerning UM/CalAIM Referrals and Authorizations.

- Maintains departmental documents
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated
- Responsible for clerical processing of appeals (as applicable) in accordance with policy, procedures, timeframes and requirements of various regulatory bodies for all lines of business
- Acts as liaison to Claims Department in coordinating timely response to all claims inquiries
- Participates in special projects, tasks and assignments as directed

Committees

Board of Commissioners

The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority and responsibility for a comprehensive and integrated UM program. The Commission is ultimately accountable for the efficient management of healthcare resources and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the UM program to the Q/UAC which reports to the PAC, the committee with overall responsibility for the program. Members of the Commission are appointed by the county Boards of Supervisors for each geographic service area and include representation from the community as follows: consumers, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health Departments. The Commission meets six times a year.

The purpose of the Commission is to negotiate exclusive contracts with DHCS and to arrange for the provision of health care services to qualifying individuals, as well as other purposes set forth in the enabling ordinances established by the respective counties.

Community Advisory Committee (CAC)

The CAC is composed of Partnership members, advocates and stakeholders who represent the diversity and geographic areas of Partnership's membership, including hard-to-reach populations. The CAC is a liaison group between our members and Partnership, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. Additionally, the CAC provides Partnership members with a forum to discuss common issues of interest and importance, while creating a supportive and informative environment. The CAC meets quarterly, reviews and makes recommendations regarding Member Services' quality improvement activities, provides feedback on quality and health equity initiatives and serves in the capacity of a focus group. Three CAC members are selected to serve on the Board of Commissioners to provide member input and report back to the CAC.

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee is chaired by Partnership's Chief Medical Officer (CMO), or designee such as the Director of Pharmacy, and is comprised of Partnership's Pharmacy Director, Associate and Regional Medical Directors, Partnership staff and network practitioners including pharmacists, primary care physicians, behavioral health and other specialists. P&T makes decisions and recommendations on development and review of the physician administered drugs (PADs) provided under the medical drug benefit, medication policy and procedures, and drug approval criteria. P&T Committee also serves as Partnership's Drug Utilization Review (DUR) Board to review Partnership's DUR program and activities and make recommendations where necessary to improve Partnership's drug utilization. The P&T meets quarterly, providing regular activity reports and recommendations to the PAC, the approval authority for P&T related activities.

Physician Advisory Committee (PAC)

The PAC monitors and evaluates all Health Services activities and is directly accountable to the Board of Commissioners for the oversight of the UM program. The PAC meets at least ten (10) times a year and may not convene in the months of July and December, with the option to add additional meetings if needed. Voting membership includes external Primary Care Providers (PCPs), board certified high-volume specialists, behavioral health practitioners and non-physician clinicians. A voting provider member of the committee chairs the PAC. The Partnership Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer, Medical Director for Quality, Regional Medical Director(s), Behavioral Health Clinical Director, Chief Health Services Officer and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, Pharmacy, and Network Services departments attend the PAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The PAC oversees the activities of the Q/UAC and other quality-related committees and reports activities to the Board of Commissioners.

Quality/Utilization Advisory Committee (Q/UAC)

The Q/UAC is responsible to assure that quality, comprehensive health care and services are provided to Partnership Members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external providers who are contracted primary care providers (PCPs) and board-certified specialists in the areas of internal medicine, family medicine, pediatrics, OB/GYN, neonatology, behavioral health, and representatives from other high volume specialties. These external providers represent hospitals, medical groups, and practice sites in geographic sections of Partnership's service area. The Partnership Chief Medical Officer (CMO) (chair of the committee), Behavioral Health Clinical Director, Director of Health Equity, Medical Director for Quality, Manager of Member Safety-Quality Investigations, Associate and Regional Medical Directors and leadership from the Health Services departments (*e.g. Quality and Performance Improvement, Utilization Management, Care Coordination, Pharmacy, Population Health, Health Equity, Enhanced Health Services*), Grievance and Appeals, and Provider Relations departments attend the Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The committee meets monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to the PAC and at least quarterly to the Commission. The Q/UAC provides guidance and direction to the UM program by coordinating activities and by functioning as the expert panel when needed. Coordination includes but is not limited to:

- Annual oversight of the UM Program
- Annual evaluation of the UM program structure, scope, processes, and information used to determine benefit coverage and medical necessity.
- Annual identification of actions needed (based on evaluation)
- Annual review of the UM rates (as prescribed in the NCQA standards) for each of the following:
  - Non-Behavioral Health UM rates
  - Behavioral Health UM rates
  - Pharmacy UM rates,
  - UM Appeals rates
- Assuring individual Member needs are taken into consideration when determinations for care are rendered and in the development of medical policy and procedures.
- Analyzing summary data and making recommendations for action
- Reviewing action plans for quality improvements of UM activities and providing ongoing monitoring and evaluation
- Reviewing medical policy, protocol, criteria and clinical practice guidelines
- Approving and ensuring implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives
- Providing oversight of delegated activities

Quality Improvement and Health Equity Committee (QIHEC)

The Quality Improvement and Health Equity Committee (QIHEC) meets bimonthly for analyzing and evaluating the results of Health Equity related Quality Improvement activities. This includes annual review of the results of performance measures, utilization data, grievance and appeal data, consumer satisfaction surveys, and findings and activities of other Partnership specific committees. (e.g. Community Advisory Committee, Population Needs Assessment (PNA) Committee, etc). This committee shall also be responsible for instituting actions to address health equity performance deficiencies, including policy recommendations, and ensuring appropriate follow-up of identified performance deficiencies.

The QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) Committee. The Q/UAC provides recommendations to the Physician Advisory Committee (PAC). PAC is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to Partnership Members and is comprised of the Chief Medical Officer (CMO) and participating clinician representatives from primary and specialty care disciplines.

Substance Use Services Internal Quality Improvement Subcommittee (SUIQI)

A committee comprised of appropriate Partnership and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the Partnership's Substance Use Services oversight. The SUIQI meets at least quarterly. Activities and progress are reported to the IQI. This also includes

- Review of Utilization Management retroactive and appeals review
- Review of inter-rater reliability for peer review and utilization management
- Review of quality of service, quality of facility, and access complaints and grievances
- Investigation of potential overuse, underuse, and misuse of services.
- Review of policies related to provision of SU services

Members of the committee include the Behavioral Health Clinical Director, the CMO, Senior Director of Behavioral Health, Senior Manager of Behavioral Health and representatives from the Provider Relations, Member Services, Claims, Compliance, Behavioral Health and Quality Improvement Departments.

