AmeriHealth Caritas North Carolina, Inc.

Utilization Management Program Description 2024

Contents

Background

North Carolina (ACNC) is a Medicaid plan offered by AmeriHealth Caritas Family of Companies (ACFC). AmeriHealth Caritas Family of Companies is a nation leader serving low-income families, individuals with disabilities and those who are chronically through a state sponsored health care program, managing health care for the most vulnerable people since 1983. Our Quality award-winning managed health care plans include Medicaid, Medicare, long-term services and supports (LTSS), behavioral health and pharmacy benefit management services. Our next-generation model of care treats the whole person and puts healthy outcomes at the center of our services. Each plan is dedicated to the unique clinical and administrative features of its contracted members.

Introduction

ACNC works congruent to a contract with North Carolina Department of Health and Human Services (NCDHHS). ACNC services include providing coverage for physical and behavioral health, Long Term Support and Services (LTSS), pharmacy benefits, utilization management (UM), integrated care management, rapid response outreach, quality management, member services, claims management, fiscal management, and information data system.

ACNC mission is to coordinate the physical and behavioral healthcare of eligible member, offering a continuum of targeted interventions, education and enhancing access to care to facilitate improved outcomes and quality of life for eligible members. ACNC works with healthcare providers, and community resources to fulfill our mission and provide cost-effective quality driven care. ACNC Utilization management program is designed to uphold and mirror ACFC corporate values while administering contracted benefits and services. The values that are innate to our operations are:

Advocacy, Competency, Dignity, Stewardship

Care for the Poor, Hospitality, Compassion, Diversity

Purpose

The purpose of the UM Program is to assist ACNC in ensuring that members receive the most clinically appropriate service in the most efficient manner possible while safeguarding consistency in decision making.

Scope

The ACNC UM program establishes a process for implementing and maintaining an effective, efficient utilization management program. Utilization management activities are designed to assist the practitioner with the delivery of appropriate health care services to members within the structure of their benefit plan. ACNC promotes integration of medical and behavioral health to provide a comprehensive approach to meeting the member's needs. Through collaboration with Integrated Population Health Care management, Long-term services and supports(LTSS) case management and practitioner engagement help to facilitate the delivery of the most clinically appropriate medically necessary care in the appropriate clinical setting. Integration of behavioral health and medical services is accomplished through communications with providers as well as a

collaborative approach to managing the member's overall care. Utilization management, LTSS case management, and integrated Population Health Care management work together to facilitate communication of member's health status, needs, and coordination of care between providers involved in the member's care.

Program Structure

The UM purpose is designed to:

- Safeguard the delivery of quality, medically necessary, appropriate health care services within the members' benefit plan both in and out of network.
- Promote continuity and coordination of care among physical, behavioral health and LTSS practitioners and providers.
- Identify members with complex or chronic medical needs that may be appropriate for Case Management, LTSS case management, Maternal Case management, or care coordination services.
- Advocate and promote delivery of care and services in a culturally competent manner within the context of the members' cultural beliefs, practices, and language preferences.
- Adopt objective, evidenced based guidelines, protocols, and criteria that support appropriate clinical decision- making.
- Promote clinical quality and outcomes.
- Analyze UM data to identify over/under utilization of services.
- Improve member satisfaction with the UM program through feedback received from member satisfaction surveys.
- Improve provider satisfaction with the UM program through direct provider feedback, review UM process to ensure these are not burdensome to the provider.
- Ensure benefits provider are within the State of North Carolina benefit offering.
- All processes, activities, components, and information sources used to manage and/or make determinations for benefit coverage, including behavioral health and medical appropriateness, including:
    - Utilization Management processes and functions: prior authorization, concurrent review, discharge planning, care management, and LTSS care management
    - Utilization monitoring processes (e.g., over/under utilization of services, drug utilization reviews)
    - Performance monitoring process (e.g., inter-rater reliability, telephone answer time, abandonment rate, productivity, decision notification timeframes.)
    - Evaluation of outcome data
- Maintain compliance with State, federal, local, and accreditation bodies (e.g., NCQA)

Behavioral Health Aspects of the UM Program

The scope of the Behavioral Health UM program is integrated within the medical and behavioral health program to provide a comprehensive approach to meeting the member's needs. Behavioral Health Care collaborates with other programs to ensure effective care coordination, discharge planning. and case management to meet the needs of ACNC members. The program adopts an

integrated medical management model of care based on the behavioral, physical, and social needs of eligible members. The BH program facilitates the delivery of the most appropriate medically necessary care and services to members in the most appropriate setting.

The Utilization Management Call Center performs a variety of services to assist the UM team in managing care. Precertification requests are typically initiated in the UM call center, where associates receive requests for services for members and providers. All requests that require a medical necessity review are forwarded to licensed clinical staff for review.

ACNC maintains a toll-free 24-hour availability for providers seeking the availability of behavioral health services and is staffed by trained personnel 24 hours a day, seven days a week, three hundred sixty-five days a year. ACNC does not perform centralized triage and referral functions for Behavioral Health. Members may directly access behavioral health services and are not required to contact ACNC to determine the appropriate setting of care or a referral.

Mental Health Parity

Medical management standards are applied equally with respect to mental health/substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits. Application of standards includes medical necessity criteria, admission standards for provider networks, provider reimbursement rates, restrictions based on location, facility, type or provider specialty, fail-first policies, or step therapy protocols, and exclusions based on failure to complete a course of treatment.

Staff Roles and Responsibilities

Clinical Shared Services:

Vice President, Medical Affairs

The Vice President, Medical Affairs is the senior-level physician who provides oversight, implementation, and evaluation of the UM program. He/she is actively involved in all UM activities and sponsors the ACFC Clinical Policy Committee (CPC) and chairs Enterprise the Utilization Management Committee. and Enterprise Corporate Population Health and Utilization Management Committee. The VP is a licensed, board-certified physician with an unrestricted license to practice.

