10. Utilization Management (Section 20.0 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:

Our Utilization Management (UM) program promotes high quality, preventive and evidence-based care to make sure enrollees receive appropriate care in the right setting at the right time. We continually evaluate data at the population, community, enrollee, provider and facility level to analyze the effectiveness of our care management programs by using several mechanisms. We compare our performance to nationally recognized standards (e.g., HEDIS) and evaluate trends, such as increasing ED use or inpatient utilization. With our other lines of business and broad national footprint in Medicaid, we can see patterns and share knowledge across the enterprise. Our clinical leadership team uses these analyses to evaluate the effectiveness of our clinical programs, monitor utilization patterns and identify trends and opportunities for operational improvement.

Our Healthcare Quality Utilization Management (HQUM) Committee routinely reviews data for services that are historically overutilized or underutilized (e.g., overutilization of ED or underutilization of flu vaccinations). The HQUM Committee acts on patterns of overutilization and underutilization by creating or revising clinical policies, procedures and processes, educating participating providers and implementing enrollee education outreach programs. One way we address underutilization of wellness services is by providing PCPs with a list of their enrollees who have gaps in care. Members of our quality team will visit large practices to review gaps in care with the provider. For smaller practices, this outreach is conducted telephonically. We also use mailings, live and automated interactive voice response (IVR) calls and community outreach events, along with provider and enrollee incentives, to drive engagement with targeted populations. Our overarching population health strategy provides enrollees with preventive services and tools to promote wellness and assist at-risk individuals and those with complex conditions to manage their conditions better.

Strategies to Identify Inappropriate or Preventable Utilization of Emergency Department

We monitor unnecessary ED utilization through advanced data analytics and reporting. Our health care economics team integrates and analyzes medical, behavioral and pharmacy claims, social determinants data and lab test results to produce a suite of reports, dashboards and scorecards that help our clinical leadership team monitor utilization patterns. For example, our *Emergency Department Escalation Report* identifies hospitals with a higher than average ED to observation or inpatient level of care compared to peer hospitals across Kentucky. We share this data with hospital partners during Joint Operating Committee meetings and discuss opportunities to partner and reduce avoidable utilization.

- Our ***Clinical Profile*** provides real-time alerts, historical claims, and ED utilization patterns. We use this information to monitor, engage and support the people we serve more effectively. Our clinicians have access to a common set of

Reducing ED Utilization through Care Management

We are committed to the Triple Aim of better care for our enrollees, better health for populations and lower costs. Comparing utilization from the period of October 2016 through September 2017 to October 2017 through September 2018, our care management program has achieved the following results in Louisiana:

- ***5.3% decrease*** in emergent ED visits for our non-expansion population
- ***4.7% decrease*** in non-emergent ED visits for our non-expansion population
- ***7.7% decrease*** in total inpatient admissions per 1,000 across our TANF population

population and individual health data, including demographics, claims, PCP and care team, gaps in care, lab results, pharmacy and active medications. For example, if we see a person with diabetes admit to the ED frequently with complications, we can outreach and engage them in a complex care program so their condition can be better managed.

- The ***Hotspotting*** tool enables our chief medical officers to identify individuals and geographic areas with high utilization, along with the drivers of that utilization. We are refining these analytics to improve our ability to predict future utilization — preventing future ED visits by deploying interventions to get enrollees the services they need before their needs escalate into an ED visit.
- ***Admission, Discharge and Transfer (ADT) Feeds:*** We regularly receive and use ADT feeds to reduce inappropriate ED utilization. By receiving ADT feeds, we identify complex enrollees to engage them while in the hospital or ED. In addition, monthly ADT information is incorporated into our predictive analytics tool by using claims, including the most recent ED and inpatient utilization, and clinical data to identify enrollees in the priority conditions and populations. These enrollees are most likely to benefit from care management to avoid unnecessary utilization (including avoidable ED use).

Strategies to Reduce Inappropriate Emergency Department Utilization

We use innovative technologies, processes and tools to monitor the health status of our enrollees to minimize avoidable ED visits and implement individualized interventions to empower individuals in their health care to improve outcomes. Our population health management approach identifies each enrollee's situation, engages them with locally based care teams and supports enrollees and providers with programs tailored to their needs. As part of our overall population health program, we identify those enrollees who may benefit from care management and engage them with a care team. We provide tools and programs to help enrollees appropriately access services, such as whole person care. We also address the needs of enrollees with inappropriate ED use, increasing enrollee access to care through telehealth and providing telephonic support to help enrollees use health care services appropriately. We work with enrollees and providers to offer ED alternatives for non-emergent care and encourage individuals to establish PCP relationships and use more appropriate services and supports using the following strategies:

