C.10. Utilization Management

a. Describe strategies the Vendor will implement to identify and reduce inappropriate utilization of services, including emergency departments. Address the following at a minimum:

   i. Proposed approach to using data to inform the Vendor's efforts to improve appropriate use of service and cost efficiencies, as well as to identify potential Fraud and Abuse referrals.

   ii. Overview of the Vendor's methods for monitoring appropriate health care utilization, including two examples of identified negative trends, initiatives undertaken to improve them, and the results of these initiatives.

   iii. Frequency in which the Vendor proposes to re-evaluate its approaches to identify need for adjustments (e.g., re-evaluation of existing prior authorization requirement for appropriateness)?

b. Describe the Vendor's proposed Utilization Management (UM) Program, assuring that it addresses requirements of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices." In the description, include information about the following, at a minimum:

   i. Approach to align the UM Program with the Department's required clinical coverage policies.

   ii. Proposed evidence-based decision support tool(s).

   iii. Innovations and automation the Vendor will implement, for example, to reduce provider administrative burden under the UM Program.

   iv. Methods and approach to balance timely access to care for Enrollees with the administration of the UM Program.

   v. Approach to integrate medical and behavioral health services in the UM program.

   vi. Approach to ensure UM Program is compliant with mental health parity.

   vii. Approach to ensuring accountability for developing, implementing, and monitoring compliance with Utilization policies and procedures and consistent application of criteria by individual clinical reviewers.

   viii. Processes and resources used to develop and regularly review Utilization Review (UR) criteria.

   ix. Prior Authorization processes for Members requiring services from non-participating providers or expedited Prior Authorization, including methods for assuring services are not arbitrarily or inappropriately denied or reduced in amount, duration, or scope.

   x. How the Vendor will use its Utilization Management Committee to support Utilization Management activities.

Passport Highlights: Utilization Management

How We're Different	Why It Matters	Proof
Our UM program earned the highest level of National Committee for Quality Assurance (NCQA) accreditation based on our exceptional standards of quality and care.	• Demonstrates that Passport has stringent review processes in place to ensure safe and high-quality care	• 2019 NCQA surveyors found **no issues** in their most recent UM accreditation survey of our program
We have long-standing and established relationships with Kentucky providers.	• Our UM nurses and physicians engage with our network based on long, trusting relationships • Helps enable appropriate use of services—right service, right time, right place • Timely access to service approvals and care	In 2019, we showed: • 71% of providers reported loyalty to Passport • A 96% voluntary retention rate for our providers
Evidence-based provider-oriented UM is supported by Identifi℠, our medical management technology platform.	• High provider satisfaction; optimum engagement • Minimal delay for members to receive care • Real-time authorization requests fulfilled	• Passport exceeds Department for Medicaid Services (DMS) requirements to expedite timely access to care
We have demonstrated ability to reduce inappropriate emergency department (ED) use in the Medicaid population in Kentucky through innovative population health care management programs and value-based payment (VBP) framework.	• Appropriate use of place of service • Enhanced integration of behavioral health (BH) pre-ED use • Improved access to health services to avoid necessity of an ED visit • Engaged providers to reduce ambulatory care sensitive condition (ACSC) ED use through VBP	• 27% reduction in ED visits among members with serious mental illness (SMI) in the Partners in Wellness program • 35% reduction in ED visits for members enrolled in Complex Care programs • 43% reduction in ED visits with HealthPlus VBP providers

Introduction

As a Kentucky-based provider-directed plan, Passport Health Plan (Passport) has unique access to its providers, who provide input and guidance on its medical and UM policies. Our Partnership Council and its subcommittees, including our Quality Improvement Committee (QIC), Behavioral Health Advisory Committee (BHAC), UM Committee (UMC), and our primary care provider (PCP) work group, include representation from our Kentucky participating providers. Passport's UM program safeguards its members against unnecessary and inappropriate medical care. The program allows us to review member care from perspectives of medical necessity, quality of care, appropriateness of decision-making, place of service and length of hospital stay.

These programs assist in ensuring services are available in a timely manner, provided in the appropriate settings, and planned, individualized and evaluated for effectiveness.

Passport Delivers Excellence in Utilization Management

Passport is NCQA Health Plan accredited and, with its NCQA UM accredited partner and delegate Evolent Health, provides a full range of UM services, including prior authorization, concurrent review and retrospective review, designed to ensure members' needs are addressed holistically through application of evidence-based medical necessity, state-specific criteria and a review of members' assessed needs, resources and living situation.

The Passport UM program is designed to promote delivery of high quality, medically necessary and cost-effective health care on behalf of its clients and their members. The program is under the administrative and clinical direction of the chief medical officer (CMO).

Our CMO works closely with our Partnership Council, and its committee structure, to ensure members have access to high quality services, including the UM program. Passport retains full accountability for medical policy but delegates the processing of UM transactions to specialist organizations with nationally recognized expertise. To ensure a holistic approach to UM, and compliance with requirements, Passport oversees each delegate through a comprehensive delegation oversight process.

C.10.a. Describe strategies the Vendor will implement to identify and reduce inappropriate utilization of services, including emergency departments. Address the following at a minimum:

Our Strategies to Identify and Reduce Inappropriate Use of Services

Passport's UM program establishes continuum-of-care principles that integrate an appropriate range of services, including medical, BH and pharmaceutical, to meet members' needs while maintaining flexibility in modifying services.

Passport's Utilization Management Program Effectiveness

The goal of the UM program is to maintain the quality and efficiency of health care delivery by caring for members at the appropriate level of care, by coordinating health care benefits, ensuring the least costly but most effective treatment benefit and ensuring medical necessity. Our strategies for reducing inappropriate utilization of services, including inappropriate use of the ED, are described below.

Inpatient Reviews

UM clinicians review medical service requests for medical necessity. Passport's medical director conducts care rounds three times a week and reviews inpatient stays that fail to meet InterQual® criteria or long lengths of stay.

We focus all inpatient reviews—acute care, rehab, long-term acute care (LTAC), neonatal intensive care unit (NICU) and intensive care unit (ICU) level of care—on ensuring appropriateness of service and setting. We also evaluate whether the member needs ongoing inpatient care or can be transitioned to a subacute setting or home.

Outpatient Reviews

Our outpatient review program focuses on high-cost and high-utilization services. We ensure that the outpatient service is medically necessary and appropriate in frequency and duration.

Specialty Care

Passport has tools to simplify UM for our members who require oncology and cardiology care and the providers who care for them. We streamline workflows for instant treatment authorization and provide point-of-care decision guidance that incorporates appropriate use criteria and incentives. We structure episodic UM around critical events, such as tumor progression, complications of therapy or new diagnostic findings. We collaborate with the physician at the beginning of each critical episode of care and authorize the clinical plan in a multimodality "SuperAuth."

Pharmacy Utilization Management

Passport's multifaceted Drug Utilization Review (DUR) program ensures that prescriptions are appropriate, medically necessary and unlikely to result in adverse health outcomes. Through prospective and retrospective DUR, our programs provide the control necessary to achieve optimal UM and enhanced financial control. Passport's DUR program supports appropriate prescribing practices by:

- Promoting member safety, including reviews for mental health/substance use and narcotic drugs
- Ensuring adherence to approved treatment protocols
- Proactively addressing medication interactions
- Verifying plan design compliance
- Managing expenses by shifting utilization to more cost-effective, clinically appropriate drugs

Reducing Inappropriate Emergency Department Utilization

Passport takes a multifaceted approach to positively influencing where its members seek care. Not all ED care is inappropriate or avoidable, but many ED visits are. Our comprehensive approach includes member education, effective care management for high ED utilizers and members with co-occurring medical and BH concerns, provider incentives through our VBP programs, and performance improvement projects overseen by our Quality Medical Management Committee (QMMC).

Physical and Behavioral Health Integration Strategies and Results

To support our commitment to truly integrated care, our UM and BH care managers work together to provide the UM review and assist in transitions of care from one level to another. We hold weekly care rounds within the BH team with a physician reviewer. While informal collaboration happens between the medical reviewers and specialized BH reviewers daily, collaborative care rounds with the medical care management team and BH care management team occurs biweekly to address the needs of members with complex needs.

Care Management for High Utilizers

Members with complex medical conditions or multiple comorbidities may need an extra hand in coordinating all their health care needs. Engaging with a care management program may help members avoid ED visits or hospitalizations that result from not understanding how to follow their treatment regimen or respond to symptoms of chronic or complex conditions. Care Advisors and health educators collaborate with all providers involved in the members' care to create a consolidated, individualized care plan and to be sure the members or caregivers fully understand their condition(s) and their care plan.

Care management programs use a multidisciplinary care team, led by the member's PCP and Care Advisor or health educator, to coordinate care for members. The member-centric, team-based model focuses on optimizing the health of the member by using the skills of the PCP, Care Advisor or health educator, registered dietitian, licensed social worker, community health worker and pharmacist to develop and implement personalized care plans that will help the member effectively use the health care services and achieve a better quality of health and life.

Quality Management and Performance Improvement Projects

As part of our collaborative ACSCs Performance Improvement Project (PIP), we identify barriers to members seeking preventive and primary care related to Social Determinants of Health (SDoH). We aim to reduce potentially preventable hospitalization and ED visits for ACSC through targeted provider and member interventions as well as internal process improvement. Program interventions include:

- Expansion of our Complex Care Management program for high-risk members, focusing on care coordination, self-management and multidisciplinary care plans to improve Passport member ACSC-related ED and hospitalization visits
- Enhancement and expansion of monthly interdisciplinary care conferences with high-volume

providers with focus on high risk members to reduce preventable hospitalizations and ED Visits

- Education and intervention tactics will include member education to drive members to alternative sites of services such as our 24-hour Nurse line or urgent care

HealthPlus Value-Based Payment and Primary Care Provider Incentive Programs

In 2018, we designed our primary care VBP program for seven multisite practices covering nearly 120,000 health plan lives (37% of total members) across 2,100 contracted PCPs (61% of total PCPs).

One of the key metrics measured in this domain is the ACSC ED rate. We compare providers on this metric and provide VBPs based upon their success. In 2020, we will incorporate population health management support.