UTILIZATION MANAGEMENT PROGRAM SCOPE

UM activities are developed, implemented and conducted by the Partnership Health Services Department under the direction of the Chief Medical Officer and the Chief Health Services Officer. The UM staff performs specific activities.

Specific functions include:

- Prospective, concurrent and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care and continued inpatient confinement on a frequency consistent with evidence-based criteria and Partnership guidelines, Partnership criteria/ medical policy and the Member's condition. This review is performed cooperatively with the facility care team which may consist of the attending physician(s) and any associated health care personnel who can provide information that will substantiate medical necessity and level of care.
- Discharge planning in collaboration with the facility care team
- Review inpatient and outpatient UM data to determine appropriateness of Member and provider utilization patterns
- Use of most current edition of InterQual® Criteria for medical authorization, and other Partnership UM guidelines and medical policy as developed and approved by the Quality / Utilization Advisory Committee (Q/UAC)
- Use of California Department of Health and Welfare Code of Regulations Title 22, Center for Medicare & Medicaid Services (CMS) Code of Federal Regulations (CFR) Title 42 and National and Local Coverage Determinations
- Review certification requests for skilled nursing care, home health care, durable medical equipment, ambulatory surgery, ambulatory diagnostic and treatment procedures such as physical, occupational and speech therapies.

The UM program incorporates the monitoring and evaluation for the subsequent services and reviews and updates policies and procedures as appropriate but at least annually.

- Acute hospital services
- Subacute care
- Ambulatory care
- Emergency and urgent care services
- Durable Medical Equipment and supplies
- Ancillary care services, including but not limited to home health care, skilled nursing care, subacute care, pharmacy, laboratory and radiology services
- Long-term care including Skilled Nursing Facility (SNF) Care and Rehabilitation Facility Care
- Residential Substance Use Disorder (SUD) treatment
- Behavioral Health Therapy (BHT)
- Community Supports
- Enhanced Care Management
- Physician administered drugs (medical drug benefit)

PHARMACY PROGRAM SCOPE

The Pharmacy Department within Health Services is responsible for the utilization management of the medical drug benefit – those medications administered to a Member directly during a medical stay/visit at a clinic, office, or hospital, and billed to Partnership as part of a medical service claim; this includes drugs administered at time of service by physicians, dentists, podiatrists, nurse practitioners and physician assistants. Drugs and other prescription services provided to a Member by a pharmacy are not within the scope of Partnership's Pharmacy Program because the pharmacy benefit is carved-out to State Medi-Cal through the Medi-Cal Rx Program.

Out of Scope for Partnership Pharmacy Program:

- Pharmacy benefits and services pursuant to Executive Order N-01-19 and the Medi-Cal Rx program. The Medi-Cal pharmacy benefits and services administered by DHCS in the FFS delivery system is identified collectively as Medi-Cal Rx. This includes:
  - Covered Outpatient Drugs, as defined by SSA 1927(k)(2): prescription drugs which are not provided as part of *medical* service and thus are under the scope of the Pharmacy Benefit.
  - Self-administered medications provided to a Member to take/inject/inhale/apply/insert (or otherwise administer) at home.
  - Medication and supply services provided to Members at long-term care and skilled nursing facilities.
  - Medications administered by an infusion pharmacy or home health agency in a pharmacy infusion suite or in the Member's home
- Medications and services statutorily defined as a non-Medi-Cal benefit
- Medications provided in a medical setting which are carved out of the Managed Care Plan (MCP) capitation agreement: antivirals for HIV/AIDs, drugs and blood factor products for Hemophilia, drug and alcohol substance use disorder treatment (prescribed outside a narcotic treatment program), antipsychotics, and certain antidepressants (MAOI).

In Scope for Partnership Pharmacy Program:

- Utilization management of drugs administered in a medical setting and billed by the medical provider under the medical benefit, which includes:
  - Drugs other than Covered Outpatient Drugs. The SSA 1927(k)(2) definition of a Covered Outpatient Drug does not include any drug, biological product, or insulin provided as part of, or as incident to, the provision of and billing for medical or institutional services [SSA 1927(k)(3)]
  - Development of coverage criteria for injectable drugs requiring prior authorization based on current nationally accepted treatment guidelines, current medical literature, and input from specialists. These criteria may be drug-specific or class-specific.
  - Application of billing limits, restrictions, or requirements based on FDA approved indications and dosing &/or State Medi-Cal billing requirements. Such utilization management examples include maximum daily dose, allowed dosing frequency, age limits, place of service (e.g. dialysis centers) and current ICD (diagnosis) requirements.
  - The medical provider submits prior authorization requests directly to the pharmacy department. See policy MCRP4068 *Medical Benefit Medication TAR Policy* for further details.
  - Pre-service, Concurrent, and Post-Service (Retrospective) pharmaceutical utilization reviews of medical necessity using established prior authorization criteria requirements set forth by Partnership Pharmacy & Therapeutics (P&T) Committee, or as required by State Policy (All Plan Letters), or in accordance with Partnership case-by-case review guideline (below) when Partnership criteria are not yet established. Timeliness standards mirror those for UM Program Timeliness (see page 26).
  - Case-by-case review shall consider:

- The Member's individual medical needs (allergies, disease history, treatment history, concurrent medications, concurrent disease states, contraindications) and assessment of access and local delivery system
- Prescriber's scope of practice/areas of specialization
- The FDA approved package labeling for indication(s), maximum safe & effective dosing, appropriate age group, recommended screenings and monitoring,
- Prescribed drug's recommended place in therapy according to indication &/or nationally recognized treatment guidelines
- Availability & effectiveness of preferred treatments for the same indication
- Industry-standard clinical resources including (but not limited to): Lexi-Drug, Elsevier/Gold Standard Clinical Pharmacology, National Comprehensive Cancer Network (NCCN), UpToDate, IPD Analytics, and Facts & Comparisons
- Trials of preferred alternatives: There is no set number of preferred medications that must be tried before a non-preferred medication can be approved. Trials of preferred alternatives is unique to each drug and may depend on factors including but not limited to available treatment alternatives, pharmacologic and therapeutic similarities between different treatments, indication, and Member's reason for failure with previous treatments. The number of trials required will be based on the clinical judgement of the physician or clinical pharmacist reviewer.