Our **UnitedHealthcare Doctor Chat** uses technology to enable virtual visits. This chat-first platform is supported by live video and connects enrollees to a doctor for non-emergent care. Doctor Chat helps us engage enrollees, improve access to care, reduce health care disparities within traditionally underserved populations and decrease avoidable ED use. **UnitedHealthcare Doctor Chat can resolve 90% of Medicaid enrollee issues without having to refer the individual to in-person care.** In addition to using this capability to improve access to care for enrollees in rural areas, we will promote this program to enrollees who have visited an ED two or more times in one year as a way of reducing medical costs driven by unnecessary ED visits.

Our Housing + Health program was started in October 2017 and is supporting 248 high-risk, high-cost Medicaid enrollees in Arizona, Nevada and Wisconsin. The program is producing positive results:

- 10% to 20% reduction in total cost of care
- Average monthly cost of clinical care is down 44% – 51%
- ED visits down 33% – 43%
- Inpatient admissions down 55%
- Inpatient days down 67%

Kentucky-based Housing Navigator: Our health plan staff includes a housing coordinator who will support our clinical teams to address one of the most

critical issues facing those in poverty, homelessness. We recognize the impact of housing insecurity on helping enrollees focus on health and wellness. By successfully addressing housing insecurity, we will reduce ED utilization and increase primary care visits. We offer enrollees who are experiencing housing insecurity the necessary supports by using our local housing navigator, who connects enrollees with local housing resources. Those resources can include assistance with obtaining housing vouchers, verifying a home is safe from environmental dangers and negotiating short-term rental relief.

Housing + Health Program: We are deploying our proven Housing + Health program, which pays for stable housing and wraparound supports for targeted enrollees experiencing homelessness. For example, we will collaborate with key organizations, such as Homeless and Housing Coalition of Kentucky, Community Action Kentucky, Fletcher Group and other housing advocacy groups to combat homelessness in Kentucky.

Care Navigation available 24 hours a day, seven days a week: Our care navigators are available 24 hours a day, seven days a week to guide and direct enrollees quickly and compassionately and encourage appropriate ED use. Our after-hours staff includes:

- ***NurseLine:*** Qualified RNs are available to address enrollee questions and triage immediate health concerns. Enrollees can call NurseLine directly or they can be connected through our call center. Since 2008, NurseLine has earned and held NCQA's Health Information Product certification.
- ***Behavioral Health Services Hotline:*** Staffed by master's level, licensed clinicians, this hotline is available 24 hours a day, seven days a week to triage enrollee crisis calls. Clinicians triage enrollees who are experiencing emergency issues to 911 or local crisis services (e.g., mobile crisis team, crisis respite). Our clinicians further assess enrollees who are experiencing urgent issues and refer them to a network provider for additional support.

Discharge Planning: Our collaborative, clinical case management platform *CommunityCare*, brings together ADT data, UM data, which includes our Blended Census Report Tool (BCRT) that identifies and tracks enrollees in facilities (e.g., hospital daily census), and direct hospital data feeds. This information is used to alert our inpatient care manager (ICM) and complex care team about an enrollee's admission when an enrollee is admitted to a medical inpatient facility,

The ICM who is part of our UM team initiates pre-discharge activities right away to manage the enrollee's care during the inpatient stay and to plan for their discharge from the hospital. The ICM collaborates with the enrollee, caregiver, UM staff, attending physician, hospital case manager, our community health worker (CHW) or complex care manager, the enrollee's PCP and other providers. The ICM:

- Reviews the enrollee's inpatient care plan for appropriateness of scope, level of care and quality of care by applying evidence-based criteria to the inpatient admission
- Uses an interdisciplinary approach to manage the enrollee's inpatient stay, monitor the enrollee's response to the inpatient care plan

We assess the enrollee's risk of readmission using our readmission predictive module (RPM) to develop a risk score based upon historical claims and current admission data. The RPM identifies those admissions that have a high probability of subsequent readmission within 30 days. Predictors include age, sex, diagnosis, number of admissions in the past year, distinct count of medications in the past year, presence of ED, durable medical equipment, home health care or outpatient surgeries in the last year, current admission length of stay and readmission status.