Emergency Department Lock-In Program:

Passport's goal of ensuring members receive the appropriate level of care by coordinating health care benefits, ensuring that services are rendered in a timely manner and provided in appropriate settings, and that services are planned, individualized and evaluated for quality and effectiveness is further supported by its participation in the DMS ED Lock-In program initiative.

2019 Lock-In Program Statistics

- 1,100 members were enrolled
- 1,400 letters of concern sent
- 85 referrals to Mommy Steps maternity program
- 255 referrals made to BH services

We developed the program in accordance with 907KAR 1:67 to address the rising utilization of the ED for nonemergency diagnoses. Our approach includes engaging primary care and ED providers in the program. With the overarching goal to reduce inappropriate use of health care services, the program connects members with care managers who can solve for the root cause and provide education about how best to meet their health care needs.

Under the ED Lock-In program, a member's claims history and diagnoses are reviewed for possible overutilization. A member is placed in the ED Lock-In program when, in two consecutive six-month periods, the member has had four hospital ED visits for a condition that was not an emergency medical condition or has received services from at least three different hospital EDs for a condition that was not an emergency medical condition.

We send a letter of concern to members regarding their utilization of the ED and reach out by phone to coordinate with other services prior to entering the member into the Lock-In program. When members do enter the program, they are locked into a designated hospital for nonemergency services. We send notices alerting all designated providers (i.e., PCPs, hospitals) of the member's lock-in status.

Improving Access and Emphasizing Primary Care to Reduce ED Visits

Passport's philosophy has long recognized that the medical home model of having one provider who knows the member's history, medical conditions and medication history is an integral piece of quality, cost-effective medical care. We encourage members who may be unable to receive care from their PCP to seek

care at urgent care centers rather than the ED. We track when members receive care from these locations and coordinate follow-up care with the member's PCP to promote coordination of care through the following mechanisms:

- **Nurse Advice Line:** Passport educates its members on the importance of calling their PCP for medical questions and in using the 24-hour nurse advice line for additional questions regarding medical conditions or care. We educate members on what a true emergency is and when it is appropriate to seek care in the ED.
- **Network Adequacy:** Passport continually reviews its network adequacy and looks for opportunities to recruit new PCPs into its network. We also use the information gained during reviews of ED utilization to identify opportunities for providers to expand their office hours.
- **Provider Extended Hours:** As Passport has transformed its business model, it has reevaluated its provider contracts and incorporated extended hour requirements into these contracts to ensure members have the ability to access providers after traditional work hours and on Saturdays, which may help reduce ED use.
- **ED Coordinator:** We have an assigned staff member to contact members who go to the ED for nonemergency reasons. The outreach focuses on PCP follow-up, education on contacting the PCP with non-life-threatening medical conditions, defining a true emergency, use of the 24-hour nurse advice line and standards of care for common ED use, such as fever, nausea/vomiting, rash and cold symptoms.
- **ED Navigator:** ED navigators are deployed at high-volume facilities. After treatment, these registered nurses (RNs) speak with members or caregivers who frequent the ED for nonemergency use to evaluate the reason for the ED use, evaluate the member's discharge needs, discuss discharge needs, make referrals to community resources/agencies and assist with PCP/test follow-up. In 2019, ED navigators met with and educated 438 members on appropriate use of the ED and connected them to their PCP.

C.10.a.i. Proposed approach to using data to inform the Vendor's efforts to improve appropriate use of service and cost efficiencies, as well as to identify potential Fraud and Abuse referrals.

Our Approach to Data-Informed, Appropriate Use of Services

Passport relies heavily upon data to evaluate utilization trends. We monitor five key components for the management of utilization opportunities:

1. Monthly UM authorization data reviews
2. Medical economic reviews—provider data reviews
3. BH spend outpatient work group
4. Fraud, waste and abuse (FWA)—Program Integrity Unit (PIU) data reviews
5. DURs

We monitor our data for trends, year-over-year comparisons and variability among providers. When we identify an outlier, we complete a root cause analysis to identify causal factors and conduct a more detailed analysis as needed. If the trend is unusual or demonstrates any clusters, more investigation is undertaken.

Utilization Management Authorization Reviews

We analyze and trend data to evaluate the UM program's efficiency and effectiveness and under- or overutilization trends. Data is evaluated in the areas shown in **Exhibit C.10-01**.

Exhibit C.10-1: Passport Utilization Management Authorization Metrics

Metric	Description
Inpatient admissions per 1,000 members	An indicator calculated by taking the total number of inpatient admissions for a specific period of time (usually one year), dividing it by the average number of covered members in that group during the same period, and multiplying the result by 1,000
Inpatient days per 1,000 members	An indicator calculated by taking the total number of inpatient days for a specific period of time (usually one year), dividing it by the average number of covered members in that group during the same period, and multiplying the result by 1,000
Readmission rates	Readmission rates within 30 days of discharge same or similar diagnosis for both BH and physical health
Average length of stay (ALOS)	ALOS is computed by dividing the number of days stayed (from the date of admission) by the number of discharges during the year
Utilization by category of aid (CoA)	Resource utilization by eligibility type under Medicaid
Outpatient	Analysis of outpatient trends in BH and physical health, such as home health therapies, high-tech radiology, high-cost durable medical equipment (DME), substance use disorder (SUD), targeted case management (CM), intensive outpatient program (IOP)
Maternity utilization	Resource utilization by maternity patients, including: • Use of obstetrical ultrasound in low-risk maternity patients • Potentially avoidable cesarean sections (primigravid, singleton, vertex, term) • Inappropriate genetic testing in low-risk patients • Antepartum admissions • Lengths of stay for specified conditions
BH utilization	• Similar analysis of BH trends across levels of care • Post discharge visits within seven days of discharge
Rx UM requests per 1,000 members	An indicator calculated by taking the total number of Rx UM requests for a specific period of time (usually one month), dividing it by the average number of covered members in that group during the same period and multiplying the result by 1,000; this analysis is done for both Rx coverage determination and appeal requests

Metric	Description
Concurrent and retrospective DUR	To identify potentially inappropriate or medically unnecessary prescribing, including savings estimates based on the cost of those claims that are rejected or not filled after DUR edits are processed and evaluated

Quarterly, our UM clinicians, together with a medical director and the UMC, review key indicators and compare against goals outlined in the UM plan. Committee members actively participate in oversight of UM activities and help to identify opportunities to improve utilization, quality and clinical outcomes.

These key indicators reviewed by our UMC are compared to stated goal(s), month over month, quarter over quarter, year over year, provider to provider (same specialty) and against external benchmarks when available. We review, trend and develop action plans to address targets not met, including additional provider education, additional reviews with hospitals if hospitals repeatedly exceed targets, alteration of services on the preauthorization list and economic credentialing.

We review the following data to evaluate for under- or overutilization:

- **Claims Data:** Medical, BH and pharmacy claims are examined for under- or overutilization trends.
- **UM Data:** UM data is evaluated to identify overutilization and variances in provider practice patterns.
- **Disease State Data:** Incidence and prevalence of disease states are assessed, and preventive services and outcomes are analyzed.
- **Gaps in Care Data:** Gaps in care are addressed by the clinical team, in coordination with other functional areas as appropriate, through member and provider outreach and investigation and formulation of a member- or provider-specific plan to resolve barriers to care or a provider's lack of adherence to clinical practice guidelines (CPGs). When we identify an underutilization trend across multiple members and providers, we develop a performance improvement plan.
- **Member/Provider Complaint Data:** We review member and provider complaints, such as quality of care, access issues or ongoing failure by providers to remain compliant with Passport protocols.

From the review of this data, if a pattern of inappropriate utilization trends is detected, the findings will be discussed with Passport's Medical Management team members to create an action plan to improve performance. Based on the nature of those findings, Passport's compliance or FWA-PIU team will be included in the action plans.

Drug Utilization Review

On a quarterly basis, we review DUR reports from CVS/Caremark that combine all retroactive, point-of-sale and detailed DUR edits from the previous quarter. These sophisticated reports provide an in-depth review of certain drug categories and outline opportunities for interventions, actions taken and outcomes. We then review quarterly comparison reports to identify opportunities for improvement through new outreach methods, care management referrals and targeted prescriber, or pharmacy outreach using embedded pharmacists.

Our Approach to Cost Efficiencies—Passport's Medical Economics

To have effective reviews of the five components, outlined earlier, Passport leans on effective clinical data and resulting reports. Through our analytic and actuarial group, we use the Identifi Analytics and Reporting Tool to identify and address trends in under- or overutilization of services through reporting and data mining, analyzing claim transactions, pharmacy claims data, eligibility files, authorization records and other ancillary records, such as historical claims data, laboratory results or immunization registry data. Our Cost and Use Report, on an inpatient and outpatient basis, profiles Passport providers to benchmarks and to similar specialty providers.

The key components of our Medical Economics review process include:

- **Cost and Utilization Assessment**: Identify opportunities through setting and service category review and comparison to benchmarks, isolating the impact of cost versus utilization on overall trends, and drilling down to further explain trends and highlight opportunities for savings without an impact on clinical results.
- **Population Assessment**: Evaluate demographic characteristics and changes over time, assess enrollment trends, profile high-cost member characteristics and trends, and measure chronic disease burden.
- **Provider Network Assessment**: Analyze PMPM, utilization and key performance indicator trends by provider practices and areas, drilling down on key focus areas and assessing in-patient versus out-of-network services.
- **Care Management Assessment**: Summarize care management engagement rates and drill down to unengaged members to identify root causes.

The Medical Economics team uses the reporting in these key categories to determine which insights are actionable and to recommend prioritization of actions. These reviews allow us to identify specific areas of opportunity related to key priority areas of DMS, including SUD, opioid use disorder (OUD) and the use of psychotropic medications in children and adolescents.