- Retrospective Drug Utilization Review (DUR) (post-claim analysis, educational programs)
  - Improve medication therapy outcome and reduce and prevent inappropriate use, fraud, or abuse.
- AB 1114 Pharmacist Services pursuant to APL 22-012 *Revised* "Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX" (12/30/2022)
- Disease/Medication Management Programs
  - Improve medication adherence, address therapeutic gaps, and optimize medication therapy outcome.
- Support of Care Coordination and Case Management
  - Support Members with complex medication regimen, multiple health conditions, behavioral and substance use disorder.
- Support of Quality Improvement (e.g. HEDIS, outcomes measures)
  - Performance improvement in medication related quality measures.

Mental Health

Members may self-refer for mental health services to mental health providers using Partnership's toll-free Behavioral Health referral number (855) 765-9703 or by contacting the preferred behavioral health provider directly. Members do not need a referral or prior authorization to receive mental health services.

In an effort to coordinate the Member's overall health care, mental health providers are instructed to ask Members to sign a release of information so that the mental health provider can contact the Member's PCP or other providers. However, the release of information is not a condition for the approval or provision of services.

Mental health services for Members with Medi-Cal as their primary insurance are provided as follows:

- Members determined to have Non-Specialty Mental Health Services (NSMHS) needs that require mild to moderate mental health treatment are served by Partnership's behavioral healthcare department which can be reached by calling (855) 765-9703.

- Members determined to require Specialty Mental Health Services (SMHS) for moderate to severe mental health conditions are referred to the County Behavioral Health Plan (BHP) in the Member's county of residence. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each respective County Behavioral Health Plan, consistent with California statutes and regulations.
- DHCS requires Managed Care Plans (MCPs) and BHPs to use specific Screening and Transition of Care Tools for Members under age 21 (youth) and for Members age 21 and over (adults) to determine the appropriate mental health delivery system referral for Members who are not currently receiving mental health services when they contact the MCP or BHP seeking mental health services. These tools can be found on the DHCS website on this page: https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx

County Behavioral Health Plans provide crisis assessments and authorizations for care. Immediate access to the crisis service remains an option throughout all phases of treatment by any provider. Each County operates crisis services which to address clients in crisis; crisis services also act as a backup after hours and on weekends as well as at other times of provider unavailability. Members may call the County crisis line directly, without a referral. Members eligible for mental health services from Partnership will be re-directed to appropriate County crisis services as needed.

A certain level of mental health services is appropriately dealt with in a primary care practice, including screening and referrals to services. Primary Care Providers may contact each county's Behavioral Health Plan or Partnership, as applicable, for telephone consultation. For detailed referral and consultation procedures, PCPs can refer to Partnership Policy MPCP2017 Scope of Primary Care—Behavioral Health and Indications for Referral Guidelines.

Partnership is responsible for the delivery of non-specialty mental health services for children under age 21 and outpatient mental health services for adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Outpatient mental health services are delivered as specified in policy MPBP8003 *Mental Health Services* whether they are provided by PCPs within their scope of practice or through Partnership's provider network. Partnership continues to be responsible for the arrangement and payment of all medically necessary, Medi-Cal-covered physical health care services, not otherwise excluded by contract, for Partnership beneficiaries who require specialty mental health services.

In compliance with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR Section 438.930, Partnership ensures direct access to an initial mental health assessment by a licensed mental health provider within the Partnership provider network. No referral from a PCP or prior authorization is required for an initial mental health assessment to be performed by a network mental health provider.

Partnership meets the general parity requirement (Title 42, CFR, §438.910(b)) which stipulates that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Neither a referral from the PCP, nor prior authorization, is required for a beneficiary to seek any mental health service, including the initial mental health assessment from a network mental health provider.

If a dispute occurs between the local County Behavioral Health plan and Partnership HealthPlan of California, both parties will participate in a dispute resolution process as defined in Partnership Policy MPBP8005 Dispute Resolution Between Partnership and BHPs in Delivery of Behavioral Health Services. This is consistent with the dispute resolution process outlined by State regulations and the individual County/Partnership Memoranda of Understanding.

Triage and Referral for Mental Health

Partnership monitors triage and referral protocols to ensure they are appropriately implemented, monitored and managed. Protocols utilized are based on sound clinical evidence and accepted industry practice. They must define the level of urgency and appropriateness of the care setting.

Triage and referrals are performed by the Behavioral Health Access Line with oversight by Partnership's Senior Director of Behavioral Health and Behavioral Health Clinical Director. Partnership works collaboratively with the respective County Behavioral Health Plans to coordinate and ensure Members receive care at the appropriate level in a timely manner.

Substance Use Disorder Treatment Services/ Wellness & Recovery Program

Partnership works to ensure that Members receive effective and appropriate behavioral health care services for both mental health and substance use disorders. Partnership provides Substance Use Disorder (SUD) treatment services as outlined in the Regional Drug Medi-Cal Model (Regional Model). SUD services are administered either by Partnership or through individual counties not participating in the Regional Model. Partnership

The range of services in the Wellness & Recovery Program include:

- Outpatient treatment (licensed professional or certified counselor, up to nine hours per week for adults)
- Intensive outpatient treatment for individuals with greater treatment needs (licensed professional or certified counselor, structured programming, 9-19 hours per week for adults)
- Detoxification services (withdrawal management)
- Residential treatment (Prior authorization is required as per policy MCUP3144 *Residential Substance Use Disorder Treatment Authorization*)
- Medication assisted treatment (MAT) (methadone, buprenorphine, disulfiram, and naloxone). *Partnership is financially responsible for the dispensing of these medications when services occur in a contracted Narcotic Treatment Program (NTP)/ Opioid Treatment Program (OTP) facility. When MAT is prescribed outside of a NTP/OTP (e.g. dispensed through a pharmacy) the medications will be authorized through the state Medi-Cal Rx program.*
- Care Coordination
- Recovery services (aftercare)

Behavioral Health Treatment (BHT) for Members Under 21 Years of Age

Partnership has provided benefits for Behavioral Health Therapy for children diagnosed with Autism Spectrum Disorder (ASD) since September 2014. Effective July 1, 2018, Partnership expanded its benefit coverage to include Behavioral Health Treatment (BHT) for eligible Medi-Cal Members under the age of 21 as required by the Early and Periodic Screening and Diagnostic Treatment (EPSDT) mandate.