- The Clinical Policy Committee (CPC) is comprised of licensed physicians who are Medical Directors, Chief Medical Officers across ACFC, Behavioral Health Medical Directors, Clinical Policy Leadership, Corporate Quality Management, Corporate Utilization Management, Provider Network Management, Pharmacy Benefit Management and Legal Affairs.
    - Responsibility includes:
        - Review, discuss, and approve clinical policies.
        - Review requests for new technology or application of existing technology for behavioral/physical health, pharmaceuticals
        - Review and approval of vendor clinical criteria (e.g., InterQual®, Evolent, PerformRx)
- Enterprise Population Health Policy Council
    - Responsibilities include:

  - Provides a formalized structure and process for planning, developing, evaluating, and approving the enterprise-wide policies for Population Health and Utilization Management
  - Providing clinical guidance on enterprise policies; ensuring policies are based on nationally accepted & accredited standards of care and key treatment elements.
- Coordinates UM activities within the QI program, including but not limited to monitoring and evaluating the utilization of health services (including over- and under-utilization and outliers) and the effectiveness of utilization management activities.

Corporate Behavioral Health Medical Director

The Corporate Behavioral Health Medical Director is the senior-level behavioral health physician who provides oversight, implementation, and evaluation of the behavioral health aspects of the UM program. He/she is a licensed, board-certified psychiatrist with an unrestricted license to practice. Responsibilities include:

- Active participation in all major clinical utilization and quality management of the behavioral health decisions for shared services
- Designated BH physician in the development and implementation of medical policies related behavioral health and substance use disorders, including making recommendations for modifications to enhance efficiency and effectiveness.
- Provides clinical leadership, expertise, and education on the development, implementation, and interpretation of behavioral/substance use disorder clinical policies and procedures.
- Identifying and implementing evidence-based practice guidelines

Medical Director

The medical director is a licensed, board-certified physician with an unrestricted license to practice. Responsibilities include:

- Assisting in the development and implementation of medical policy, including making recommendations for modifications to enhance efficiency and effectiveness.
- Providing medical leadership, expertise, and education to the UM department, including the development, implementation, and medical interpretation of medical policies and procedures
- Providing final determinations for payment of services based upon Medical Necessity or eligibility for outpatient and inpatient services, including delegated UM services.
- Communicating with participating providers during the care management/utilization management process in both outpatient and inpatient settings
- Educating participating physicians about ACNC's managed care philosophy while functioning as the medical liaison between the physician network and ACNC administration
- Intervening and negotiating with attending/consulting physicians in areas of questionable medical necessity, treatment, quality of care and discharge planning

- Coordinating with board-certified specialists to provide expertise in problem-solving issues, quality of care referrals, care management, and UM medical necessity reviews, including appeals.
- Participating in the review and resolution of member and provider appeals

Behavioral Health Medical Director

The behavioral health medical director is a licensed PhD, PsyD, or psychiatrist with an unrestricted license to practice. Responsibilities include:

- Assisting in the development and implementation of medical policy related to behavioral health/substance use disorder, including making recommendations for modifications to enhance efficiency and effectiveness.
- Providing medical leadership, expertise, and education to the UM department including the development, implementation, and medical interpretation of behavioral health policies and procedures
- Providing final determinations for payment of services based upon Medical Necessity or eligibility for behavioral health/substance use disorder outpatient and inpatient services, including delegated UM services.
- Communicating with participating providers during the care management/utilization management process in both outpatient and inpatient settings for behavioral health services
- Intervening and negotiating with attending/consulting clinicians in areas of questionable Medical Necessity, treatment, quality of care, and discharge planning
- Assisting with recruitment and oversight of an adequate, high-quality behavioral health provider network.
- Coordinating with board-certified specialists to provide expertise in problem-solving issues, quality of care referrals, care management, and UM medical necessity reviews, including appeals.
- Participating in the review and resolution of member and provider appeals

Corporate Director of Utilization Management Operations

The Corporate Director of UM Operations reports to the Senior Vice President, Associate Medical Officer, and is primarily responsible for directing the activities of the UM teams ensuring compliance with regulatory standards. Additional responsibilities of the Corporate Director of UM Operations include:

- Collaborate with the UM Manager to ensure a written integrated UM program is updated annually with approval from ACNC's Quality Assessment Performance Improvement Committee (QAPIC)
- Work with the UM Manager to ensure departmental policies and procedures are updated to increase efficiency and maintain compliance with State regulations and accreditation standards.
- Ensures compliance with plan policy and standards regarding the UM process.
- Implements UM/CM collaboration initiatives.

- Collaborate with the UM Manager to ensure readiness for accreditation and regulatory surveys.

Corporate Director Appeals

The Corporate Director of Appeals reports to the Senior Vice President of Enterprise operations and is primarily responsible for directing the activities of the Appeal teams ensuring compliance with regulatory standards. Additional responsibilities include:

- Collaboration with the Appeals Manager to ensure the written UM Program Description is updated annually with approval ACNC's QAPIC.
- Ensures the implementation of the QAPIC recommendations and strategies as they relate to the Appeals Team
- Collaborates with Manager of Appeals in the monitoring and adherence of compliance timeliness and tracks trends out outcomes of appeal.
- Ensures Appeals Policies and Procedures are up to date.
- Ensures compliance with plan policy and standards regarding appeals processes.
- Implements UM/CM collaboration initiatives.
- Works with the Appeals manager to ensure readiness for accreditation and regulatory surveys.