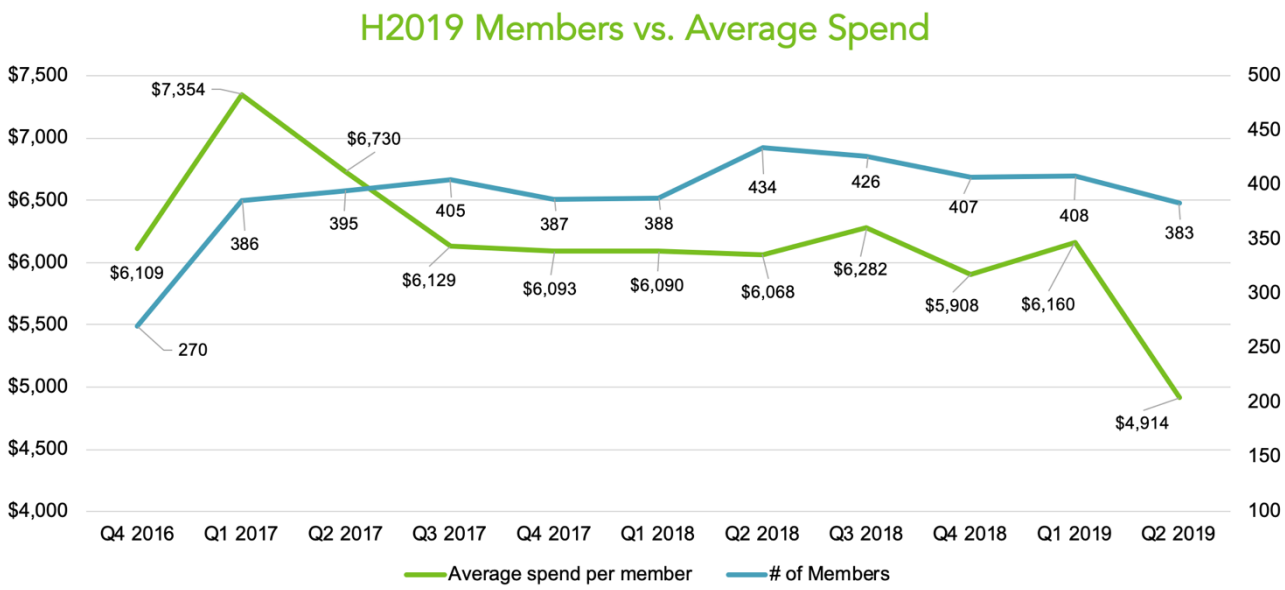
Behavioral Health Spend Work Group

A BH Spend work group was established in 2018 to provide a deeper dive analysis into some of the utilization and spending trends observed. The Health Integration team led this process. Here are some examples of trends investigated:

- **Large Provider Billing Under the National Provider Identifier (NPI) of One Site:** A large provider in Kentucky has been billing 98% of its services under the NPI of one site instead of the NPI of the sites in which the services took place. In review of their billing, the work group identified the primary site being billed was contracted by Passport at 110% the DMS rate (the only site with that rate). Although the review determined the only rate that increased was for one specific code, concerns regarding billing practices, large increases in utilization and inappropriate diagnosis codes for treatment was sent to the Passport Program Integrity team to investigate.
- **Impact of Institution for Mental Diseases (IMD) Expansion:** An analysis of Passport members between the ages of 22 and 64 years with inpatient admissions into IMD facilities was conducted and identified a $4.5 million spend over the first three quarters of 2018. This was used to help better predict utilization for future time periods.

- **Therapeutic Rehab Program (TRP-H2019):** The duration, intensity, cost and effectiveness of TRP has been a focus for the work group. Over the course of 2017 and 2018, utilization of TRP has been increasing quarter over quarter. Examination has been ongoing into the effectiveness of this service in improving the health and quality of life of members. Passport conducted several site visits to these programs in 2018, using the information and findings from the work group efforts to drive a message of general expectations for services, use of person-centered planning and helping members achieve recovery and develop a life integrated into the community that has lessened dependence upon professional support when possible. Additionally, the work group has been scrutinizing the medical necessity criteria from the clinical perspective and guidelines to ensure adherence to the Kentucky regulations for the service. Further education to providers on expectations for outcomes and time frames will be ongoing. **Exhibit C.10-2** illustrates a spike in unique utilizers and cost per member in Q1 2017. Since that time, the number of unique utilizers has increased, but the cost per member has been steadily decreasing.

Exhibit C.10-2: Impact of BH Spend Work Group Efforts on Therapeutic Rehab Program



Identifying Fraud, Waste and Abuse—Passport's Program Integrity

Passport's FWA program identifies, audits and investigates behaviors that suggest actual or potential FWA. We understand the overwhelming effect that FWA can have on health care. Our PIU is a separate and distinct operation, whose staff is autonomous from the UM department. Under health care reform and as a result of rising costs, scrutiny has increased to ensure that claims paid are for the right person, in the right setting, at the right time, in the right amount and for the right service. To that end, Passport provides a comprehensive approach to detect, prevent and correct FWA to reduce costs and ensure appropriate utilization.

Our PIU helps to identify aberrant trends in utilization. Through data analytics, Passport's PIU identifies provider and member outliers and allows for comparisons between peers. In addition, the clinical and Health Integration teams will look at utilization patterns and trend data to determine any if any changes in patterns are expected or warrant further investigation. They also review member data to determine if care management or care coordination should be offered and make referrals the appropriate area.

Based on the findings of the analytic review, the PIU may request and review medical records. Findings may be discussed with the Passport medical director to determine next course of action, if needed. Once determined, findings and action may be shared with the provider or member, if applicable. Once a provider is notified of investigation findings, the appeals process will allow them to provide additional supporting documentation. If a PIU investigation uncover nefarious activities related to fraud or abuse, Passport will report those findings to Commonwealth, federal or Office of the Inspector General (OIG) investigators, as required by the contract.

Through our data analytics, we have access to national tracking and trending data. Specific configurations based on Kentucky regulations or FWA findings can be built in a proactive manner to prevent identified trends of FWA. Through Passport's membership in the Healthcare Fraud Prevention Partnership, we have access to fraud schemes that are trending regionally and nationally, and we are able to perform analytics to determine the impact to Passport. In addition, specific system configurations based on Kentucky regulations or FWA findings can be built in a proactive manner to prevent identified trends of FWA.

Application of this trending information in a proactive way helps manage the health care dollar.

Passport works in a collaborative fashion with all Commonwealth and federal regulators in the identification, detection and prevention of any FWA activities.

C.10.a.ii. Overview of the Vendor's methods for monitoring appropriate health care utilization, including two examples of identified negative trends, initiatives undertaken to improve them, and the results of these initiatives.

Monitoring for Appropriate Service Utilization

Claims Review

As part of an ongoing review for process improvement through our UMC, the committee members review detailed claims data and examine for under- or overutilization. From the review of the data, if a pattern of inappropriate utilization trends is detected, the findings will be discussed with Passport's Medical Management team and the QIC to create an action plan to improve performance and outcomes.

Utilization Management Data Review

We review UM data as part of UMC and examine for under- or overutilization. From the review of the data, if a pattern of inappropriate utilization trends is detected, the findings will be discussed with Passport's Medical Management team and the QMMC to create an action plan to improve performance and outcomes.

Integrated Rounds

In our integrated rounds process, a medical director conducts care review in an interdisciplinary approach that brings clinicians, care managers, pharmacists and physicians together to review the care for comorbid and complex conditions, support, placement issues and access to services. Nurse reviewers refer cases directly to our medical director based on an individual case review and from daily inpatient census reports. Our BH medical directors also provide a level of support where we partner with our facilities and conduct case reviews while the member is receiving services. This will drive the plan of care and coordinate appointment setting prior to discharge to ensure members are connected to their provider and reduce recidivism.

If quality issues or concerns are identified by the medical director, the medical director immediately reaches out to the management team to discuss, and UM nurses track cases that are reviewed by the medical director. Through this process, UM nurses and the medical director are able to identify any members who require referrals to higher-intensity levels of care management. They also, identify provider trends, barriers to care and claims with high dollar amounts.

Negative Trends, Improvement Initiatives and Results

Urine Drug Testing

Passport's review of utilization data showed that urine drug testing (UDT) expenditures increased by 54.6% between 2016 and 2017, resulting from a 61.9% increase in utilization. This increase translated to a $13 million increase in the amount paid. 2018 saw further exacerbation, resulting from an 11.9% increase in cost.

To combat the increased utilization trend, Passport implemented a program from January 2019 to July 2019 that required authorization for UDT for SUD and pain management. Providers were permitted an allotted number of tests without authorization, with authorization then required for subsequent tests.

During the review time frame, Passport received an average of 1,400 requests per month and denied 34-36% of those requests based on inappropriate frequency of testing (testing weekly for an established member) and the provider making no changes to the treatment plan based on prior testing. This equates to a savings of approximately $90,000/month. Analysis of data also identified certain providers with atypical utilization who accounted for 60% of total requests. We provided education to the providers on the requirements for a review, and we developed a detailed form for them to use during the review process

Prescribed Pediatric Extended Care

Auditing that showed the potential for providers to bill a higher level of acuity when medical documentation did not support that level was reintroduced in 2016. Passport performed an audit that identified the acuity level for enrolled members was being billed at a higher acuity than the clinical scenario indicated. This audit was used as the basis for an ongoing investigation into potential overutilization.

To remediate the audit findings described above, in October 2016, Passport introduced a prior authorization program for prescribed pediatric extended care (PPEC) review to include medical necessity review of admission and level of acuity. Passport provided documentation to assist providers in gathering and providing the required information for the reviews to facilitate timely processing of authorizations. As a result of this program, we were able to recontract the largest PPEC to reduce the fees paid for higher levels of care.

Controlled Substance Management

Controlled Substance Safety Edits Reduce Member Harm: Passport pioneered many significant controlled substance safety edits in 2016. Since then, these edits have been refined and coordinated with DMS fee-for-service edits implemented in 2018. Passport extended these edits to address both acute and chronic opioid utilization and limit daily morphine equivalent dose (MED) and prescription days supply. These edits reflect Kentucky Board of Medical Licensure guidance with respect to promoting safety and curbing abuse potential associated with acute opioid prescribing. In the last 18 months, we have seen a reduction of approximately 22% in total opioid users.

C.10.a.iii. Frequency in which the Vendor proposes to re-evaluate its approaches to identify need for adjustments (e.g., re-evaluation of existing prior authorization requirement for appropriateness)?

Frequency of Initiative Evaluation

Passport evaluates its UM approach continually to ensure it cost-effectively provides members with the most effective care. We observe an evaluation schedule that, at a minimum, results in evaluations monthly, quarterly and annually, as detailed below.