Treatment services may include Applied Behavioral Analysis (ABA) and other services known as Behavioral Health Treatment (BHT).

BHT is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior.

BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services include a variety of behavioral interventions that have been identified as evidence-based by nationally recognized research reviews and/or other nationally

recognized scientific and clinical evidence that are designed to be delivered primarily in the home and in other community settings.

Partnership will provide medically necessary BHT services covered under Medicaid (Medi-Cal) for all Members who meet the eligibility criteria for services as stated in 1905® of the Social Security Administration (SSA) and outlined in DHCS All Plan Letter (APL) 23-010 *Revised*.

- Additional detailed information regarding the BHT benefit can be found in the following Partnership Policies and Procedures:
  - MPUP3126 *Behavioral Health Treatment (BHT) for Members Under the Age of 21*
  - MCCP2014 *Continuity of Care*

Quality Improvement Collaboration

The UM team works collaboratively with the Quality Improvement (QI) Department to enhance the care provided to our Members through venues such as the Internal Quality Improvement Committee (IQI), the Quality/ Utilization Advisory Committee (Q/UAC) and daily UM activities.

In the committee environment, the UM team takes an analytical, evaluative and strategic look at predetermined metrics to evaluate and offer recommendations which further enhance the UM program. Data is reviewed and discussed at least bi-annually during the IQI and Q/UAC meetings. The Q/UAC provides guidance and direction to the UM program by coordinating activities and by functioning as the expert panel when needed. Collaboration includes but is not limited to:

- Reviewing, making recommendations to, and approving the *UM Program Description* annually
- Assuring individual Member needs are taken into consideration when determinations for care are rendered
- Analyzing summary data and making recommendations for action
- Reviewing the recommendations of Process Implementation Teams to develop UM improvement action plans, ongoing monitoring, and evaluation
- Recommending medical policy, protocol, and clinical practice guidelines based on provider and Member experience information.

During daily activities, the UM team supports QI efforts in the identification of potential quality of care issues, reporting adverse occurrences identified while conducting UM case review, improvement of Healthcare Effectiveness Data and Information Set (HEDIS®) scoring by referrals to care coordination, and care coordination efforts to ensure Members are seen by the appropriate provider for their condition.

UTILIZATION MANAGEMENT PROCESS

Partnership applies written, objective, evidence-based criteria (InterQual® and pharmaceutical criteria) and considers the individual Member's circumstance and community resources when making medical appropriateness determinations for behavioral health and physical health care services.

On an annual basis, Partnership distributes a statement to all its practitioners, providers, Members and employees alerting them to the need for special concern about the risks of under-utilization. It requires employees who make utilization-related decisions and those who supervise them to sign a statement which affirms that UM decision making is based only on appropriateness of care and service.

Furthermore, Partnership does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization and Partnership does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

Working with practitioners and providers of care, the following factors are taken into consideration when applying guidelines to a particular case in review:

- Input from the treating practitioner
- Age of Member
- Comorbidities in existence
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Consideration of the delivery system and availability of services to include but not be limited to:
  - Availability of inpatient, outpatient, transitional and residential treatment (SUD) facilities
  - Availability of outpatient services
  - Availability of highly specialized services, such as transplant facilities or cancer centers
  - Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge
  - Local hospitals' ability to provide all recommended services
- Benefit coverage

Referrals and requests for prior authorization of services are to be submitted by the provider of service to the Partnership UM department by fax or through Partnership's Online Services portal, which is a Secure Electronic Internet system. The following information must be provided on all requests.

- Member demographic information
- Provider demographic information
- Requested service/procedure to include specific CPT/HCPCS code(s)
- Member diagnosis (Using current ICD Code sets)
- Clinical indications necessitating service or referral
- Pertinent medical history, treatment or clinical data
- Location of service to be provided
- Requested length of stay for all inpatient requests
- Proposed date of procedure for all outpatient surgical requests

Pertinent data and information is required to enable a thorough assessment of medical necessity.
If information is missing or incomplete, the requestor will be notified and given an opportunity to submit additional information.

Addition of Benefits and Modifications of TAR Requirements

The process for adding a new Partnership benefit and specifying TAR requirements, as well as the process for adding or removing TAR requirements for existing benefits, both begin when a request is submitted by a Provider, Member, or Staff. The following information should be included:

- Justification for the new benefit and/or change in TAR requirements
- Identification of Member population that would benefit
- Relevant clinical information
- TAR requirements (e.g. Will a TAR be required? Will TAR requirements be removed?)

The Chief Medical Officer (CMO) or Physician Designee reviews the request, with input from the Chief Health Services Officer. Feedback may also be sought from relevant specialists, physician committees, or advisory committees to determine whether new benefits and/or TAR requirements should be added, and under what criteria, or if existing requirements should be removed.

Operational review is conducted through the Benefit Review and Evaluation Workgroup (BREW), which includes leaders from clinical, operational, financial, and regulatory areas. BREW examines the medical, financial, and operational implications and presents findings to the Executive Committee. The Executive Committee may consult the Physician Advisory Committee (PAC), approve minor changes such as single CPT codes, or recommend larger benefit changes to the Board for approval. They also oversee necessary IT, claims, and financial adjustments, including potential recommendations to state regulators. This structured process

ensures medical necessity, operational feasibility, and financial sustainability are carefully considered before new benefits are adopted and TAR requirements are applied.

Elective Admission Precertification
The UM department evaluates every proposed treatment plan, and determines benefit eligibility, suitability of location and level of care prior to the approval of service delivery for select diagnoses and procedures.

Utilizing written criteria such as InterQual®, Medi-Cal Criteria and Partnership medical policy approved by the Q/UAC, licensed and professional UM staff review and approve completed Treatment Authorization Requests (TARs).

Only the Chief Medical Officer or physician designee may make a medical necessity determination and have the authority to deny a service request based on lack of medical necessity. Partnership offers the practitioner the opportunity to discuss any medical necessity denial determination with the physician reviewer rendering the decision.

Referral Management
Referrals are generated by the primary care provider and submitted to Partnership's Online Services (OLS) portal (or by fax or mail). Partnership monitors and analyzes requests to identify trends and assist in follow-up care. Requests for out-of-network referrals are reviewed to determine if the service is available and can be provided within Partnership's network. Out-of-Network requests are also used to evaluate provider access and to determine if the local network requires enhancements to meet Member needs.