Market Chief Medical Officer

The Market Chief Medical Officer (CMO) The Market Chief Medical Officer (CMO) holds the role of the designated physician in the QAPI program, chairs the QAPI Committee, and participates in or advises subcommittees that report to the QAPI Committee. The CMO has a shared responsibility for the utilization management program with the Senior Vice President, Associate Medical Officer. The CMO must be a licensed, board-certified physician in the State with an unrestricted license to practice medicine. The CMO's responsibilities include the following:

- Provides market-based clinical leadership and execution of all care affordability and clinical quality initiatives.
- Oversees the proper provisions of covered services to members and the grievance systems.
- Actively involved in all major, clinical, utilization, and quality management decisions of the health plan.
- Developing, implementing, and interpreting medical policies and procedures. These duties may include, but are not limited to; service authorizations, claims review, discharge planning, credentialing, referral management, and culturally competent care.
- Identifying and implementing evidence-based practice guidelines throughout the provider network
- Overseeing the quality of clinical care for network and non-network providers.
- Engaging the Plans provider network in continuous quality improvement through the diffusion of practice standards and through an internal quality assurance program that measures the network provider's performance against standards of high quality, especially the performance standards embodied in the HEDIS® program.
- Overseeing, reviewing, and resolving disputes related to the quality of care.

- Assisting with recruitment and oversight of an adequate, high-quality provider network
- Ensuring culturally competent care and access for individuals who have limited English proficiency and/or require accommodations.
- Communicates with participating providers during the care and utilization management process in both outpatient and inpatient settings.
- Formally communicates with practitioners through the provider newsletter, integrating input from the health plan's operational areas and the QAPI Committee.
- Educates participating physicians about the health plan's managed care philosophy while functioning as the medical liaison between the physician network and the administration.
- Intervenes and negotiates with attending and consulting physicians on questionable medical necessity, treatment, quality issues, and discharge planning.

Utilization Management Manager

The Utilization Management Manager reports to the Corporate Director of Utilization Management Operations and is primarily responsible for directing the activities of the Utilization Management Department and ensuring compliance with regulatory standards. Additional responsibilities of the UM Manager include the following:

- Preparing the annual UM Program Evaluation and updating the Program Description
- Planning, organizing, and directing the UM staff in departmental education, training, and procedures as they relate to Utilization Management program components.
- Ensuring implementation of QAPI recommendations and strategies as they relate to the UM department.
- Continuing to review and update departmental policies and procedures to increase efficiency and maintain compliance with applicable federal and state laws and regulations, other regulatory requirements, and accreditation standards.
- Ensuring compliance with ACNC policies and standards regarding UM processes
- Implementing UM/CM collaboration initiatives
- In conjunction with the UM Supervisors, provide direct supervision of UM staff to ensure adherence to departmental policies and procedures.

Utilization Management Supervisor

Utilization Management Supervisor reports to the Utilization Management Manager and is responsible for facilitating and supervising the daily activities of the UM team, including oversight of physical and behavioral health.

Licensed and non-licensed professionals. Additional responsibilities include:

- Assist UM Manager with data collection related to quality audits and plan goals.
- Identifies barriers to reaching identified plan goals.
- Assists the UM Manager with departmental policy revisions and the distribution and implementation of new or revised policies and procedures to staff.
- Assists and participates in staff education and training
- Provides day-to- day supervision of assigned UM staff
- Supervises staff in problem-solving case issues.

- Monitors for consistent application of UM criteria at each level and type of UM decisions
- Monitors staff documentation for adequacy and completeness
- Monitors service metrics and turnaround times for compliance with contract and regulatory standards.
- Reviews the quarterly staff audit results which are conducted by the corporate auditing team, preforms necessary follow-up/feedback of clinical and non-clinical staff.
- Available to UM staff onsite and telephonically

Utilization Management Staff

Utilization Management staff report to and are overseen by the Utilization Management Supervisors. Utilization staff includes licensed clinical and non-clinical staff such as Registered Nurses, BH clinicians, utilization management technicians, clinical appeal reviewers, and appeal coordinators. Licensed physicians oversee UM decisions to ensure consistent medical decision-making.

- Intake Specialist may have medical or call center background. They support the physical health and behavioral health clinician by gathering information needed to process requests for physical and behavioral health outpatient treatment, diagnostic procedures, and inpatient physical and behavioral health authorizations that require medical necessity review. The intake specialist does not apply medical necessity criteria.
- UM clinicians may be registered nurses, licensed clinical social workers, licensed social workers, licensed marriage and family therapists, certified addictions counselors, and/or licensed professional counselors.
- Appeal Coordinators have intake specialist background or claims experience. Appeals coordinators research appeal request and process member and provider appeal with a clinical component. The coordinators forward the dispute or member appeal to the appropriate clinical reviewer for completion.

Utilization Management staff responsibilities include:

- Reviewing and applying medical necessity criteria for specified physical and behavioral health outpatient procedures, elective and emergent inpatient admission.
- Facilitating planning and delivery of services upon discharge.
- Referring cases not meeting established criteria to the ACNC Medical Director/BH Medical Director or designee for review
- Completing case reviews within timeliness standards set forth by ACNC and appropriate regulatory agencies.
- Referring members to Integrated Health Care Management/LTSS programs as appropriate.
- Preparing, and reviewing appeal cases and associated reports.
- Identifying and referring potential quality of care issues for review.
- Identifying and referring suspected fraud and abuse cases for investigation.

Appeal Manager

The Appeals Manager reports to the Corporate Director of Appeals and is responsible for managing the activities of the UM Appeals and Provider Appeal teams, ensuring compliance with contractual and regulatory compliance. Additional responsibilities include:

- Monitors compliance, adherence, and timeliness and tracks and trends reasons and outcomes related to the resolution of appeals.

- Ensures compliance with state and departmental policies and procedures.
- Assist with implementing Quality Assessment Performance Improvement Committee (QAPIC), Improvement, Quality of Service Committee (QSC), NCQA, and state standards and recommendations.
- Serves as the liaison with the State regarding State Fair Hearings
- Performs root cause analysis to examine, determine, and provide recommendations related to challenges associated with organizational and departmental process.
- Maintains open communication and collaboration with other departments to identify initiatives and areas of improvement.