Monthly

We examine claims, authorizations, drug trends and provider complaints related to the authorization process on a monthly basis. This review provides insights into sudden spikes in usage or unanticipated provider impact of changes and allows us to adjust as needed to address the issues.

Quarterly

We engage in Medical Economics reviews to see larger data trends on a quarterly basis. We also examine consistency of approvals, so that we can streamline our authorization requirements and reduce provider abrasion. For example, if we determine that we are approving a procedure 100% of the time, we may remove the prior authorization requirement. These quarterly Medical Economics reviews also allow us to look at seasonal trends on a year-over-year basis to understand utilization trends and potentially identify disease trends like a difficult flu season. The Pharmacy team also brings any recommendations from monthly and quarterly evaluations to the Pharmacy and Therapeutics (P&T) Committee to address drug trends.

Annually

Our annual evaluation includes medical, behavioral, pharmacy, dental and vision services. The annual evaluation is designed to:

- Evaluate the overall effectiveness of the UM program (medical, BH and pharmaceutical management) to assist in the promotion and maintenance of optimally achievable quality of care
- Ensure systematic reevaluation of the policies and procedures currently in force
- Promote consistency in authorization processing through the application of defined criteria for clinical decision-making
- Evaluate compliance with policies, procedures and regulations related to the appeals process
- Evaluate documentation consistency among clinical reviewers
- Evaluate clinical initiatives efficiency and effectiveness
- Evaluate program objectives, activities and targets for the coming year
- Verify the UM program complies with and is responsive to applicable requirements of federal and Commonwealth regulators and appropriate accrediting bodies

We include the results from these evaluations in our annual UM program evaluation.

Pharmacy: The Pharmacy program and UM department program descriptions and the annual evaluations are reviewed and approved by the Passport QMMC, Passport's QIC. The BH Advisory Committee also reviews BH UM materials. The programs are subject to continuous review to ensure they meet the needs of Passport. Select data from the evaluation is also submitted to the Quality department on a quarterly basis for submission to the DMS Quality Work Plan.

Behavioral Health: The BH UM program description, annual evaluation and monthly reporting, including Senate bill (SB) 20 appeal results, are reviewed by the Delegation Oversight Committee, BH Advisory Committee and QMMC. Providers, advocates and members who participate in these committees provide oversight and feedback regarding the UM process.

Ad Hoc

On an ad hoc basis, we examine new drug and technology releases, new therapy recommendations and provider complaints.

Our Approach to Identifying Needed Adjustments

Passport formally reviews the prior authorization (PA) list annually. However, the UM Director reviews the PA list quarterly and makes recommendations through our committees, and ultimately to DMS, based on the annual description of covered benefits. In 2019, we removed chiropractic services. After UM analysis and provider feedback from the provider survey, the authorization requirements for chiropractic services were removed. The analysis showed appropriate utilization of services within the benefit limits.

C.10.b. Describe the Vendor's proposed Utilization Management (UM) Program, assuring that it addresses requirements of RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices." In the description, include information about the following, at a minimum:

Ensuring Medicaid Managed Care Contract Compliance

Passport and its delegated partners Evolent Health and Beacon Health Options are NCQA accredited for UM. Evolent Health was pleased to learn that the NCQA surveyors had no findings in their most recent UM accreditation survey.

Under the direction of Passport's directors for medical and BH services, Passport's UM program meets the requirements of request for proposal (RFP) Draft Contract—Attachment C Draft Contract and documents in its plan as required in KRS 304.17A-600. Our UM program, processes and time frames are developed, implemented, managed and monitored in accordance with Title 42 of the Code of Federal Regulations (CFR) 431, 438 and 456. Our medical director and BH director are accessible and available for consultation as needed.

Passport's innovative and effective UM processes ensure a high quality, clinically appropriate yet highly efficient and cost-effective delivery system. We continually evaluate the cost and quality of medical services delivered by providers.

Our program description, included as **Attachment C.10-1_Passport 2019 Utilization Management Program Description,** details our program structure, complies with KRS 304.17A-600 and includes the information detailed in RFP Attachment C Section 20.1 that network providers may participate in UM activities to the extent that there is not a conflict of interest. Our UM policies and procedures define conflicts and remedies.

In all of our subcontractor agreements, we include that, consistent with 42 CFR Section 438.6(h), we do not provide financial incentives to deny, limit or discontinue medically necessary member services.

Utilization Management Program Description

Passport submits its UM program description to the Department for approval within 30 days of signing the contract annually and at any time when making material revisions.

Passport's UM leadership team, including its CMO and BH director, evaluates its program annually, including an assessment of the effectiveness in improving clinical and service outcomes and resulting changes to the UM program. We include an evaluation of subcontractor UM activities. Our CMO and BH director review and approve the annual program evaluation prior to submission to DMS.

Utilization Management Committee

Chaired by Passport's medical director, its UMC includes Kentucky-based providers overseeing clinical service delivery trends across its membership, including evaluating utilization, patterns of care and key utilization indicators.

Our UMC evaluates the need for and approval of UM policy, standards or procedural changes, including approval and implementation of clinical guidelines, and approving and monitoring the UM program description and work plan.

The UMC also reviews Passport's grievances and appeals (including expedited appeals and State Fair Hearings) related to UM activities to determine needed policy changes.

Clinical Practice Guidelines

Passport uses CPGs to support its providers in the care and education of its members and to reduce variation in diagnosis and treatment. Our guidelines, which are reviewed and approved by the QMMC, are based on valid and reliable medical/BH evidence or consensus of health professionals, consider the needs of our members, and are developed or adopted in consultation with Passport participating providers. We source CPGs from nationally recognized experts in treating a variety of conditions. For example:

- Centers for Disease Control for attention deficit hyperactivity disorder
- National Institutes of Health for the diagnosis and management of asthma
- National Kidney Foundation for evaluation and management of chronic kidney disease
- The American Psychiatric Association for the treatment of members with SUDs

We make these CPGs and many others available to our providers on our public website at passporthealthplan.com. We will also make them available to members or potential members upon request through our Member Services team.

C.10.b.i.Approach to align the UM Program with the Department's required clinical coverage policies.

Our Utilization Management Program Aligns with DMS Clinical Coverage Policies

Passport works to ensure members receive the appropriate level of care by coordinating health care benefits and ensuring that services are rendered in a timely manner, provided in appropriate settings, and planned, individualized and evaluated for quality and effectiveness. We have implemented a comprehensive UM program focused on identifying and reducing inappropriate utilization of services while ensuring timely access to appropriate care.

Our UM program provides complete prior authorization, concurrent review and retrospective review support as part of overall medical management administration. Our UM philosophy is centered on partnering and collaborating with providers to ensure members receive appropriate high quality, whole-person care. The UM program establishes continuum-of-care principles that integrate a range of services, including medical, BH and pharmaceutical services, that appropriately meet members' needs while maintaining flexibility in modifying services, as needs dictate. In fact, we view each step of the process as an opportunity to better understand the needs of the member and provide additional decision support for the provider, thereby allowing for identification of the most appropriate service to answer those very needs.

Passport's Compliance department ensures that all departments are in compliant with DMS Clinical Coverage Polices and Commonwealth regulations. DMS submits any policy changes to the Passport Compliance department, which then disseminates the requirements to the respective department. The Passport Compliance department requires action plan development to meet any required policies or regulations.

C.10.b.ii. Proposed evidence-based decision support tool(s).

Our Proposed Evidence-Based Decision Support Tools

Passport's integrated UM approach leverages a variety of tools to ensure that we apply the most appropriate evidence-based guidelines to service authorization requests that are transparent to providers and support integrated care. As required by DMS, we use InterQual to support medical necessity decision-making review of requested adult and pediatric medical services.

Along with the use of approved criteria, we consider the following when evaluating requests for medical necessity:

- Member demographics, eligibility and CoA
- Cultural diversity and linguistic barriers
- Local delivery system
- Appropriateness of site/place of service
- Level of care
- Member characteristics and information (e.g., educational level that may present barriers to care)
- Information regarding responsible family members and home environment
- Information regarding benefits for services or procedures, if applicable
- When the services requested are for a member from foster care, Passport has established a modified review process requiring authorization only for select services

Our Technology and Systems Supporting These Tools

Evidence-based criteria are only as effective as their integration into the care management process through effective technology. Passport is supported by Identifi, its web-based solution that brings local CM teams, providers and UM team members together on a single platform. UR/Quality Improvement and Surveillance UR subsystems are supported by the Identifi Population Health Management system Identifi Review module.

Identifi Review

Identifi Review is Passport's UM application with service-level agreement (SLA)-driven workflows and medical policy administration to support DMS utilization/quality improvement and surveillance UR by reducing inappropriate utilization. Passport's full suite of UM interventions includes prior authorization/prospective review, inpatient concurrent review, post-acute care/retrospective review, referral management, member and provider appeal, and member complaints and grievances. The data derived within the Identifi Review application fosters the development of robust utilization data to aid in

quality improvement activities. Identifi Review allows Passport to actively monitor and manage under- and overutilization of services across its health plan. Identifi Review provides our UM nurses with complete and real-time clinical and financial information.

C.10.b.iii.Innovations and automation the Vendor will implement, for example, to reduce provider administrative burden under the UM Program.

Our Approach to Reducing Provider Administrative Burden

As a physician-aligned organization, Passport understands that an overly burdensome UM program can cause physician abrasion and—at worst—lead to delay in members receiving needed care.

Innovations

Innovation in supporting our providers begins with delivering flexibility in authorization request methods. We offer providers multiple ways to request an authorization through our web-based UM portal or by phone or fax. Our UM portal is easy to use and features intuitive design. We display fields that are mandatory for completion and offer a guide that walks the provider through the submission process, explaining the information needed to complete a review.

We are also dedicated to easing the administrative burden on those provider practices who have demonstrated compliance with certain prior authorization guidelines through gold carding and episodic authorizations for oncology and cardiology providers.

Gold Card for Providers: Gold card providers have demonstrated consistent adherence to evidence-based practices, cost-effectiveness and quality. We grant a different level of request for specific medical services to these providers, allowing them to provide the service without the need for prior authorization or review. We monitor to ensure ongoing high quality, cost-effective results for the provider to remain in the program.