and collaboratively modify the plan, as needed

- Assesses the enrollee's risk of readmission, using the readmission risk assessment
- Notifies the enrollee's current care manager (for enrollees in high-risk, complex care management). The care manager also receives an alert about the inpatient admission through *CommunityCare* and engages the complex care team for enrollees needing additional discharge care coordination
- Engages the enrollee during their inpatient admission to introduce the Transitional Case Management program and the care manager who will manage their care for 30 days after the enrollee's discharge from the hospital
- Plans for the enrollee's needs after discharge by collaborating on a person-centered discharge plan with the enrollee and aligning services and supports to prevent readmission, including coordinating with secondary level of care, as needed
- Notifies the enrollee's PCP of the inpatient discharge and provide the PCP with the discharge summary

Complex Care Management Strategy: As part of whole person care, a multidisciplinary care team (MCT) works with the enrollee to develop a personalized and comprehensive care plan supports high-risk enrollees with complex needs. The MCT includes clinicians providing comprehensive physical, behavioral and functional assessments in the enrollee's home. The MCT includes ARNPs (who will work with physicians and make home visits as needed), behavioral health clinicians, RN care managers and community health workers. The MCT provides home visits to enrollees who are discharged from hospitals (including psychiatric hospitals) and have complex needs. If the enrollee prefers, the MCT can even act as their PCP providing direct physical and behavioral health care, including medication reconciliation and management, counseling, primary care and medication-assisted treatment for opioid use disorder (OUD).

Enrollee Education on Appropriate ED Use: We will educate our enrollees on the appropriate use of ED services, including care management outreach to high utilizers of the ED. We will simultaneously educate our provider network on inappropriate ED use and ways to help enrollees receive appropriate care.

Primary Care Access: Our Provider Recommendation Engine (PRE) is an intelligent rules engine that systematically matches enrollees with preferred PCPs who have the highest quality scores and best outcomes, costs and location for enrollees. If an enrollee prefers a different provider, our MSAs help them search for one according to their needs, including location, gender, specialty or language. Changing a PCP is one of the top three call types for our member services call center. MSAs can also help schedule provider appointments.

In Virginia, we partnered with the Virginia Department of Health and Virginia HIE to implement the Emergency Department Care Coordination (EDCC) program. EDCC provides a single, statewide technology solution connecting all hospital EDs in the Commonwealth to facilitate real-time communication and collaboration among physicians, PCPs and other health care providers, including clinical and care management personnel for individuals receiving services in the ED. Increasing the quality of care provided to individuals in EDs and decreasing inappropriate ED use are this program's goals. All hospitals operating EDs in Virginia and all Medicaid health plans are participating in the EDCC program, which provides ADT feeds and a shared care coordination platform for enhanced care management and shared clinical guidelines. The ADT feeds from the EDCC are integrated directly into our *CommunityCare* platform and provide real-time alerts to care coordinators so they can provide appropriate outreach when an enrollee receives treatment in the

ED. We created population cohorts to prioritize outreach for pregnant women, children with asthma, behavioral health high utilizers, individuals with opioid overdoses, children in foster care and individuals with more than three ED visits in the past 12 months.

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.

Using Data to Improve Appropriate Use of Service and Cost Efficiencies

Our clinical leadership team identifies opportunities to improve service and cost efficiencies by reviewing services on our prior authorization list. We use claims and cost data, including approval and denial data, to add or remove services from the prior authorization list to make sure we are meeting the needs of our enrollees while addressing cost and efficiency. For example, services with low denial rates may be removed from the prior authorization list to improve efficiencies. On the other hand, complex or high-cost services may be added to the review list.

We integrate and assess medical data, behavioral health claims, pharmacy claims and lab test results using Impact Pro™, our multidimensional, episode-based predictive modeling tool and our Strategic Management Analytic Reporting Tool (SMART) data warehouse. These tools allow us to develop and produce reports, dashboards and scorecards and conduct clinical, quality and UM/care management analyses to monitor and evaluate medical and behavioral health utilization and care management. Our health care economics team performs utilization reporting and analysis to:

- Identify overutilization, underutilization and inappropriate utilization
- Understand the clinical and utilization events affecting an enrollee's health risk, which allows us to identify individuals who may benefit from care management and care coordination
- Evaluate the ongoing effectiveness of clinical care management interventions
- Identify opportunities for improvement in the way we deliver services to enrollees
- Identify care management and care coordination opportunities
- Evaluate the efficiency and appropriateness of service delivery
- Monitor outpatient practice management outcomes for fraud, waste and abuse

Recognizing the importance of housing security, we use our **predictive housing instability tool** to validate the appropriate utilization of services. Not only do we connect enrollees who are homeless and experiencing housing insecurity with the necessary supports by using our housing navigator and our Housing + Health program (described earlier), but we also take active steps toward prevention. We identify early risks factors for housing instability so we can promptly intervene to help our enrollees avoid the catastrophic loss of home. This predictive data tool applies 21 variables from nine different state and national data sources onto our enrollee data to identify individuals exhibiting a high probability of housing instability proactively, resulting in a 75% accuracy rate.