Table A: UM Staff Roles and Responsibilities

Component	Performed By	Expected Outcome
Intake	Intake Specialist (non-clinical	Data collection and entry of emergent inpatient admissions, received via call or fax. Data entry and triage of DME and Prior Authorization faxes to the appropriate designated staff (RN, MD, DME, Specialist).
Prior Authorization	Registered Nurse	Assessment of elective inpatient as well as outpatient services; (such as skilled nursing, physical therapy, etc.) based on appropriate clinical guidelines; or referral to Medical Director for review and determination.
Concurrent Review	Registered Nurse	Assessment of medical necessity of inpatient stays to include observation (hospital or skilled nursing facility/rehabilitation facility) based on medical criteria, or referral to Medical Director for review and determination
Appeals	Appeal Coordinator (non-clinical under the supervision of a registered nurse)	Assess and facilitate all member and provider appeals
Appeals Nurse	Registered Nurse	Assess and facilitate provider appeals for claim denials and member appeals for medical necessity determinations based on appropriate medical necessity criteria or referral to Medical Director for review.
Behavioral Health Review	Registered Nurse with psychiatric/substance use disorder experience, licensed clinical social workers, licensed social workers, licensed marriage and family therapist, certified addictions counselor or licensed professional counselor	Assessment of medical necessity of inpatient stays to include observation as well as BH outpatient services; based on appropriate clinical guidelines; or referral to Medical Director for review and determination.

Medical Necessity Decision Making

Within Utilization Management, the role of each staff member is clearly defined and operationalized to ensure all aspects of the UM process exemplify care coordination efforts for quality administration of health care benefits, in accordance with the most restrictive applicable guidelines North Carolina requirements, state and federal laws and regulations, and accreditation guidelines.

Utilization management staff involved in medical management review determinations has the knowledge and skills to evaluate clinical information used to support medical management decisions. Job descriptions are written to outline the qualifications responsible for each level of medical management decision-making. Documentation of current licenses for nurses, physicians, and behavioral health professionals, is maintained in the individual's personnel or credentials file.

Current licensed nurse reviewers and behavioral health clinicians, whose education and experience meet the job qualifications, perform the initial review of the clinical information against criteria. Requests for benefit coverage or medical necessity determinations are made through staff supervised by a Registered Nurse or Masters Level Licensed Behavioral Health Clinician. Decisions to approve coverage for care may be made by utilization management staff when listed within ACNC written guidelines. Certain services may be authorized by clinical (licensed nurse or licensed behavioral health clinician) or non-clinical staff if the request is supported by Plan approved review criteria.

The Medical Director/Behavioral Health Director are supported by other licensed physicians, behavioral health clinicians, and healthcare professionals. Qualifications for practitioners who review requests for care based on medical necessity include education, training, or professional experience in medical or clinical practice and current U.S. license to practice without restriction. Together they provide clinical review of medical information and/or peer-to-peer contact with attending/treating physicians and/or other healthcare practitioners when there is conflicting medical information or there are questions on the application of medical necessity guidelines.

Only a Medical Director may issue an adverse benefit determination. Any request that is not addressed by, or does not meet, medical necessity guidelines is referred to the Medical Director/Behavioral Health Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure, or extension of stay, based on medical necessity, or to approve a service in an amount, duration, or scope that is less than requested is made by the Medical Director/Behavioral Health Medical Director under the clinical direction of the Senior Vice President, Associate Medical Officer/Corporate Behavioral Health Medical Director.

Medical necessity decisions made by the ACNC Medical/Behavioral Health Medical Director or designee are based on the North Carolina definition of Medically Necessary Services in conjunction with the member's benefits. At the discretion of the medical director or designee, participating board-certified physicians from an appropriate specialty, other qualified healthcare professionals, or the requesting practitioner/provider may provide input to the decision. If a decision requires specialized judgment, ACNC contracts with External Independent Review Organizations with sub-specialist physicians available to participate in utilization review. The ACNC Medical/ Behavioral Health Medical Director or designee makes the final decision.

In accordance with Policy UM.008NC Utilization Management Clinical Criteria

1. North Carolina Department of Health and Human Services (NCDHHS) North Carolina Medicaid

Provider Manuals

2. Change Healthcare InterQual© Adult Criteria (Condition Specific-Responder, Partial Responder, Non-responder)
3. Change Healthcare InterQual© Pediatric Criteria (Condition Specific-Responder, Partial Responder, Non-responder
4. Change Healthcare InterQual© Outpatient Rehabilitation and Chiropractic Criteria
5. Change Healthcare InterQual© Home Care Criteria
6. Change Healthcare InterQual© Procedures Criteria
7. Change Healthcare InterQual© DME Criteria
8. Change Healthcare InterQual© Criteria for Behavioral Health Adult and Geriatric Psychiatry Criteria
9. Change Healthcare InterQual© Criteria for Behavioral Health Child and Adolescent Psychiatry Criteria
10. Change Healthcare InterQual© Criteria for Behavioral Health Services
11. American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM Admission Guidelines)
12. Corporate Clinical Policies
13. Evolent Radiology Guidelines

The UM Medical/Behavioral Health Director may use the following information in the determination of medical necessity when the requested item or service is not included in the criteria listed above:

- Information from appropriate government regulatory bodies such as the FDA (Federal Drug Administration) and State Health and Human Services Department
- Published scientific evidence such as peer-reviewed professional journal articles.
- Publicly available reference information (including web/online resources such as UpToDate®)
- Information from a board-certified consultant familiar with the specialty.

ACNC uses a combination of licensed evidence-based clinical guidelines/criteria and proprietary clinical policies as the clinical basis for determinations, as outlined in Policy UM.008NC Utilization Management Clinical Criteria. ACNC criteria and clinical policies are reviewed and updated at least annually. Participating practitioners participate in the development, adoption, and review of UM clinical criteria through the Quality Assessment Performance Improvement Committee (QAPIC). At least annually, ACNC provides practitioners with an opportunity to make suggestions for UM guideline revisions.

Clinical Policies are made available to/members/practitioners/providers on the ACNC website. Members/Practitioners may request copies of guidelines used for a medical necessity determination at any time by contacting the plan.