Episodic Authorizations: As a provider-driven plan, Passport knows first-hand how complicated treating members with cancer and cardiac issues can be. We treat UM for these conditions differently, bundling authorizations for multiple service requests into SuperAuths related to specific clinical episodes of care. Each episode of care is defined by clinical events, such as progression of tumor, complications of therapy or new diagnostic findings, rather than by a duration of time. Passport collaborates with the physician at the beginning of each critical episode of care to use its industry-leading clinical decision support tools to identify the optimal, highest quality and affordable care plan for each member. These Clinical Decision Checkpoints will collect the most recent data for the member's condition and use our Precision Pathways library to authorize the clinical plan for the full episode of care in a multimodality SuperAuth. Rather than requiring the physician to submit separate authorizations for each service or treatment, a SuperAuth covers all key elements of the required treatment for the member, including essential diagnostic and imaging tests, and medical, radiation and surgical treatments.

Automations

Passport's UM system supports auto-authorization of specific services when certain criteria are met, streamlining authorization processes and enhancing provider satisfaction. For example, we can use the provider taxonomy code to auto-authorize services commonly needed by specific types of providers for diagnostic purposes, such as a neurologist requesting an magnetic resonance image (MRI).

Identifi Practice (Practice) is Passport's provider-facing portal that supports utilization/quality improvement. Practice is designed to inform providers about actionable opportunities within their member panels by surfacing information about gaps in care, active care management programs, and cost and utilization metrics. Practice integrates with provider electronic health record systems to promote data exchange, improving care efficiency and the accuracy of our risk stratification models.

Practice includes several prebuilt member rosters that can be further customized by providers and their staff. The Total Members roster includes a snapshot of all members attributed to a provider or practice, detailing the risk of impactable ED visits and inpatient admissions, status of care management programs (based on activity in Identifi Care), the number of open care gaps for each member, and chronic conditions identified for that member. A more focused roster highlighting members with care gaps identifies all the open care gaps within a provider's panel.

Even beyond the Identifi Practice module, the overall Identifi platform leverages automation to fully support all medical management activities and includes the following medical management features:

- Easy-to-use authorization creation workflow for any staff at the provider's office
- Required fields that are clearly defined so all medical information is captured at the time of authorization entry
- Built-in logic enabling member lookup, prior authorization policy check and member eligibility check
- Built-in rules and criteria based on UM policies and customization to support auto-authorization, resulting in faster turnaround times for service request decisions
- Real-time status of authorization requests
- Identifi Practice enables providers to participate directly in a member's care plan, view authorizations and manage gaps in care

Identifi uses machine-learning techniques to improve processes, continuously improving the auto-authorization rules based on historical authorization data and trends. Identifi supports highly configurable auto-authorization rules that reduce administrative burden and the time a provider must wait for a decision. These rules can be configured according to a variety of member (e.g., age, gender, diagnosis code), procedure, and provider (e.g., requesting, attending, or rendering) data elements. Passport uses machine-learning and other analytics on historical authorization data and trends to identify potential auto-authorization rules to configure in Identifi.

These rules are based upon evidence-based guidelines selected to ensure services requested are medically appropriate for our members and leverage InterQual guidelines, internally developed medical policies, Medicaid criteria/guidelines and statutory or regulatory guidelines. Machine learning is the scientific study

of algorithms and statistical models that computer systems use to perform specific tasks without explicit instructions, relying on patterns and inference instead. Machine learning allows streamlined analysis and decision support for initial authorizations based on thousands of records of experience. This informs our authorization decision rules as to which authorizations can automatically occur and which authorizations should be removed. Machine learning is only applied to initial requests that are within a nurse's control. The BH team also uses other DMS-mandated tools, including Level of Care Utilization System (LOCUS), Child and Adolescent Needs and Strengths (CANS), American Society of Addiction Medicine (ASAM) and Child and Adolescent Service Intensity Instrument (CASII).

C.10.b.iv. Methods and approach to balance timely access to care for Enrollees with the administration of the UM Program.

Our Approach to Balancing Timely Access to Care with Program Administration

As noted, Passport is a provider-directed organization. As such, we are committed to providing member centered care and timely authorization of services that do not delay or interrupt medical services, divert significant resources from member care, or complicate medical decisions.

Methods that Support Our Approach

Passport uses these methods to support our approach to timely, member centered, cost effective care:

Monitoring performance with SLAs. Passport applies strict standards to meeting SLAs that exceed DMS requirements. These medical and BH SLAs include responding to urgent requests for authorization within 24 hours; treating all requests for members with SUD as urgent; communicating non-urgent determinations within two business days; completing continued stay determinations within 24 hours of receipt of the request; and completing retrospective review determinations within 14 calendar days. Our performance of SLAs is detailed in **Exhibit C.10-3**.

Exhibit C.10-3: UM Service Level Agreements

	Description	SLA* Target	Goal	Performance
Case Turnaround Times for Medical Review Determination				
Urgent	Case Types	24 Hours	95% completed within 1 Business Day	97.1%
Non-Urgent		2 Business Days	95% completed within 1 Business Day	85.5%**
Retrospective		14 Calendar days	95% Completed within 1 Business Day	97.6%

	Description	SLA* Target	Goal	Performance
Case Turnaround Times for Behavioral Health Review Determination				
Urgent	Pre-Service: Initial Authorization for Inpatient or Other Urgent BH Services	24 Hours	95% completed in 24 hours	99.75%
Non-Urgent	Pre-Service: Initiation Authorization for Non-Urgent BH Services	2 Business Days	95% completed in 2 business days	100%
Urgent/ Expedited	Concurrent: Continued Auth for Inpatient and Other Urgent Behavioral Health Services	24 Hours	95% completed in 24 hours	99.6%
Non-Urgent/ Retrospective	Non-Urgent/Standard	30 Business Days	95% completed in 30 days	100%

** We did not meet our goal for non-urgent case turnaround in 2019. We implemented a corrective action plan process and completed a root cause analysis. We found that a combination of the following contributed to the decline in our performance:

- Increase in authorization calls due to new authorization requirements increased our fax request volume by 130%
- Changes in our radiology prior authorization program and implementation of a specialty oncology program increased the call volume to our UM team by 20%
- By the third quarter of 2019, our service levels returned to expectation, no members were adversely impacted, new staff were hired and we implemented cross-coverage among teams with a resumption of our performance meeting goals

Ongoing Provider Education

We develop training and job aids to ensure appropriate provider education to address identified updates, issues or new information. This messaging will then be incorporated into Passport's ongoing training and education curriculum. The curriculum is reviewed and updated, as appropriate to ensure our providers continually have the knowledge and information needed to best care for our members in the most effective and efficient manner.

Passport's ongoing provider education includes prior authorization processes and procedures. We communicate to providers via the following communication channels:

- Provider letters and bulletins
- Preferred Drug List (PDL) drug changes and distribution

- Point of Service (POS) messaging
- Training sessions, webinars, quarterly newsletters and other training activities as requested by the Department
- Billing instructions and claim resolution communication
- Website postings

Leveraging Technology

Identifi Review provides UM nurses with complete and real-time clinical and financial information. Automated workflows trigger follow-up action items for UM staff in a single, integrated platform and provide the ability to share UM requests with physicians and team members for review. The work queue prioritizes follow up actions based on SLA-configured requirements.

Our Utilization Management Team Administering the UM program

Passport is committed to its Kentucky-based staffing model. Hiring Kentuckians who are familiar with regional and cultural influences allows us to better serve our members and providers through a tailored approach developed in accordance with DMS requirements. Living and working right here in Kentucky helps them understand the Kentucky provider referral patterns and gives them an intimate understanding of the network; this enables our teams to support the management of care more appropriately.

Medical Director

Passport's CMO, Dr. Stephen Houghland fully supports our whole-person integrated care and population health approach. Dr. Houghland is accountable for leadership pertaining to all major health programs related to the DMS contract, as well as Passport's treatment processes and policies, medical management (including UM), quality management and improvement efforts, and population health management activities.

Director

Anna Page serves as Passport's director, utilization management. She is responsible for the overall management of the activities relating to the strategy, tactics, policies and programs that drive utilization for plan provider owner network providers and members. Anna is responsible for developing new capabilities and efficient and effective programs that achieve cost and quality goals in a way that is integrated into the local delivery system.

See **Exhibit C.10-4** for additional UM Staff.

C.10-4: Additional UM Staff

Title	Responsibilities
Manager Clinical	• Oversee daily operations of the UM department
Manager Non-Clinical	• Oversee daily nonclinical operations of the utilization department
Medical Directors	• Serve as consultant to the medical management associates • Conduct denials when serving as a clinical reviewer
Appeals Director	• Direct the implementation and oversight of the appeals process
Utilization Review Nurses	• Perform medical necessity review • Ensure compliance with policies, procedures and regulations • Refer for higher level of care • Identify potential FWA
Mommy Steps Maternity and New Born Program Nurses	• Conduct concurrent review and care coordination • Acts as a member of the health care team to coordinate activities with physician, NICU staff and caregiver
ED Navigators	• Conduct member interviews Evaluate the member's discharge needs • Provide member education Track and trend ER utilization
Appeals Nurse	• Perform clinical oversight of appeal decisions • Ensure compliance with policies, procedures and regulations • Identify potential FWA
Intake Specialists	• Provide nonclinical support to the clinical staff
Research Appeals Coordinators	• Provide nonclinical support to the clinical staff
ED Coordinators	• Provide nonclinical support to the clinical staff
Medical Systems Analyst	• Maintain a current knowledge base with regards to rules, all federal and commonwealth regulations, DMS contract requirements • Develop, edit and maintain multiple medical management systems • Assist with the development and delivery of system training programs and processes
Data/Business Analyst	• Assist in the development of reporting and analysis of medical data, metrics and measures • Assist with clinical and physical data modeling to support medical management initiatives • Develop weekly, monthly, quarterly and annual medical management reports and results

Title	Responsibilities
Medical Management Trainer	• Assess training needs and methods of instruction • Develop, implement and maintain training strategies for both short-term and long-term training goals and initiatives • Develop and maintain training material • Serves as the training liaison between medical management and other departments within Passport Health Plan
Medical Management Auditor	• Perform internal chart audits on medical management associates for completeness and accuracy • Perform internal chart audits on medical management associates to ensure compliance with criteria, regulations, NCQA requirements and policy and procedures • Develop and maintain clinical and nonclinical audit tool • Prepare audit reports • Assist in the development of individual/team corrective action plans based upon audit results

C.10.b.v. Approach to integrate medical and behavioral health services in the UM program.