Continued Stay/Concurrent Review
Acute care hospitalization reviews are performed by licensed professionals to ensure medical necessity of continued stay, the appropriateness of level of care, and care duration. This review is conducted either on site, by accessing the facility electronic medical record through a secure portal, or telephonically using written Partnership medical policy, InterQual®, and/or Medi-Cal guidelines.

Requests for authorization are reviewed within 24 hours of notification of admission and concurrently throughout the stay. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to Partnership case management and social services as appropriate.

Consideration of available services in the local service area or delivery system and the ability to meet the Member's specific health care needs are evaluated as part of application of criteria and the development of an ongoing plan of care and discharge plan.

Only the Chief Medical Officer or physician designee has the authority to deny a request for service based on lack of medical necessity. Partnership offers the practitioner with clinical expertise in the area being reviewed the opportunity to discuss the application of criteria in determining medical necessity or any determination based on lack of clinical justification with the physician reviewer.

In addition to individual conversations with practitioners on specific case reviews, Partnership conducts several committees for the purpose of hearing and incorporating practitioner input in the development of medical policy. Partnership, through the Physician Advisory Committee (PAC), the Quality/ Utilization Advisory Committee, and the Pharmacy and Therapeutics Committee (P&T) , provides practitioners with clinical expertise in several areas the opportunity to advise or comment on the development and/or adaptation of UM criteria and provide feedback or instruction on the application of that criteria. Within the previously stated committees, Partnership evaluates UM criteria and procedures against current clinical and medical evidence and updates them accordingly.

Skilled Nursing/Sub acute/ Long-Term Acute/Rehabilitation Facility Review
Review of all Skilled Nursing and Rehabilitation Facility confinements are performed by licensed professionals to ensure medical necessity of continued stay and the appropriateness of level and duration of

care. This review is conducted telephonically using written Partnership medical policy, Title 22 criteria, and/or InterQual® criteria. Requests for authorization are reviewed within 24 hours of notification of admission. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to Partnership case management and social services as appropriate.

Consideration of available services in the local service area or delivery system, and the ability to meet the Member's specific health care needs are evaluated as part of applying criteria and the development of an ongoing plan of care and discharge plan.

Discharge Planning
Discharge planning is a critical component of the utilization management process and begins upon admission with an assessment of the patient's potential discharge needs. It includes preparation of the family and the patient for continuing care needs and initiation of arrangements for services or placement needed after acute care discharge.

Partnership Nurse Coordinators work with hospital discharge planners, case managers, admitting/attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs.

Post-Service Retrospective Review
Post-service retrospective reviews may occur when a Member is retroactively granted Medi-Cal benefits by the State of California, when a provider does not realize an authorization is required prior to rendering a service, when the rendered service code billed does not match the code authorized, or the service may have been rendered after the expiration of the authorization. TARs must be received by Partnership within 15 business days of the date of service or within 60 calendar days of either a denial from the primary insurance carrier or retrospective eligibility. (TARs submitted beyond these timeframes are considered late but will still be reviewed for medical necessity.)

All retrospective reviews are completed within 30 calendar days of receipt of request. Electronic or written notification of the decision and how to initiate a routine or expedited appeal if applicable, is communicated to the provider within 24 hours of decision, but no longer than 30 calendar days from the date of the receipt of the request. Written notification is mailed to the Member within two (2) business days of the decision.

Services requiring an authorization can be retrospectively reviewed for medical necessity, appropriateness of setting, and length of stay up to one year after services are rendered and may result in an adverse determination.

Emergency Room Visits
Emergency room visits where a prudent layperson, acting reasonably, would believe an emergency condition exists, DO NOT require prior authorization.

TIMELINESS OF UM AND PHARMACY DECISIONS

Partnership makes UM and Pharmacy decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of care. Partnership measures the timeliness of decisions from the date when the organization receives the request from the Member or PCP, even if the Partnership does not have all the information necessary to make a decision. Partnership documents the date when the request is received and the date a decision is rendered in the UM documentation system.

Partnership has communicated to both providers and Members the practice of processing non-urgent requests during the next business day if the request is received after business hours.

Partnership Utilization Management abides by the following timeliness guidelines when processing health services requests.

Urgent Requests
A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations could jeopardize the live, health or safety of the Member or others due to the Member's psychological state or, in the opinion of the practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment requested.

Concurrent Review Request:
A request for coverage of medical care or services made while a Member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Pre-Service Request
A request for medical care or services that Partnership must approve in advance, in whole or in part.

Non-Urgent Request
A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the Member or the Member's ability to regain maximum function and would not subject the Member to severe pain.

Post-Service Request / Retrospective Review
A request for medical care or services that have been received.

Non-Behavioral Healthcare Decisions, Pharmacy Decisions, and Behavioral Healthcare Decisions

Type of Request	Decision Time Frame	Notification[1] Time Frame	Extended Time Frame
Urgent concurrent review	72 hours of receipt of request	72 hours of receipt of request	May be extended one time up to 14 calendar days from receipt of request
Urgent pre-service	72 hours of receipt of request	72 hours of receipt of request	May be extended one time up to 14 calendar days from receipt of request
Non-urgent pre-service	5 business days of receipt of request	24 hours of determination date[1]	May be extended *two (2)* times for up to 14 calendar days each period (28 days total from receipt of request)[2]
Post-service	30 calendar days of receipt of request	30 calendar days of receipt of request	N/A

[1] Notification: Give electronic or written notification of decision to practitioner (and Member when required).
Per DHCS requirement, written notification must be mailed to a Member within two (2) business days of the decision.
[2] Per DHCS regulations

Review Criteria
Current InterQual® criteria sets are used as the main review guidelines. Additional criteria are selected or developed using other resources as necessary to help in determining review decisions which include, but are not limited to, Medi-Cal (State of California) guidelines and State policy letters (see policy MCUP3139 *Criteria and Guidelines for Utilization Management*). InterQual® criteria are produced using a rigorous development process based on evidence-based medicine and reviewed at least annually, but as frequently as quarterly, by a panel of board-certified specialists. All UM policies are based on InterQual® criteria and are reviewed annually by the Quality/Utilization Committee (Q/UAC) and the Physician Advisory Committee (PAC) which also include board-certified specialists who are practicing network physicians. All Pharmacy policies are reviewed annually by the Pharmacy and Therapeutics (P&T) Committee and PAC. Refer to pharmacy policies MCRP4068 *Medical Benefit Medication TAR Policy* and MPRP4001 *P&T Committee* for further details regarding pharmaceutical criteria.