Consistency in Criteria Application

The UM staff involved in medical necessity decisions is assessed for consistent application of review criteria a minimum of two times a year as outlined in Policy UM.708 Inter- Rater Reliability Testing. Medical Directors/behavioral health physicians or designees are assessed annually. An action plan is created and implemented for any variances among staff outside of the specified range. Clinical and nonclinical staff are audited for adherence to policies and procedures.

Delivery of UM services

UM is an interactive process designed to provide services to members to assist them in obtaining covered benefits that are medically necessary. UM staff is available by a toll-free telephone number/ TTY during ACNC business hours, Monday through Friday from 8:00 AM to 5:00 PM Eastern Standard Time. To facilitate availability seven days a week, 24 hours a day, a registered nurse, behavioral health clinicians, and medical director are available after business hours and weekends to respond to authorization requests for inpatient hospitalization.

Referrals

No referrals are required for a member to access care at participating specialists, or ancillary providers. Members are encouraged to work through their PCP for coordination of healthcare needs including the use of specialists and ancillary services. Members can seek care from participating specialists without direction from their PCP; ancillary services will require a physician's prescription/order. Female members have direct access to a participating women's health specialist for covered services to provide women's routine and preventive care.

Members may access all behavioral health services directly without contacting ACNC or their PCP for referral. ACNC has established standards to ensure timely member access to behavioral health services based on level of need. Providers will triage members and ensure they can access services within the established access standards.

On occasion, a member with special needs may be referred to an out-of-network practitioner or provider because of the qualifications of the out-of-network practitioner/provider. ACNC makes the coverage decisions on a case-by-case basis in consultation with a Plan Medical Director. ACNC will cover and pay for all care that it has been pre-authorized and provide out of its established network. The member will have no additional cost associated with pre-authorized out-of-network care than if the services were provided by an in-network provider.

Second Opinions

Members have the right to a second opinion about their care. Members may obtain a second opinion from a qualified health care professional within the network without referrals or prior authorizations. If there are no qualified health care professionals available in the network, ACNC will assist the member to obtain the second opinion from a qualified health care professional outside of the network, at no cost to the member.

Emergency Room Services and Post Stabilization Services

ACNC does not require an authorization for any emergency medical services or treatments that may be required to stabilize the identified medical condition, including transfer to another medical facility regardless of provider/practitioner plan participation status. All emergency room claims and payments are automatically paid and will not be denied regardless of diagnosis except in instances the diagnosis is a benefit exclusion (e.g., for a medical legal purpose). Emergency room claims will not pend for medical necessity review.

Prior Authorization

ACNC decision to require prior authorization for certain services is based on data, such as utilization data that identifies services that are likely to be over-utilized, costly, or that may potentially signal conditions that might require extensive clinical or care management interventions. ACNC performs non-urgent and urgent prior (pre-service) authorization reviews for select health services to determine medical necessity and eligibility for coverage under the member's benefit package. At certain times, when information is not available to make a prior or concurrent determination and services have already been provided, member records are reviewed retrospectively to determine benefit coverage and/or medical necessity.

The information collected for the authorization process includes, but is not limited to the member's name, ID number, and date of birth; the Practitioner's name; the planned date of service; plan of care, clinical information related to the initial service and any continued service, the dates of the planned procedure (if applicable); and clinical information to support the need for the service or admission. ACNC's process is not burdensome for the member, practitioner, or health delivery organization's staff.

Authorization requests may be submitted by the practitioner, provider and,/or member. ACNC will intervene on behalf of the member to collect and process the clinical information needed for the authorization process if the member is requesting a service that the Practitioner/Provider has not requested timely or is refusing to request. ACNC may request the member to see another provider to facilitate the clinical evaluation necessary to process the service request.

Utilization staff may approve services based on the application of ACNC criteria. ACNC will not arbitrarily deny or reduce the amount, duration, or scope of a required service because of the diagnosis, type of illness, or condition of the member. Determinations are made and communicated in accordance with Policy UM.010 Decision Response Time. Both telephonic and written communications contain the process for appealing any adverse determination that is prospectively made.

ACNC will not deny, terminate, reduce, or suspend reimbursement for a covered service provided to an eligible member by a provider who relied on written or oral authorization from ACNC or an agent of ACNC unless there was material misrepresentation or fraud in obtaining the authorization. , In instances of probable fraud, ACNC will provide written notice of a termination, suspension, or reduction of service to the member/practitioner within 5 days before the date of the action.

Concurrent Review

ACNC concurrent review of inpatient hospitalizations, to include observation requests to assess the inpatient stay based on clinical information related to the member's care, evaluate appropriate utilization of inpatient services, and promote delivery of quality care on a timely basis. In addition, concurrent review provides information to facilitate the discharge plan and allows for peer consultation between the attending physician and a plan's Medical Director as needed. Concurrent review also identifies and facilitates transition to alternate levels of care when appropriate.

Retrospective Review

At certain times, when information is not available to make a prior or concurrent determination and services have already been provided, member records are reviewed retrospectively to determine benefit coverage and/or medical necessity. In these instances, the record is reviewed, and a decision is reached within 30 calendar days of receiving the necessary information. In the case of an adverse determination, the attending or treating health care professional, institutional provider and/or member are notified of the decision and the reason for the decision.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Related Request

ACNC covers services, products, or procedures for an ACNC member less than 21 years of age if medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. ACNC covers EPSDT services in amount, scope, and duration no less than for the same services under Fee-for-Service. EPSDT policies shall not make an adverse benefit determination on a service request for a child until the request is reviewed per EPSDT criteria.

ACNC covers medically necessary services within the categories of mandatory and optional services, regardless of whether such services are covered under the ACNC Medicaid State Plan and shall refer to and arrange any services not included within the scope of the contract. While an EPSDT request is under review, ACNC may suggest alternative services that may be better suited to meet the child's needs, engage in clinical or educational discussions with the member or providers, or engage in informal attempts to resolve member concerns. ACNC provides referral assistance for non-medical treatment not covered by the ACNC but found to be needed because of conditions disclosed during screenings and diagnosis.