Our Approach to Integrating Behavioral and Physical Health In UM

Health Integration is Passport's collaborative, member-centric team-based model of care delivery combining medical, BH and social needs services.

Passport's "No Wrong Door" Approach Integrates Medical and Behavioral Health Services

Member health and well-being needs are met through a "No Wrong Door" and equitable whole-person approach to care. Our UM and BH teams refer requests seamlessly to each other to ensure timely action and resolution. Regardless of the type of service being requested, our integrated approach to UM ensures that providers may request a plan of care and receive approvals quickly and efficiently. Integrated workflows ensure communication across UM teams who work in tandem to meet member needs. During the review process UM asks questions of the provider related to symptoms, treatment plan, diagnosis including behavioral and medical, and all medications as well as housing, family, education and legal concerns. Referrals to CM are made as appropriate. Additionally, UM reviews are audited on an annual basis to ensure all staff are including these elements in their reviews.

Physical and Behavioral Health Joint Staffing

Passport and Beacon Health Options, our NCQA accredited managed behavioral health organization (MBHO) are co-located as they address member needs. When a member presents with physical health/BH comorbidities, our co-location model facilitates a seamless case review. This helps ensure that care is authorized holistically from a whole-person perspective. When discussion on a member's unique needs is required, our collaborative care rounds provide a forum for cross-discipline discussion and care planning

among UM and BH teams. Our BH and physical health team members are co-located allowing for consultation, discussion and referrals.

To ensure our teams understand the importance of integrated care, we conduct annual integrated care training jointly with our medical and BH teams. During this training, we review specific cases and evaluate our processes to look for opportunities for improvement. Integrated care experts present in these meetings, including providers from integrated care settings and people from other health plans in other states, to learn from experience and ensure we are continuing to stay updated on best practices.

For BH, Passport ensures UM criteria are applied consistently and appropriately across all levels of care and lengths of stay through annual inter-rater reliability (IRR) audits of all staff who complete utilization reviews including clinicians, clinical supervisors and medical directors. The process includes conducting focused monthly supervisory reviews of the clinical staff, reviewing and providing feedback on specific input, and reviewing process metrics that cover the continuum of the UR and case management clinical process. The BH IRR uses approximately 15 to 20 vignettes in which clinicians apply medical necessity criteria to make determinations. The BH IRR also utilizes monthly monitoring of service request calls from providers that include a review of the documentation received against the audit tool to confirm that the request addresses all the elements required to make a determination. If frequent errors are noted, we increase the frequency of the monitoring and implement an assessment of the reason for deficiencies and the related corrective action which may include policy clarification and/or provider training.

Integrated Rounds

Our provider centered governance structure provides a unique system for integration. Provider representation on our PCP Workgroup and Behavioral Health Advisory Committee allow for provider input around our processes to ensure integration across Passport's organization, including UM.

For example, when we implemented the Partners in Wellness program to create an integrated care model for members with SMI, we sought input from both groups. Partners in Wellness had BH case managers receive medical case management training at Centerstone Kentucky (Seven Counties Services). Members also had access to nursing 24 hours a day. With feedback from our provider representatives, we worked to ensure the UM process was not a barrier to entry into the program. Members for possible participation were identified in advance as having an SMI and high medical utilization through review of medical and BH claims data. We met with Centerstone Kentucky (Seven Counties Services) in advance to streamline the process. Instead of completing the usual pre-authorization process, the team at Centerstone Kentucky (Seven Counties Services) sent over the name of the person and treating diagnosis from the pre-generated list of possible participants and were auto-approved. An authorization was then entered into our system for an integrated care model to be delivered. We met frequently to get feedback about this process and ensure the UM process was working properly so members could access this integrated and collaborative program.

Whole Person Care

A member is admitted to a hospital for an overdose. It is immediately recognized that this member has both medical and behavioral health (BH) issues from the inpatient authorization request to our UM staff. The member's case is assigned to our Health Integration team to ensure that both Passport medical and BH care teams are alerted. The Health Integration lead ensures that our Transitions Care Program Manager reaches out to the member and hospital to provide support during hospital stay while also preparing for discharge and transition.

Our Health Integration team discusses the member at Interdisciplinary Care Team rounds weekly to plan for the member's complete care needs. Our integrated approach ensures that the medical and BH providers are aligned and the member understands his or her care plan.

Psychiatric evaluation during the hospitalization determines that acute inpatient psychiatric care is the appropriate next step for the member's recovery. The Passport UM team authorizes and helps find an appropriate psychiatric facility and works with the hospital to support discharge and transition. The Health Integration care team continues to monitor the member's progress and care plan and ensures coordination between medical and BH providers. The same Transitions Care Manager will stay with the member to support the transition to outpatient BH and primary care follow up and then facilitate a warm hand off to the Beacon BH care team with the member.

Integrated Health Considerations for Special Populations, Co-Occurring BH Conditions and Intellectual or Developmental Disabilities (IDD)

For members with IDD, our clinicians collaborate with other members of the Passport care team to reach out to the member's current providers and other supports. Service plans, assessments, and other relevant information are combined with the clinical issues associated with the request for authorization for services or treatment. When needed, our clinician requests consultation with members of the care team who have expertise in IDD. All available information is then reviewed, and services, BH or physical health, are recommended by the member's IDD care team and are authorized.

Clinical Care Guidelines Development – Collaboration with the American Psychological Association

Passport understands the challenge in providing services to a member who may have another co-morbid BH condition along with IDD. Members of the Health Integration team participate in providing feedback through the Kentucky Psychological Association to the American Psychological Association as they develop a clinical practice guideline to ensure the use of evidence-based practices to meet the needs of individuals with IDD. This national clinical practice guideline will articulate the importance of addressing the whole-person needs of individuals with IDD, as well. When complete, the national clinical practice guideline will address the importance of addressing the whole-person needs of individuals with IDD.

C.10.b.vi. Approach to ensure UM Program is compliant with mental health parity.

Ensuring UM Program Compliance with Mental Health Parity

We developed our integrated health approach (described in C.10,b.v above) in consideration of mental health parity principles enabling us to support whole-person care.

Passport ensures parity compliance by systematic review of the physical and behavioral health benefits, including pharmacy, upon implementation and whenever a change is made to the benefit structure. During this review the following items will be assessed:

- Quantitative treatment limits
- Non-quantitative treatment limitations
- Preauthorization and pre-service notification requirements
- Fail-first protocol
- Geographical limitations

We monitor our compliance using the Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) created by the Department of Labor on an annual basis and as requirements change.

Systematic Review of MH and SUD Equity to Physical Health Conditions

In 2018, upon DMS request, we analyzed prior authorization and claims data to ensure mental health and SUD were treated equally with physical health conditions. Parity was examined in the requested areas of:

- Medical necessity
- Criteria development
- Prior authorization
- Concurrent review
- Prior notification
- Retrospective review
- Outlier management
- Experimental/investigational determinations
- Medical appropriateness reviews
- Practice guideline selection/criteria
- Blanket exclusions for medically necessary court-ordered or involuntary treatment

Our analysis confirmed parity between the BH and physical health benefits in the delivery of services to our members. We shared our results with DMS as required. We monitor physical health and BH parity annually and as prior authorizations and benefits may change.

C.10.b.vii. Approach to ensuring accountability for developing, implementing, and monitoring compliance with Utilization policies and procedures and consistent application of criteria by individual clinical reviewers.

Our Oversight and Committees

In order to set a culture of accountability and to ensure we ultimately develop, implement and monitor compliance with utilization policies and procedures, we must start with an effective governance structure. Passport's framework is designed to bring accountability and compliance from the top of the organization then drive it throughout so that we apply consistent and effective approaches. Passport has strong, existing partnerships with local provider groups, community advocates, and members because of our roots as a Kentucky-based, provider-led organization. To help us maintain these deep community ties and inform decision-making, we have implemented a unique governance structure that integrates stakeholders. In total, well over 100 volunteer clinicians, representing multiple specialties, consumers and member advocates inform Passport's governance process through these committees. This structure brings alignment into our UM approach.

Board of Directors

The Passport Board of Directors has broad oversight of the health plan's strategic direction and performance. Through its unique relationship with the Partnership Council, Passport's Board also maintains oversight of quality of services, UM and clinical programs.

Partnership Council

The Partnership Council receives and reviews management and improvement actions from the Partnership Council committees/subcommittees to continuously improve the quality of our team's service delivery. Passport works closely with our Partnership Council and its committee structure to ensure members have access to high quality services. The Partnership Council is comprised of Passport providers and community advocates and operates as a committee of the Board of Directors to assist in oversight of programs such as UM.

The Council meets bi-monthly and has ongoing responsibility for recommending policy decisions, reviewing and evaluating the results of quality activities, and instituting actions as appropriate. It has oversight authority for Passport programs, including Quality, Utilization Management, Care Management, Pharmacy, etc., and receives and reviews quality management and improvement activities from the Partnership Council committees and subcommittees.

Passport's Quality Medical Management Committee

The QMMC is Passport's QIC. The QMMC provides oversight and input for quality improvement and accreditation activities throughout the health plan and the provider network. The committee is chaired by Dr. Stephen Houghland, our CMO and includes representatives from Norton Healthcare, UofL Health, a rural Community Medical Health Center (CMHC), a clinical pharmacist, and private practice OB/GYN, among

others. The QMMC serves as the primary conduit for achieving our holistic organizational goals for quality which flow from DMS's stated priorities of transforming the Medicaid program: engaging individuals to improve their health and engage in their health care; significantly improving quality of care and health care outcomes; and reducing or eliminating health disparities. Through its oversight of quality for the entire Passport organization, the QMMC facilitates our focus on whole-person care across the full spectrum of needs and services, regardless of whether these services are delivered directly by Passport or via a subcontracted arrangement. The Partnership Council is an approving body for the QMMC.