We regularly use data to identify procedure types not currently on the Site of Service review list of codes. If there is a significant unit cost discrepancy between settings for a procedure, we explore opportunities to do site of service reviews where there would not be an adverse clinical impact.

Using Data to Identify Potential Fraud, Waste and Abuse Referrals

Our practice management team conducts systematic reviews of provider practices. They identify instances of atypical patterns of behavior to determine if the behavior warrants intervention. Preventing and detecting fraud, waste and abuse (FWA) occurs in two primary ways: analytics and tips/referrals.

Analytics serve as the foundation for our FWA program. Our analytics team includes clinicians, bio-statisticians and certified health care coding experts. Our Analytics Office, using claims data that is continuously updated through our fraud and abuse practice, provides a research and development function that discovers new patterns of potential FWA and defines new rules to identify aberrant billing patterns. These new rules undergo extensive testing and validation before being put into production. We use several different methods to identify patterns of fraud and abuse, including link analysis, fraud history, peer comparison, vector analysis, distance vector, acceleration, numbers theory and various forms of regression analysis.

Health plan enrollees, providers, other insurers and the general public can refer tips on FWA. Enrollees can submit referrals based upon an Explanation of Benefits. Such referrals are received via the Special Investigative Unit's (SIU's) dedicated fraud website and its online referral form. The SIU is responsible for referring incidents of fraud to the appropriate state entity as outlined by state regulations.

Our practice management team meets internally with appropriate departments to inform them of identified patterns and to gather additional information. The practice team reviews aberrant claims billing patterns with the provider; provides education on clinical and billing guidelines; conducts clinical audits with potential performance improvement plans or network termination; and refers to our SIU if they identify prospective flag or recoupment opportunities. We monitor identified providers to validate appropriate behavior change.

After continuing to see an ongoing negative trend for utilization of speech, occupational and physical therapy services, UnitedHealthcare changed its approach to monitoring these services. In mid-2018, we hired licensed therapists and nationally recognized subject matter experts on documentation, coding and billing practices for their respective fields. Together, our therapists partnered with our data analytics team to develop therapy-specific algorithms. These algorithms are used to identify unlikely scenarios, the use of inappropriate CPT codes by provider specialty and patterns of suspicious code stacking. Our national footprint again provides value here — by looking at variances across states, we can more quickly determine if there is a suspicious pattern that merits further investigation. For instance, we saw a particular code-stacking pattern that one of our markets was using nearly a thousand times more than another market. Further digging revealed that nearly all of this utilization in the problem market traced back to a single provider — and that provider was referred on to the state's Office of Inspector General (OIG).

Since forming our skilled therapy team less than a year ago, UnitedHealthcare has identified more than $8 million in suspicious claims payments and referred 15 speech therapy practices for fraud, waste and abuse investigations across multiple markets. Many of these cases have since been referred to their respective state's OIG for further investigation. Because of our efforts, we are partnering with several of our impacted states to inform policy changes related to speech therapy services. For example, Arizona Medicaid recently asked our speech therapy subject matter expert to provide resources to help inform other open investigations. They also were willing to consider removing a CPT code from the speech therapy fee schedule that is not traditionally recognized as a speech therapy-related procedure code.

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.

Our systems identify areas for improvement in health care service utilization and track overutilization, underutilization and inappropriate utilization patterns. We have implemented a multifaceted approach; it comprises an oversight structure, policies, processes, data analysis tools and provider outreach programs, which allow us to evaluate enrollee and provider utilization patterns to improve our health plan operations. Core components of our approach include:

Monitoring overutilization, underutilization and inappropriate utilization through clinical oversight and integration with quality management. We provide oversight of our program through our clinical leadership team and monitor utilization through our quality management (QM) department and QM committee structure.

Under the leadership of our chief medical officer, our QM program is a formal, documented, comprehensive program. It includes quality improvement measures and studies, clinical practice guidelines, health promotion activities, service measures and monitoring, ongoing monitoring of key indicators (e.g., overutilization and underutilization), continuity of care, health plan performance analysis and auditing (e.g., HEDIS), care coordination, enrollee and physician education, risk management and compliance with all external regulatory agencies.

Our UM program is closely aligned with our QM program through the integrated UM/QM committee structure and program description. The UM activities support our QM program by providing objective and systematic monitoring and evaluation of the necessity, appropriateness, efficiency, timeliness and cost-effectiveness of care and services provided to enrollees. Inputs from our UM program provide critical evidence about health care patterns and practices and translate into effective policies and procedures for assuring high quality health care. For example, using UM data analysis, our QM and provider services teams work with providers to help them identify and close gaps in care and encourage them to refer enrollees to needed services through our provider-profiling program.