Transition of Care/Discharge Planning

ACNC clinicians and licensed BH clinicians work collaboratively with the Care Managers from Integrated Health Care Management, and LTSS care management to provide appropriate access to non- hospital-based health care. From the point of admission, the concurrent review nurses and behavioral health clinicians work collaboratively with the facility staff by performing care coordination to provide appropriate access to non-facility-based health care. The UM clinicians work with the facility discharge planners to review and update the discharge plan, and proactively plan for the discharge, including coordination of Skilled Nursing Facility, and Rehabilitation Hospital care and authorization of step-down services and discharge medications. Integrated Health Care Management/ LTSS Case Management Team provides support to the member post-discharge in actively participating in post-discharge care services. Collaboration between the UM and BH MCO

occurs through the contacts within the Integrated Health Care Management team. Notifications are made to the behavioral health entities for coordination of discharge and follow-up after discharge.

ACNC provides real-time support to difficult discharge planning issues, with the goals of reducing the length of stay and improving member outcomes. The clinicians work closely with the plan medical directors and care managers to address the needs of the member and bridge gaps in care. For mental health inpatient admissions, the UM clinicians work to ensure that an appointment with a mental health provider is scheduled by the hospital to occur within seven (7) calendar days from discharge.

ACNC UM team meets weekly with representatives from Care Coordination, LTSS team, Provider Network Management, Behavioral Health, and a Medical Director to discuss and assist with difficult discharge planning and/or issues for our members.

Determinations to Deny Coverage

Prior to any determination to deny coverage or authorization for health care services, it is the policy of ACNC to make reasonable efforts to contact the requesting provider to bridge any gap in information, clarify medical needs, and reach agreement on a plan of care that will meet the member's needs.

At the time of the notification of a determination to deny or limit coverage or authorization, the healthcare practitioner/provider is informed verbally or via fax of the availability to discuss the determination with the ACNC Medical Director and/or Designee who made the determination to deny or limit coverage.

The member and requesting health care practitioner/provider will receive a written notice of any decision to limit or deny coverage or authorization that contains the reason for the decision, the right to a peer-to-peer discussion, and the process to appeal the decision, in accordance with Policy *UM.017 Notice of Adverse Benefit Determinations*.

Table B: UM/Appeal Decision Notification Timeframes for Behavioral/Physical Health Services

Review Type	Notification Timeframe	Extension Timeframe
Urgent/ Concurrent	Based on the member's need but no more than 72 hours of receipt of the request	ACNC may extend the timeframe once, by up to 14 calendar days, under the following conditions • The member requests the extension, or • ACNC needs additional information, provided it documents that it made at least one attempt to obtain the information. • ACNC notified the member/authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension

Preservice Urgent	Based on the member's need but no more than 72 hours of receipt of the request	ACNC may extend the timeframe once, by up to 14 calendar days, under the following conditions. • The member requests the extension, or • ACNC needs additional information, provided it documents that it made at least one attempt to obtain the information; and justifies the request to the State upon request that it is in the best interest of the member but no later than the date the extension expires. • ACNC notified the member/authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension
Preservice Non-urgent	Based on the member's need but no more than 14 calendar days of receipt of the request	ACNC may extend the timeframe once, but up to 14 calendar days under the following conditions: • The member requests the extension, or • ACNC needs additional information, provided it documents that it made at least one attempt to obtain the information; and justifies the request to the State upon request that it is in the best interest of the member but no later than the date the extension expires. • ACNC notified the member/authorized representative of its decision as expeditiously as the member's heath condition requires, but no later than the expiration of the extension
Post Service	Based on the member's need but no more 30 calendar days of the receipt of the request	N/A
Pre-service and Post Service Appeals	30 calendar days of receipt of the request	ACNC may allow a 14-day extension if the member requests the extension or if ACNC demonstrates that more information is needed, and the delay is in the member's best interest.
Expedited Appeals	72 hours from receipt of the request	14 calendar days (if requested by member or Provider/practitioner; or if ACNC justifies (to the State upon request) that it is in the best interest of the member.

Member Appeals

ACNC appeal policies and procedures are based on the requirements established in the Balanced Budget Act, State and CMS regulations and requirements. The ACNC Member Handbook, Provider Manual, and policies and procedures describe how a member, practitioner, or provider acting on the member's behalf who is dissatisfied with an adverse benefit determination can file an appeal.

Members are provided information about the grievance, appeal, and State Fair Hearing process in the member handbook and in the adverse benefit determination letters that are issued in conjunction with the utilization review process. Changes in the appeals process are published in member and provider newsletters or applicable documents.

Provider Services department gives each practitioner, information about the member appeal and State Fair Hearing process at the time they enter a contract with ACNC as well as through a variety of other sources, including the provider manual, provider newsletters, and the Plan website.

The Member or Member's representative may file or request an Appeal within 60 calendar days of the Notice of Adverse Benefit Determination. ACNC will resolve standard appeals as expeditiously as the Member's health conditions require but no more than 30 calendar days of receipt. For expedited appeal requests ACNC will resolve standard appeals as expeditiously as the Member's health conditions require but no more than within 72 hours from receipt of the request. When an appeal is overturned, ACNC will provide authorization for the services within 72 hours. ACNC may extend a decision on an appeal or expedited appeal for up to 14 calendar days if needed.

The appeals coordinator completes a full investigation of the appeal's substance, including any aspect of clinical care and actions taken. The member is given the opportunity to submit written comments, documents, or other information related to the appeal. Members are given reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request. Authorized representatives, including an attorney, are permitted to act on a member's behalf with written member consent. The appeal process and notices are provided to members in a culturally and linguistically appropriate manner. Members may request continued coverage pending the outcome of the appeal, however, if an appeal decision is adverse to the member, the plan may seek reimbursement for services provided during the appeal.

All appeals of medical necessity decisions require a review from a same-or-similar specialist. A Medical Director who was not involved in the initial determination and who is not a subordinate of any person involved in the initial determination will render the determination.