Our Utilization Management Committee

The UM Committee is a subcommittee reporting to the above outlined QMMC and supports provider clinical decision-making by providing medical and BH expertise for medical necessity criteria selection and approval. It provides continuous review of the entire UM program and all delegated entities to assure the UM program meets the needs of Passport and DMS. The UM Committee achieves its end goal of safeguarding our members against unnecessary and inappropriate medical care.

Additional QMMC Subcommittees

Passport believes it is important to integrate other management activities into the decision-making process for our QMMC. As a result, the QMMC encompasses several subcommittees that advise the QMMC and Passport on various issues specific to populations and/or therapeutic topics and issues. These subcommittees report to the QMMC, providing minutes and reports of activities. The QMMC can accept, reject or request more information on subcommittee recommendations. Additionally, if a matter needs immediate attention, the QMMC may act on its own authority without subcommittee input.

Our Approach to Policy and Procedure Compliance

Developing and Implementing Policies and Procedures

All policies and procedures are developed in accordance with federal and commonwealth guidelines and NCQA standards. It is the policy of Passport to develop, review and update operational and compliance policies and procedures throughout the year. All operational and compliance policies and procedures are reviewed by the operational owner for changes and updates annually. The Compliance department and operational areas monitor the changes in commonwealth and federal regulations, changes in applicable NCQA standards, and changes in business needs that affect policies and procedures throughout the year. If changes to policies and procedures are identified in either the annual review process or in the ongoing regulatory and business review, the appropriate operational area makes updates and creates a red line version of the policy and procedure. Policies that need to be retired or replaced are also identified during the annual review process or during the ongoing regulatory and business review.

Once polices are reviewed and approved, the UM trainers educate the team on the required process.

Monitoring Compliance in our Criteria Application

We focus our UM Quality Assurance Review Program (QA) on a detailed review of clinical and nonclinical staff knowledge, understanding and application of federal, commonwealth and national regulatory

requirements and guidelines, and SLA program requirements. We ensure consistent application of criteria through an extensive orientation, training and retraining program, IRRs, and feedback and continuing education as needed.

Ensuring Consistent Criteria Application

Providers may submit an authorization request via:

- Phone
- Fax
- Secure email
- Web
- Mail

Providers may submit requests using the UM department standard request form or utilizing the DMS global authorization form.

The Utilization Management department will render medical necessity determinations in a timely and consistent manner so that members with comparable medical needs receive comparable and consistent levels, amounts, and durations of services as supported by the member's medical condition, records, and previous affirmative (approval) coverage decisions.

Passport defines Medical Necessity as a covered benefit that is: reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; clinically appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice; provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons; provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided; needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; Provided in accordance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements.

An initial first level review is performed by the utilization review nurse. The request is entered in the medical management system and the following is verified:

- Authorization requirements of the requested service
- Member eligibility and plan type
- Provider network status
- Benefits
- Clinical information sufficient to render a determination is included

- Outreach attempts are conducted if required

The nurse applies the received clinical information against criteria or medical policy to establish medical necessity, length of stay and duration of requested services. The following is also considered during the review process:

- Co-morbidities
- Duration of illness and prior treatment
- Presenting signs and symptoms
- Treatment plan related to the request
- Progress/nursing notes for pertinent clinical information; consults
- Member psychosocial history
- Discharge plans to include:
  - Discussion with the facility UM staff/discharge planner
  - Planning for homecoming or transfer to another care facility
  - Determining if caregiver training or other support is needed
  - Referrals to home care agencies and/or appropriate support organizations in the community
  - Arranging for follow-up appointments or tests
  - Availability of community resources, skilled nursing facilities, sub-acute care facilities or home care in Passport's service area to support the member
  - Referrals to specialty programs

The utilization review nurse refers any request not meeting criteria to a medical director for review determination. Decisions to issue an adverse determination to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, is made by a medical director who has appropriate clinical expertise in treating the member's condition or disease. Medical director consultants from appropriate medical, surgical and psychiatric specialties are accessible and available for consultation as needed.

Passport does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

The medical director performs the review and may contact the treating provider to discuss the service request, gather additional information and make a final determination. During this review process our medical director evaluates the standards of care, conducts clinical research, reviews Commonwealth and federal guidelines and if applicable completes a peer-to-peer discussion. In this way, we avoid administrative denials due to lack of documentation.

If an adverse determination is made by the medical director, regardless of the type of service requested, the member, the PCP, the ordering/rendering provider and the facility rendering services, if applicable, are notified in writing. In addition, we notify the requesting provider via phone of the decision and provide information about how to request a peer-to-peer review or initiate an appeal.

The Passport UM team provides the member with written notice that meets the language and formatting requirements for member materials and includes in easily understandable language:

- The adverse benefit determination the UM department has taken or intends to take
- The specific reason for the adverse benefit determination in clear, nontechnical language that is understandable by a layperson
- A reference to the benefit provision, guideline, protocol or other similar criterion upon which the adverse benefit determination is based
- Notification the member or provider can obtain a copy, free of charge, of the actual benefit provision, guideline, protocol or other similar criterion upon which the adverse benefit determination was based
- The member's right to appeal
- The member's right to request a State Fair Hearing
- Procedures for exercising member's rights to appeal or file a grievance
- Circumstances under which expedited resolution is available and how to request it
- The member's rights to have benefits continue pending the resolution of the appeal, how to request benefits be continued, and the circumstances under which the member may be required to pay the costs of these services

Members may request an appeal for any adverse benefit determination. An appeal is a request for review of an adverse benefit determination, or a decision related to covered services or services provided.

Audits to Determine Appropriate Guideline Application

We use externally and internally developed audit tools to evaluate consistency in the application of criteria and adherence to policy and procedure. The Quality Assurance Review Program (QA) activities focus on a detailed review of clinical and nonclinical staff knowledge, understanding and adherences to federal, commonwealth and national regulatory and Utilization Management (UM) program requirements. Opportunities for improvement are identified and addressed by action plans to mitigate trends. While we utilize a number of oversight activities, one method through which we identify the need for auditing and monitoring is through IRRs, outlined next.

Interrater Reliability Reviews

We conduct IRRs for all UM clinical professionals using the InterQual® IRR testing tool to evaluate consistency in the application of InterQual® criteria. The IRR program is designed to assess consistency in the application of the use of medical necessity guidelines.

Physician Reviewer Interrater Reliability. We conduct a Physician Reviewer IRR quarterly to ensure consistency and objectivity of UM decisions made by physician reviewers. The IRR reviews verify that service request determinations are consistent with our policies and state-specific requirements and guidelines. The CMO develops hypothetical Medicaid case studies that reflect the common types of requests that are

reviewed by each physician, then discussed during an IRR meeting. Physician reviewers document their review decision and any questions they would like to discuss. At the scheduled meeting, the physicians discuss their decisions and the rationale used to make the determination. They also clarify and interpret evidence-based clinical resources to encourage ongoing review consistency in the future. This is consistent with a classic peer review process.

The IRR administrator scores the physician reviewers based on the consistency and standards adhered to for each of the decisions made by each the physician. The CMO monitors the scores and establishes performance improvement plans for reviewers who score below a 90% adherence target. An annual summary report is prepared and presented to the UMC and Quality Management Committee (QMC). Additional education or action may be taken to improve consistency in the application of clinical evidence criterion and followed by the UMC until closure, if needed.

Nurse Reviewer Interrater Reliability. We conduct Nurse Reviewer IRR quarterly to ensure consistent understanding and application of evidenced-based clinical resources. The UM manager carries out IRR reviews under the direction of the senior director of utilization management. The UM manager assigns sample cases to the nurse reviewers who must complete the reviews with a 90% accuracy.

We calculate overall scores based on individual case scenario scores, and the UM manager establishes corrective education plans for reviewers scoring less than 90%. The UM manager monitors the corrective education plan to ensure the 90% standard is met within one quarter or implements a corrective action plan that includes training and retesting until the desired score is reached. Annually, the UM manager prepares a summary report for the UMC and QMC that summarizes the IRR program and details the IRR components assessed, number of clinicians evaluated, range of scores, reasons for trends or failures, and opportunities for improvement.

Pharmacist Interrater Reliability. Pharmacy IRR evaluates clinical decision-making consistency by type (prior authorization, step therapy or quantity limit, and initial request or appeal) through a careful selection of sample medication requests received and reviewed by our Clinical Pharmacy Services (CPS) team.

The CPS QIC coordinates these audits by selecting cases for review confirming sound clinical judgment, adherence to the prior authorization policy and adherence to the specific medication policy. A minimum of two cases per CPS team member are selected and reviewed biannually.

A pharmacist member of the CPS team leads a clinical discussion of the sample medication requests. Sample medication requests are selected based on questions received from the CPS team, identifiable review inconsistencies pulled from the UM prior authorization platform data or from CPS team member request. The IRR process evaluates individual clinical decision-making and overall adherence to the prior authorization process.

Other Oversight Activities

Behavioral Health Review. Passport ensures UM criteria are applied consistently and appropriately across all levels of care and lengths of stay through annual IRR audits of all staff who complete utilization reviews including clinicians, clinical supervisors and medical directors. The process includes conducting focused

monthly supervisory reviews of the clinical staff, reviewing and providing feedback on specific input and process metrics that cover the continuum of the UR and care management clinical process.

The IRR uses approximately 15 to 20 vignettes in which clinicians apply medical necessity criteria to make determinations. The BH subcontractor combines IRR with monthly monitoring of service request calls from providers that include a review of the documentation received against the audit tool to confirm that the request addresses all the elements required to make a determination. If the BH subcontractors encounter frequent errors, they increase the frequency of the monitoring and implement an assessment of the reason for deficiencies and the related corrective action, which may include policy clarification and/or provider training.