In the absence of applicable criteria, the Partnership UM medical staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of the individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system. Board-certified consultants are available through our providers on our Quality/Utilization Advisory Committee (Q/UAC). Partnership also contracts with a third-party independent medical review organization which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence. (See policy MCUP3138 *External Independent Medical Review*.)

Criteria are selected, reviewed, updated or modified using feedback from the Q/UAC and PAC as well as Member feedback identified in Member survey results and the Community Advisory Committee (CAC), State policy letters, State Memorandums of Understanding and/or medical literature, among other sources. In collaboration with actively practicing practitioners, criteria are evaluated on at least an annual basis. Relevant clinical information is obtained when making a determination based on medical appropriateness and the treating practitioner is consulted as appropriate. All information obtained to support decision-making is documented in the utilization management documentation system.

Decisions are based on information derived from the following sources:

- Clinical records
- Medical care personnel
- Facility utilization management staff
- Attending physician (attending physician can be the primary care physician, hospitalist or the specialist physician (or all three as necessary)
- Board-certified specialists are consulted when medically necessary

When applying criteria to a treatment request, reviewers consider the needs of the individual patient (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable) as well as the availability of services in the local delivery system and their ability to meet the Member's specific health care needs.

Inter-Rater Reliability (IRR)
Partnership assesses the consistency with which physician and non-physician reviewers apply UM criteria in decision making and evaluates Inter-Rater Reliability. The Inter-Rater Reliability mechanism uses live cases to ensure medical management criteria are appropriately and consistently applied in making UM determinations. The methodology employed is designed to annually assess 50 cases or 5% of reviewer case load, whichever is less, over the course of a year period.

The following types of reviews/reviewers are audited:

- Nurse Coordinator Review of Inpatient Services
- Nurse Coordinator Review of Outpatient Services
- Nurse Coordinator Review of Long Term Care Services
- Behavioral Health (BH) Nurse Coordinator Review of Residential Substance Use Disorder Treatment Authorizations
- Physician Review of Medical Necessity Authorizations
- Pharmacist and Pharmacy Technician Review of Pharmacy TARs

A performance target of 90% accuracy is set for inter-rater reliability. An audit summary is reported at least annually or more often as needed to the Internal Quality Improvement (IQI) Committee. If a reviewer falls below the targeted threshold, a corrective action plan is initiated and monitored and results are presented to the Quality/Utilization Advisory Committee (Q/UAC) for review and discussion. Please refer to policy MPUP3026 *Inter-Rater Reliability Policy* for a full description of the IRR process.

Availability of Criteria

All criteria used to review authorization request are available upon request. In the case of an adverse determination, the criteria used are made part of the determination file. Access to and copies of specific criteria utilized in the determination are also available to any requesting practitioner by mail, fax, email, or on our website: http://www.partnershiphp.org. To obtain a copy of the UM criteria, practitioners may call the Partnership UM Department at (800) 863-4155.

Members may request criteria used in making an authorization determination by calling the Member Services department to request a copy of the criteria. The UM team will work with Member Services to provide the criteria used in the review decision.

Partnership's Provider Relations Department notifies providers in writing through the New Provider Credentialing Packet and the provider's contract that UM criteria is available online at http://www.partnershiphp.org in the Provider Manual section. Providers are also notified quarterly in writing via the Quarterly Provider Newsletter about the on-line availability of UM criteria and policies at http://www.partnershiphp.org in the Medi-Cal Provider Manual section.

COMMUNICATION SERVICES

Partnership provides access to UM staff for Members and practitioners seeking information about the UM process and the authorization of care in the following ways:

- Calls from Members are triaged through Member Services staff who are accessible to practitioners and Members to discuss UM issues during normal working hours when the HealthPlan is in operation (Monday - Friday 8 a.m. - 5 p.m.).
- For after-hours communication regarding UM issues, telephonic voicemail service is available. Members and practitioners may leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day, hence, calls received after midnight on Monday - Friday are returned on the same business day.
- After normal business hours, Members may contact the advice nurse line at (866) 778-8873 for assistance with clinical concerns.
- Practitioners, both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voicemail box is confidential and will accept messages after normal business hours. Communications received after normal business hours are returned on the next business day, hence communications received after midnight on Monday - Friday are responded to on the same business day.
    - Partnership has a dedicated after-hours phone number local (707) 430-4808 or toll free (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's Chief Medical Director or physician designee is on call 24 hours per day, 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical staff are available 24 hours per day, 7 days per week to coordinate the transfer of a Member whose emergency medical condition is stabilized.
- Partnership UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. For a list of UM Program Staff and Assigned Responsibilities, please refer to the Program Staff section of this document above.
- Partnership maintains a toll-free number (800) 863-4155 that is available to both Members and practitioners.
- Members can view information about Partnership's language assistance services and disability services in the Member Handbook which is made available to Members upon enrollment and is always viewable online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf

Additionally, Partnership provides annual written notice to Members about our language assistance services and disability services (e.g. TTY for hearing impaired) in our Member Newsletter.

Linguistic services are provided by Partnership to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries as well as eligible Members with disabilities for population groups as determined by contract. These services include the following:

No Cost Linguistic Services:

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
- Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for Partnership Members according to regulatory timeframes, and into other languages or accessible formats upon request. Alternative material formats available to Members include audio format, Braille, large-size print format, and accessible electronicformat for Members with hearing and/or visual disabilities. Auxiliary aids are also available upon request. Please refer to MPND9002 Cultural and Linguistic Program Description for more information. The organization may continue to provide translated materials in other languages represented by the population at the discretion of Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735-2929 or 711]

Partnership regularly assesses and documents Member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. (See policy MPND9002 *Cultural and Linguistic Program Description*)

Denial Determinations

Denial determinations may occur at any time in the course of the review process. Only the Chief Medical Officer, or a physician designee acting through the designated authority of the Chief Medical Officer, has the authority to render a denial determination based on medical necessity which is defined as "reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury."

A denial determination may occur during continued stay/concurrent review in which case notification and/or discussion with the treating practitioner and the Health Plan physician adviser/Chief Medical Officer or physician designee is offered.