The appeal decision will be communicated to the member in easy-to-understand language. The written communication will contain the credentials, title, qualifications, and specialty of each reviewer who participated in the appeal. For appeals not resolved in favor of the member, the written notice shall include the right to file a State Fair Hearing, including the procedures to do so, and the right to request to receive benefits while the hearing is pending, including the instructions on how to make the request. The written notice shall also include notice that the member may be held liable for the cost of those benefits if the hearing upholds the plan's action.

Member request for appeals is documented in the UM authorization system for tracking and treading. Member appeals are tracked, trended, and reviewed by the Quality Assessment Performance Improvement Committee.

Quality Assessment Performance Improvement Committee

The Quality Assessment Performance Improvement Committee (QAPIC) provides monitoring, oversight, and direction for the UM Program. Committee responsibilities related to the UM Program include:

- Reviewing and approving Medical Necessity Criteria and clinical and preventive practice guidelines used by ACNC.
- Monitoring and evaluating utilization of health services (including over- and under-utilization and outliers) and the effectiveness of utilization management activities
- Monitoring and reviewing provider performance regarding quality and utilization outcomes and application of clinical practice guidelines
- Reviewing and approving program policies and procedures related to the UM process.
- Monitoring and evaluating performance related to appeals processing and service indicators.
- Reviewing results of program clinical outcome collection, clinical practice guideline adherence, medical record review outcomes, and utilization results to identify opportunities for improvement and oversight of related improvement plans.
- Monitoring and evaluating consistent application of Medical Necessity Criteria and oversight of related improvement plans
- Reviewing results of member and provider satisfaction and appeal data to identify opportunities for improvement.
- Reviewing and approving the UM Program Description, UM Program Evaluation, and UM Policies and Procedures
- Monitoring performance of program delegates and vendors and recommending interventions, as appropriate

Quality Improvement

The UM program is one component of ACNC's quality infrastructure and set of business processes that allow the achievement of high-quality outcomes and service and is an integral part of the way ACNC does business. In addition to providing an interface to the ACNC Quality Management program, the UM program employs systemic monitoring and evaluation of utilization management processes and services against objective criteria and tools. Utilization Management activities are monitored at the individual, team, and program levels.

Data on member and provider satisfaction with the utilization management processes, including the grievance and appeal process, are collected through the Quality Management program activities, and are used to leverage opportunities for improvement. Additional data used to measure quality monitoring includes, but is not limited to: Average speed of answer, call volume, call abandonment rate, inter-rater reliability review outcomes, and functional process audit results, including:

- Intake/Triage
- Prior Authorization
- Concurrent Review
- Discharge Planning
- Medical Review
- Provider Grievances and Appeals
- Member Grievances and Appeals
- Decision Timeliness

Action plans are developed to address identified variances. Performance and action plan results are communicated to staff via individual sessions, team meetings, and department communications and reported to the QAPIC.

The UM Program additionally serves as a window into the quality of care and services received by the individual member and the population. Data collected through the performance of UM activities is used in the following manner:

- Referral of potential quality-of-care issues on an individual member basis
- Identification of access issues and gaps in health care service availability
- Aggregation of data related to provider practice patterns.
- Identification of areas for medical policy development and/or revision
- Identification of opportunities to improve processes to enhance provider and member experience with utilization management activities.

ACNC Quality Management staff investigates potential quality of care issues addressing access issues, gaps in health care service availability, is medical policy changes. Provider practice patterns data is reviewed by ACNC leadership and action are taken under the direction of the ACNC Quality Program. Opportunities to improve member and provider satisfaction are reviewed by the UM program medical leadership at least annually.

If ACNC staff suspect fraud or abuse, they will report to the ACNC Compliance Director, who will then investigate, and report findings as appropriate, to the North Carolina government department responsible for Program Integrity.

UM/Appeal System Controls

Securing System Data

UM system controls are implemented to protect data from being altered outside of prescribed protocols. The medical/appeal medical management system information system JIVA® generates and stores an authorization number and the effective dates of the authorization to servicing and requesting practitioners/providers, regardless of contracted status. The system stores and reports service authorization requests, authorization decisions, clinical data to support the decision, and the notification timeframes of practitioners/providers and members of decisions. Receipt and written notification dates are used to measure timeliness of services and notification to members. ACNC defines the received date of a request for service or appeal as the date the (e.g., call, fax or electronic) request for service or appeal is received by the plan. The written notification date is defined as the date the notice of adverse benefit determination letter, appeal resolution letter or electronic notification is generated/mailed.

All data entries into the medical/appeal system are date and time stamped. JIVA® possess' advanced system controls in which each data entry in the system is automatically populated with a date, timestamp, and the staff member entering the information. The date entry into the systems cannot be changed by any user regardless of title or role within the organization. Any subsequent updates are tracked with a separate date and timestamp. All history is saved within the database and is available via history logs. Dates of receipt of electronic submissions into the systems are date stamped and cannot be altered by any individual within the organization. UM/Appeal staff enter the

date of receipt of the request into the medical/appeal system. The date of request for additional information, date of determination, and date of written notification are hardcoded in the medical/appeal system as staff completes each assigned task. Staff may make addendums in the note sections of the documentation, but the original entry is maintained as a permanent part of the medical record. An event log is created within each authorization that tracks all data entry into the individual authorization as a running log of activities.

Adverse benefit determination notifications and appeal resolution letters are initiated in the JIVA® medical/appeal system. The letter dates are system autogenerated which does not allow for date modification by any individual within the organization. If a modification is needed, such as changes to verbiage, staff must deactivate the original letter. The system records the date the modification was made, staff name, and the title of who deactivated the letter. A new letter is then generated with the correct modifications, which is date stamped at the time of entry into the JIVA® system. Both the original letter and modified letters are maintained as a permanent part of the record.