Ensuring Consistency in Application of Criteria

Inservice Training. We conduct "in-service" days to provide education to reviewers and hold annual InterQual® training to ensure all team members are fully informed about any changes to criteria. In 2019, we held educational forums addressing the following topics as they relate to consistent application of UM criteria:

- IQCI Train the Trainer.
- InterQual® (for Medical and Behavioral).
  - Acute Hospital – Adult, Pediatric
  - Rehabilitation (Acute Rehab Facility)
  - LTAC
  - Home Care
  - Outpatient Procedures
  - Outpatient Imaging
  - Specialty Rx Oncology
  - Outpatient Rehabilitation & Chiropractic
  - Outpatient DME
- Identifi Review platform by role
- Appeals Training for new Appeals Identifi Platform – Appeals
- InterQual® IRR remediation training
- March 2019 InterQual® Neonatal Intensive Care (NICU) and Transition Plan training
- Complaints Training for new Complaints Identifi Platform-Appeals team
- Documentation, NCQA, IPRO training

C.10.b.viii. Processes and resources used to develop and regularly review Utilization Review (UR) criteria.

As required by the department, Passport uses InterQual® medical necessity criteria for adult and pediatric nonemergency inpatient services, outpatient therapy, home care and DME. InterQual® Criteria are produced using a rigorous development process based on the principles of evidence-based medicine (EBM) to give complete confidence in the underlying guidance the criteria provide.

In addition to InterQual®, we may use the following evidence-based, nationally accepted, licensed, clinical decision support criteria sets is chosen for use to ensure consistent, appropriate decision-making regarding care and services:

- Centers for Medicaid and Medicare Services (CMS)
- Kentucky Medicaid regulations, fee schedules for coverage determination
- DMS guidelines for select services
- Internal Health Medical Policies
- American Society of Addiction

Processes for Utilization Criteria Development

DMS and our UMC review and approve both national, licensed evidence-based clinical resources and internally developed evidence-based clinical resources prior to use. are reviewed and approved by our Utilization Management Committee or the P&T Committee, which both include physicians and other health care professionals.

For instances where licensed evidence-based clinical resources are not available, or the request is for review of experimental or investigational health services and procedures, Passport considers both appropriate licensed evidence-based clinical resources as well as internal evidence-based clinical resources in developing criteria and the evidence application procedures using scientific evidence reviewed by actively practicing clinicians from appropriate specialties.

Processes for Regular Utilization Criteria Review

Passport ensures all medical necessity criteria are reviewed as least annually.

InterQual® Criteria Review

InterQual® criteria is updating annually using the following five-step process:

6. Identify content for development and updating
7. Teams identify and critically appraise clinical evidence
8. Physician-led groups develop new and updated content
9. Independent clinical review panel drawn from more than 900 experts provides authoritative peer review
10. Clinical team conducts final quality assurance check and releases content

Internally Developed Criteria Review

We review evidence-based clinical resources annually against current industry standards for any changes in technology or practice patterns that could impact appropriate application of the evidence-based clinical resources. We present all evidence-based clinical resources, including any revisions or modifications to the UMC or P&T Committee for review and approval. DMS approves all changes prior to use.

Resources Used to Support Review Processes

Passport uses current industry standards, changes in technology and practice patterns, our policies and procedures, and DMS requirements in the annual evaluation of internally developed UM criteria. We present all changes to the UMC or P&T Committee and DMS for annual review and approval

C.10.b.ix. Prior Authorization processes for Members requiring services from non-participating providers or expedited Prior Authorization, including methods for assuring services are not arbitrarily or inappropriately denied or reduced in amount, duration, or scope.

Passport is committed to providing medically necessary, cost-effective care through our network of over 32,000 high quality providers. Passport's network providers participate in our quality and UM programs, comply with DMS requirements on access and availability, and credentialing providers. To ensure the safety and efficacy of services provided by out of network providers, we require these providers to obtain prior authorization before providing care for our members.

Nonparticipating Provider Prior Authorization Process

Passport is committed to the shared aims of providing medically necessary, cost-effective care. There are circumstances when members or providers seek out-of-network services, or nonparticipating provider services, that may be safely and conveniently provided within our network.

Because nonparticipating providers are under no obligation to participate in Passport's quality or UM programs, access and availability requirements, or credentialing requirements, Passport requires a prior authorization to ensure continuity and coordination of care for our members.

The nonpar prior authorization process is approved by our medical director who has the following responsibilities:

- Ensure requested service is a covered benefit. If not a covered benefit, may be eligible for an EPSDT Special Services consideration
- Assess medical necessity of the request
- Assess access of the requested service from a network provider
- Assess continuity of care or service
- Assess if the service has an impact on coordination of other covered services

If the medical director's assessment confirms that the service is a covered benefit and is medically necessary and no in network provider is available, he or she will authorize a benefit exception for the out of network service within two business days of receiving the request. The timeframe may be extended up to 14 days if the provider or member requests an extension, or if Passport justifies a need for additional information (including how the extension is in the member's best interest) to DMS.

Nonparticipating Provider Expedited Prior Authorization Process

In the case of a member with a diagnosis of SUD and in cases in which the requesting provider, or Passport determines that following the standard timeframe described above would jeopardize the member's life, health or ability to attain, maintain or regain maximum function, Passport's medical director will complete an expedited authorization decision within 24 hours and provide notice as expeditiously as the member's health condition requires.

Assuring Appropriateness of Service Denials or Reductions in Amount, Duration or Scope

Passport's UM Committee ensures approval of medically necessary covered services without arbitrary reductions in amount, duration or scope by following these principles:

- Following evidenced based criteria
- Proactively contacting the requesting provider to gather additional information needed to decide appropriateness of service including through peer-to-peer consultation and discussion with the health plan Medical Director or BH Medical Director
- Consulting with the local care management team to ensure decisions take into account the member's assessed needs, living situation and other factors that may impact the need for a service
- Requiring physician review of all service requests that do not appear to meet medical necessity
- Confirming compliance with established criteria through chart audits, telephone monitoring and IRR reviews for nurses and physicians
- Adhering to specific NCQA processes
- Affirmation process that UM decision-makers may not financially gain from UM decisions
- Systematic review of appeals and denials by service type
- Systematic assessment of member appeals and complaints

In the event we identify evidence of arbitrary or inappropriate denial or reduction of service, we employ our Culture of Quality problem-solving process where we analyze the data, compare to trends, complete a root cause analysis, identify cause, design remedies to remediate, implement and re-measure to assess for effectiveness.

C.10.b.x. How the Vendor will use its Utilization Management Committee to support Utilization Management activities.

Passport's Utilization Management Committee

Passport's UM Committee (UMC) guides the overall UM program. Chaired by Passport's medical director, the Committee focuses on clinical service delivery trends. A cornerstone of our UMC is the involvement and participation of local physical medicine and BH clinicians who reside and practice in Kentucky. These committee members bring real-life experience in managing the challenges and opportunities of providing care in the urban, rural and remote areas of Kentucky.

Passport's UMC reports at least quarterly to the QIC which has formal oversight of all UM activities. The QIC reviews and approves the UM program description, work plan and annual evaluation. It makes process and quality improvement recommendations and reviews and approves, denies or recommends revisions to policies related to the UM program.

Utilization Management Activity Committee Support

Passport's UM Committee monitors utilization trends and issues to ensure members receive appropriate care. It reviews and evaluates data sets and other information, such as member demographics, costs and recommend actions. The committee reviews and approves studies, standards, clinical guidelines and trends in utilization patterns as well as quarterly utilization reports from delegated entities, and makes recommendations for improvement. Finally, it also reviews any specific utilization issues (cases) requested by the medical director.

Annual Program Evaluation

Our Utilization Management program is evaluated annually by the Utilization Management Committee, with a thorough review of the program structure, scope, and processes as well as information sources used for medical necessity and benefit coverage determinations to determine if changes are necessary.

The level of involvement in the UM program of the medical director and medical director of BH, and the resources to support the UM program will be evaluated. Modifications to the UM program will be made as necessary. Annually, in the first quarter, the CMO and vice president of clinical operations evaluate the impact of the UM program using data from:

- Under and over utilization and relevant UM data
- Timeliness of decisions and notifications
- UM telephone answering response time statistics and volume
- Access to the UM program
- Consistency in applying criteria, and
- Satisfaction with the UM program

The evaluation identifies problems and/or concerns that might limit members' equitable access to health care and provides recommendations for improvement.

Subcommittees

In addition to the guidance provided by the QIC, the UMC receives input from other QIC subcommittees advising on UM integration across medical, BH, pharmacy and other areas. These include:

- **Behavioral Health Advisory Committee:** The Behavioral Health Advisory Committee provides feedback and recommendations related to BH care and pharmacy in collaboration with the BH delegate. This group reviews utilization and performance metrics for BH. They also provide recommendations regarding proposed policy and program changes that impact the BH benefit. Having the provider, advocate, and member perspectives involved in the policy development and performance review help to ensure quality of care and increased access to BH services. Decisions and recommendations from the Behavioral Health Advisory Committee are submitted to QMMC for review and adoption. Responsibilities include:
  - BH clinical guidelines
  - BH performance standards
  - BH workplan and program activities
  - Provide recommendations to QMMC for BH activities
  - BH PIPs
  - Oversight of delegated BH activities
  - Formulary recommendations
- **Pharmacy and Therapeutics Advisory Committee:** The P&T Committee provides direction to, and oversight of, pharmaceutical issues concerning members using pharmacological, economic and clinical information. It is charged with the review, evaluation, and delivery of recommendations related to utilization (under and over) of drugs; additions and deletions to the formulary; and, monitoring and review of pharmacy programs and program results. The committee is also tasked with the review of medical policies related to pharmacy utilization. Responsibilities include:
  - Pharmacy policies and procedures
  - Operating metrics
  - Complaints and grievances
  - Clinical program descriptions
  - Analysis and evaluation of data
  - Recommend opportunities for improvement

Conclusion

Passport health plan has demonstrated its commitment to timely, medically appropriate, cost-effective care for our members. We deliver fully integrated physical and behavioral health care services, supported by dynamic technology and the dedication of our Board of Directors, our committees, our executive and functional leaders, and every Passport Associate.

The UM program Passport utilizes is NCQA accredited which demonstrates our focus on operational excellence in UM.

Passport has been honored to serve the Kentucky Medicaid and foster care populations for 22 years and will continue to comply with all provisions of the Medicaid Managed Care Contract and Appendices (including Kentucky SKY) as we continue to serve them in the future.