Denial determinations may occur at different times and for various reasons including but not limited to:

- At the time of prior authorization; when the requested service is not medically indicated or not a covered benefit.
- When timely notification was not received from a facility for an inpatient stay to foster transfer of a medically stable patient
- When an inpatient facility fails to notify the Health Plan of admission within one business day of the admission or appropriate clinical information is not received
- When out-of-network services are not clinically appropriate
- Or after services are rendered at claims review when the services were not authorized, or are medically unnecessary

A denial may also occur for inappropriate levels of care or inappropriate care. Notwithstanding previous authorization, payment for services may be denied if it is found that information previously given in support of the authorization was inaccurate.

Partnership offers the practitioner the opportunity to discuss any denial or potential denial determination based on lack of medical necessity with the Health Plan Chief Medical Officer, or a physician designee.

The denial notification states the reason for the denial in terms specific to the Member's condition or service request and in language that is easy to understand and references the criterion used in making the determination so the Member and provider have a clear understanding of the Health Plan's rationale and enough information to file an appeal.

Partnership HealthPlan of California is aware of the need to be concerned about under-utilization of care and services for our Members. Partnership monitors over and under-utilization through the Over/Under Utilization Workgroup which reviews annual utilization patterns. Decisions made by Partnership's Utilization Reviewers are solely based on the appropriateness of the care or service.

The Health Plan does not compensate any individual involved in the utilization process to deny care or services for our Members nor do we encourage or offer incentives for denials.

Process for a Provider to Appeal an Adverse Benefit Determination on Behalf of a Member

Members and providers are provided fair and solution-oriented means to address perceived problems in exercising rights as a Medi-Cal beneficiary or provider, in accordance with requirements of Partnership's contract with the Department of Health Care Services (DHCS). This process is entirely separate from that of State Fair Hearings, to which Members retain their access. Please refer to Partnership policy MCUP3037 *Appeals of Utilization Management/ Pharmacy Decisions* for a full description of the process.

Data Sources

Utilization Management supports the effective, efficient, and appropriate utilization of Member benefits through ongoing review, evaluation and monitoring of the Member's personal health information in making medical necessity determinations.

Data sources may include, but are not limited to:

- Medical records, from outpatient provider offices and hospital records (including accessing hospital Electronic Medical Records (EMR); for current and historical data
- Member handbook/Evidence of Coverage
- Consultations with treating physicians
- Network adequacy information
- Local delivery system capacity information
- Specialist referrals
- Recent Physical exam results
- Diagnostic testing results
- Treatment plans and progress notes
- Operative and pathological reports
- Rehabilitation evaluations
- Patient characteristics and information
- Patient psychosocial history
- Information from family / social support network
- Prospective/concurrent/retrospective utilization management activities
- Claim/encounter (administrative) data

Data Collection, Analysis, and Reporting

Data collection activities for analysis and reporting are coordinated by the UM department. At the data gathering/performance measurement phase, participants in the process include programmers and analysts in the Finance and Health Services departments, staff nurses, and any other personnel required for the collection and validation of data. All data collection activities are documented and reported to the Q/UAC twice a year and more often if requested. Data collection activities may include, but are not limited to:

- Member satisfaction surveys
- Provider satisfaction surveys
- Readmission statistics
- Potential quality incident data
- Member appeal data
- Provider appeal data
- Internally developed databases
- Pharmacy utilization data
- Other administrative or clinical data
- Member utilization data
- Provider prescribing data

EVALUATION OF NEW MEDICAL TECHNOLOGY

Partnership evaluates the inclusion of new medical technologies and the new application of existing technologies in its benefit packages. While the basic benefits are set by the State of California Department of Health Care Services (DHCS) and outlined in Title 22 of the Health and Welfare Code, Partnership has the option of adding to this basic package of benefits for its Members.

Partnership's Policy MCUP3042 *Technology Assessment* outlines the steps taken during the determination process. The Partnership Physician Advisory Committee will review all cases and make a final recommendation to the Board of Commissioners as to new benefits. The Commission is the only entity that can add benefits.
Once a new benefit is added, the information is disseminated to all Primary Care Providers and appropriate specialists in the form of a mail notification of benefit addition, and to all Members in the next Member newsletter.

New technologies are handled on a case-by-case basis which includes obtaining information regarding the safety, efficacy and indications that support the use of the intervention. There must be evidence that the proposed intervention will add to improved outcomes as compared to what is currently available. The service provider must have a record of safety and success with the intervention and cannot be part of a funded research protocol. The Chief Medical Officer works closely with the requesting physician and specialists as needed in researching these cases.

DELEGATION

UM activities that are delegated to contract providers are reviewed and approved on an annual basis by the Q/UAC. A delegation agreement, including a detailed list of activities delegated and reporting requirements is signed by both the delegate and Partnership.

- Providers to whom UM activities have been delegated are responsible for reporting results and analyses to Partnership on a quarterly or annual basis. Reports are summarized for review and evaluation by Partnership's Delegation Oversight Review Sub-Committee (DORS) and Q/UAC.
- Audits are conducted no less than annually and evaluation includes a review of both the processes applied in carrying out delegated UM activities, and the outcome achieved in accordance with the respective policy(s) and agreement governing the delegated responsibility.
- The Q/UAC reviews evaluations and make recommendations regarding opportunities for improvement and continuation of delegated functions.

A pre-delegation evaluation is conducted when delegation of functions to providers is being considered.

Protected Health Information (PHI)

The Privacy Rule, described in 45 CFR Parts 160 and 165, applies to covered entities. The Privacy Rule allows covered providers, entities, and health plans to disclose PHI in order to carry out their health care functions.

Partnership HealthPlan of California is fully compliant with the general rules, regulations and implementation specified in The Privacy Rule. Partnership also provides reasonable administrative, technical, and physical safeguards to ensure PHI confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI.

The Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer. Partnership has implemented a comprehensive program that includes "Notice of Privacy Practices" (NPP) sent to all Members, as well as implementation of a confidential toll-free complaint line available to Members, providers and Partnership staff. For non-covered entities, Partnership requires Business Associate Agreements (BAA). Additionally, there is training on an annual basis for the Partnership workforce and Partnership providers/networks, and Partnership maintains policies and procedures around documentation of complaints of violations or suspected privacy incidents.