In instances where an episode is entered on an incorrect member, a supervisor or manager may deactivate the episode. Only supervisors or above may deactivate an episode. However, the system stores this information as a permanent part of the record.

System Auditing

Medical/Appeal system access is granted by AmeriHealth Caritas Family of Company System Security team. The level of access is granted based on job functions and roles within the organization per policy *145-035 Access Management Policy*. Annually, the Manager of the Department reviews and approves continued system access and level of access based on job roles. System security includes but is not limited to password protection per policy 145-025 *Password Management Policy*, required password updates, preventing unauthorized access or changes to the medical/appeal system per policies *145-042 Logging and Monitoring Policy* and *145-062 Configuration Management Policy*. When an individual leaves the organization or job functions change in which access is no longer necessary, IT security is notified to remove access.

Clinical Auditing

Utilization Management/Appeal Audits are completed by the Enterprise Corporate Audit team. All staff including medical directors who document within the medical/appeal system are audited. A random selection of two (2) cases per month are audited. The audit results are posted to the Auditing SharePoint site monthly. The director, manager, or designee is responsible for sharing and reviewing audit results with their reporting associates. The passing average score threshold is 90% as per policy UM 708 Inter-rater Reliability Testing for Utilization Management staff and Medical Directors.

The clinical audit is designed to mirror the NCQA requirements for documentation, which includes but is not limited to:

- Validation of the receipt date of the request matches the fax/mail received into the UM system.
- Validation of an extension request if applicable
- Validation of receipt date of additional information received into the UM system.

- Timeliness of UM decisions and notification
- Validation of written/verbal/electronic notification dates
- Validation of written notification containing the necessary factors in accordance with NCQA requirements for UM 6-7C

Staff members' audits are measured by the accuracy of documentation and actions completed. This is based upon required information pertaining to authorization requests, including receipt dates, diagnosis of the ICD-10 code and other current applicable codes, member information, names and contact information of primary care provider/ treating practitioner and any other involved providers/practitioners, the reason for the request, clinical information applicable to the request and any information that supports the decision for medical necessity. The medical director is responsible for documenting the rationale for authorization determinations pertaining to all medical necessity reviews, criteria used to render the determination, if applicable, and cases sent for secondary review.

Over and Underutilization

ACNC utilizes multiple data sources to conduct ongoing analysis and evaluation of utilization patterns to detect potential under or over-utilization practices that may warrant further investigation and intervention, as outlined in Policy UM.908NC Over and Underutilization of Services. A multitude of data collection methods are commissioned to provide greater insights into assessing potential areas of care gaps, access issues, network inadequacies, deviance from clinical practice guidelines, and other opportunities for intervention to control utilization. Upon identification of variance from the established thresholds, a thorough assessment is conducted to include drilling down to systematically evaluate the data specific to medical groups and individual practices. These efforts focus on identifying the root cause and corrective action. Subsequently, ongoing monitoring of data will continue to ensure sustained correction of the problem that led to the service over/underutilization.

Delegated Activities

All delegation arrangements are governed by agreements that outline the scope of activities, performance expectations, reporting responsibilities, and consequences for failure to meet the contract requirements. Reports from delegated entities are routinely reviewed by management and appropriate committees within ACNC's quality structure and more frequently as needed. ACNC may investigate/audit delegate performance at any time. Results of annual oversight audit and any additional investigations/audits are presented to the QAPIC, which approves the ongoing delegation arrangements for these entities.

- Evolent Radiology (Radiology Benefit Manager)
- Perform RX(Pharmacy Benefits)

Evolent and Perform RX reports its performance metrics quarterly to the ACNC Quality Committee and submits a yearly program evaluation and program description for approval.

Prohibition of Incentives

The ACNC professional staff does not receive incentives directly or indirectly related to utilization management determinations. Professional knowledge, the appropriate application of standardized resource information, adherence to regulatory and credentialing standards, and following plan policies and procedures are the requirements and accountability of the professional staff. Staff not adhering to these requirements may be placed on a performance improvement plan and/or a formal disciplinary action may be issued. All ACNC employees are required to adhere to the Code of Ethics and Conduct. The Code of Ethics and Conduct is distributed and reviewed with staff upon hire and annually thereafter.

Confidentiality

The Utilization Management process deals with sensitive member and provider information. Documents created and reviewed as a part of the Utilization Management process are confidential and are maintained in compliance with appropriate federal and state laws, regulations, and other regulatory requirements.

All employees, participating providers, and consultants must maintain confidentiality standards required by the Code of Ethics and Conduct regarding both patient information and proprietary information. All employees are required to sign a Confidentiality Statement as a condition of their employment.

Operational Responsibilities of the UM Program

Operational responsibility for the development, implementation, monitoring, and evaluation of the UM Program is the responsibility of the Chief Medical Officer a Physician licensed physician in the North Carolina, under the direction of the VP, Medical Affairs. Operational responsibility for the development, implementation, monitoring, and evaluation of the behavioral aspects of the UM program is the responsibility of the Behavioral Health Medical Director, a Physician licensed in North Carolina. The ACNC UM Manager and Supervisors have responsibility for the managerial oversight of the UM Program and for ensuring that the basic components of utilization management are established and effectively operating.

Evaluation and Annual Updates

The UM Program is reviewed, evaluated, and updated annually by the Chief Medical Officer, ACNC Behavioral Health Medical Officer, Corporate Director of UM Operations, and ACNC Utilization Manager. The updated Program is then presented to the QAPIC for approval. Recommendations are made to improve the effectiveness of the Program and the Program's ability to reach established goals and objectives.

Approval of the UM Program

Disposition	Committee	Date
Approved	Quality Assurance Improvement Committee	3.20.2024

Lenaye Lawyer MD
Vice President Medical Affairs
March 29, 2024

Diego Martinez
Market Chief Medical Officer
March 26, 2024

Akintayo Akinlawon
Corporate Behavior Health Medical Director
March 29, 2024

Drucinda G. Bell RN, CMCN, BSHA
Corporate Director Utilization Management Operations
March 26, 2024