STATEMENT OF CONFIDENTIALITY

Confidentiality of provider and Member information is ensured at all times in the performance of UM activities through enforcement of the following:

- Members of the Q/UAC and PAC are required to sign a confidentiality statement that will be maintained and securely stored in the QI files.
- UM documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, and Credentials Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to Q/UAC and Credentials Committee meeting minutes and agendas, QI and Peer Review reports and findings, UM reports, or any correspondence or memos relating to confidential issues where the name of a provider or Member are included.
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only, or they are electronically archived and stored on protected drives.
- Confidential paper documents are destroyed by shredding.
- Partnership has designated a Privacy Officer responsible to oversee compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal privacy laws.
- Partnership maintains administrative structure, reporting procedures, due diligence procedures, training programs and other methods to ensure effective compliance in use and disclosure of Members' Protected Health Information (PHI).

NON-DISCRIMINATION STATEMENT

Partnership complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin (including limited English proficiency (LEP) and primary language), age, disability, or sex (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes).

Partnership will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available. Also, Partnership will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or

restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

Partnership provides free aids and services to people with disabilities to communicate with us, such as:

- Qualified sign language interpreters or Video Remote Interpreters (VRI)
- Written information in other formats (large print, audio, Braille, accessible electronic formats, other formats)

Partnership provides free language services to people whose primary language is not English or those with limited English proficiency (LEP). These services include the following:

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact
- Information written in other languages
- Use of California Relay Services for hearing impaired

STATEMENT OF CONFLICT OF INTEREST

Any individual who has been personally involved in the care and/or service provided to a patient, an event or finding undergoing quality evaluation may not vote or render a decision regarding the appropriateness of such care. All members of the Q/UAC are required to review and sign a conflict of interest statement, agreeing to abide by its terms.

PROVIDER AND MEMBER SATISFACTION

Partnership conducts satisfaction surveys on both Members and providers. Included in the evaluation are questions that deal with both Member and provider satisfaction with the UM program. The responses to the survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by the HealthPlan. The results, as well as plans for corrective action, are developed in conjunction with the Q/UAC. Corrective actions that were in place are evaluated at the time the follow-up annual survey is done unless the committee feels an expedited time frame needs to be implemented.

ANNUAL PROGRAM EVALUATION

The Utilization Management program undergoes a written evaluation of its overall effectiveness annually by the Q/UAC, which is reviewed and approved by the PAC.

At a minimum the evaluation considers UM department activities and outcomes, the review of Key Performance Indicator metrics such as Productivity, Timeliness, Bed-days, readmission rates and denial rates along with resource effectiveness and barriers to performance.

Preparation for the Annual Program Evaluation involves participation by all Utilization Management and Pharmacy leadership including but not limited to:

- Chief Health Services Officer
- Director, Pharmacy Services
- Directors of UM
- Associate Directors of UM
- UM Managers

Elements of the program evaluation include an objective assessment of meeting targeted goals to ensure appropriate, efficient utilization of resources/services for Partnership Members across the continuum of care in compliance with requirements of state/federal and regulatory entities.

- Annual UM Program Description update
- Annual review and evaluation of UM processes (meeting goals and identifying opportunities for process improvements)
- Timely review and update of UM policies and procedures
- Obtain approval of UM policies and procedures at Q/UAC

Inter-Rater Reliability scoring and TAR timeliness are compared with regulatory compliance standards and internal benchmarks.

To determine if the UM program remains current and appropriate, the organization annually evaluates:

- The program structure
- The program scope, processes, information sources used in the determination of benefit coverage and medical necessity
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program
- Consideration of Member and practitioner experience data when evaluating the UM program

The organization updates the UM program and its description annually based on the evaluation.

To ensure the provision of healthcare services at the appropriate level of care the evaluation considers:

- Inpatient bed day rate
- Inpatient average length of stay
- SNF admit rate
- SNF average length of stay
- Readmission rate
- Denial rate
- Timely completion of notifications of denial of care
- Timely completion of notifications of authorization of care
- Rate of referrals to Care Coordination
- Effectively integrating feedback - the program reflects on Member/Provider satisfaction results concerning the UM program looking at:
    - Daily Work Flow Monitoring
    - Call Abandonment rates
    - Call Volume
    - Average caller wait time

An assessment of Department resources is determined by looking at the impact of staffing changes, learning curves and system limitations which impede work effectiveness. There is a review of Inter-Rater Reliability scoring in relation to staff training/re-education, acclimation to new technology such as documentation software/ hardware based on evaluating user acceptance, and the assessment of appropriate staffing ratio to ensure adherence to regulatory and internal performance standards.

A summary of the program evaluation, including a description of the program, is provided to Members or practitioners upon request.

REFERENCES:

- Department of Health Care Services (DHCS) standards
- National Committee for Quality Assurance (NCQA) Guidelines UM Standards
- Covered Outpatient Drugs, SSA 1927(k)(2), SSA 1927(k)(3)
- California State Department of Health Care Services (DHCS) Medi-Cal Rx Resources and Reference Materials:
- https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx
- State Medi-Cal Managed Care Plans: https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx

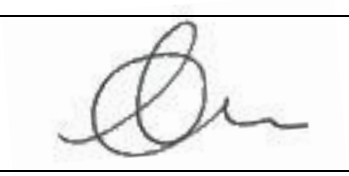
Original Date: QI/UM Program 04/22/1994 effective 05/01/1994**Revision Date(s): 08/16/95**
Revision Date(s): UM Program Description - 04/17/97; Board Approval January 28, 1998; 06/10/98; 01/20/99; 05/2000; 05/01/01; (UD100301) 03/20/02; 08/20/03; 10/20/04; 10/13/05; 06/21/06; (MPUD3001) 04/16/08; 08/03/10; 11/19/14; 02/17/16; 04/19/17; *06/13/18; 04/10/19, 06/12/19 *(Amended)*, 11/13/19 *(Amended);* 04/08/20; 06/10/20 (*Amended*); 04/14/21; 01/12/22; 05/11/22; 05/10/23; 05/08/24; 05/14/25; 10/08/25; 03/11/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

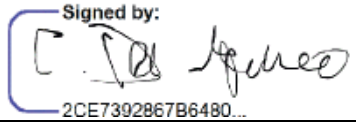
UM Program Description Approval

	***02/18/2026***

Robert Moore, MD, MPH, MBA *Date Approved*
Quality/Utilization Advisory Committee Chairperson

	***03/11/2026***

Angela Brennan, DO *Date Approved*
Physician Advisory Committee Chairperson

	***04/22/2026***

Dean Germano *Date Approved*
Board of Commissioners Chairperson