- ***Identifying overutilization, underutilization and inappropriate utilization through UM tools and data analysis*** to identify individuals who may benefit from care coordination, evaluate the effectiveness of care coordination interventions, monitor utilization patterns, identify opportunities for improvement and develop interventions to combat aberrant trends. For example, we use claims data and predictive modeling algorithms to identify service patterns that do not align with evidence-based practices, such as the type,

In addition to developing algorithms to identify suspicious billing practices, our skilled therapy team developed financial algorithms to monitor utilization patterns for speech, occupational and physical therapy services. These algorithms are used to inform our decision-making process when considering interventions to right-size negative trends. Since forming our skilled therapy team in mid-2018, UnitedHealthcare's per member, per month cost for speech therapy services across all markets has decreased by 18.3%.

One of our team's first initiatives involved adding prior authorization for speech therapy in select states. The states identified for inclusion in our prior authorization initiative are states where we suspected speech-language pathologists were providing therapy as a substitute for academic tutoring or where the therapy was being used to teach English as a second language. These are also states where we used our therapy algorithms to identify billing practices that suggested we had a disproportionate number of our enrollees receiving speech and swallowing services together on the same date of service.

frequency, or duration of services not aligned with the enrollee diagnosis. This data feeds our care management platform, *CommunityCare*, which triggers care manager involvement when we identify inappropriate utilization patterns.

- ***Evaluating the efficiency and appropriateness of service delivery*** through the adoption of evidence-based, nationally recognized guidelines and review criteria; our process to determine if a requested procedure, treatment or device meets established medical necessity criteria; and ongoing monitoring of utilization metrics that indicate the appropriate use of services. To validate our enrollees are receiving appropriate service delivery and quality care, we apply guidelines against the diagnosis and service request. We confirm appropriateness through inter-rater reliability testing to audit ourselves in the appropriate use and application of guidelines.
- ***Identifying and resolving critical quality of care issues and aberrant practice patterns*** by tracking, trending and profiling provider-level data using a variety of methods and data sources through our QM program. Our Physician Advisory Council (PAC) monitors these issues and can take a variety of actions to resolve them.
- ***Facilitating a high-quality, clinically appropriate, highly efficient and cost-effective delivery system*** through provider profiling, which identifies opportunities for reducing variation in practice patterns, improves enrollee health outcomes and provides us with a tool to discuss best practices, track practice-level improvements and partner to implement initiatives that improve the quality of care and service provided to enrollees.

The following are examples of negative trends, initiatives to improve them and results.

Example 1

UnitedHealthcare is committed to working with consumers and care providers to support improved population health outcomes, positive care experiences and affordable products. An increasingly important part of this commitment includes coordinating coverage guidelines and policies for new and emerging technologies, including genetic testing to avoid inappropriate or overutilization, which can put enrollees at unnecessary risk.

Negative Trend: Inappropriate or overutilization of genetic testing

Initiatives Undertaken: UnitedHealthcare provides access to this emerging field and promising new treatments for enrollees while balancing patient safety and clinical evidence. UnitedHealthcare developed and launched a new online notification/prior authorization process for genetic and molecular lab tests in 2019 in 10 Medicaid markets aimed at helping provide access while supporting a better care experience for enrollees and care providers. It focuses on verifying directed and appropriate testing in a rapidly changing clinical field of medicine through use of clinical guidelines, support of providers to get to the right test and alignment of network laboratories regarding standardized coding and billing.

Results: Early experience has demonstrated up to a 30% reduction in spend on genetic testing by making sure enrollees get the right test for their individual clinical situation. We have developed a program that will grow and change as this field continues to expand.

Example 2

Negative Trend: Key hospital facility experiencing a high percentage of avoidable ED use

Initiatives Undertaken: Monitoring unnecessary ED utilization through our HealthView Analytics Clinical Dashboard. In 2017, we developed our HealthView Analytics tool, a clinical dashboard for identifying key population-level metrics, such as avoidable ED use, NICU admissions, enrollees who are pregnant or have OUD. The tool allows us to identify key

concerns by community, provider or enrollee. For example, as presented in the following figure, we used the tool to create an ED hospital dashboard for a key hospital in Lafourche Parish, Louisiana, which had a high percentage of avoidable ED use. We shared details with hospital leadership on why the high ED use was occurring, such as the top diagnoses tied to those visits.

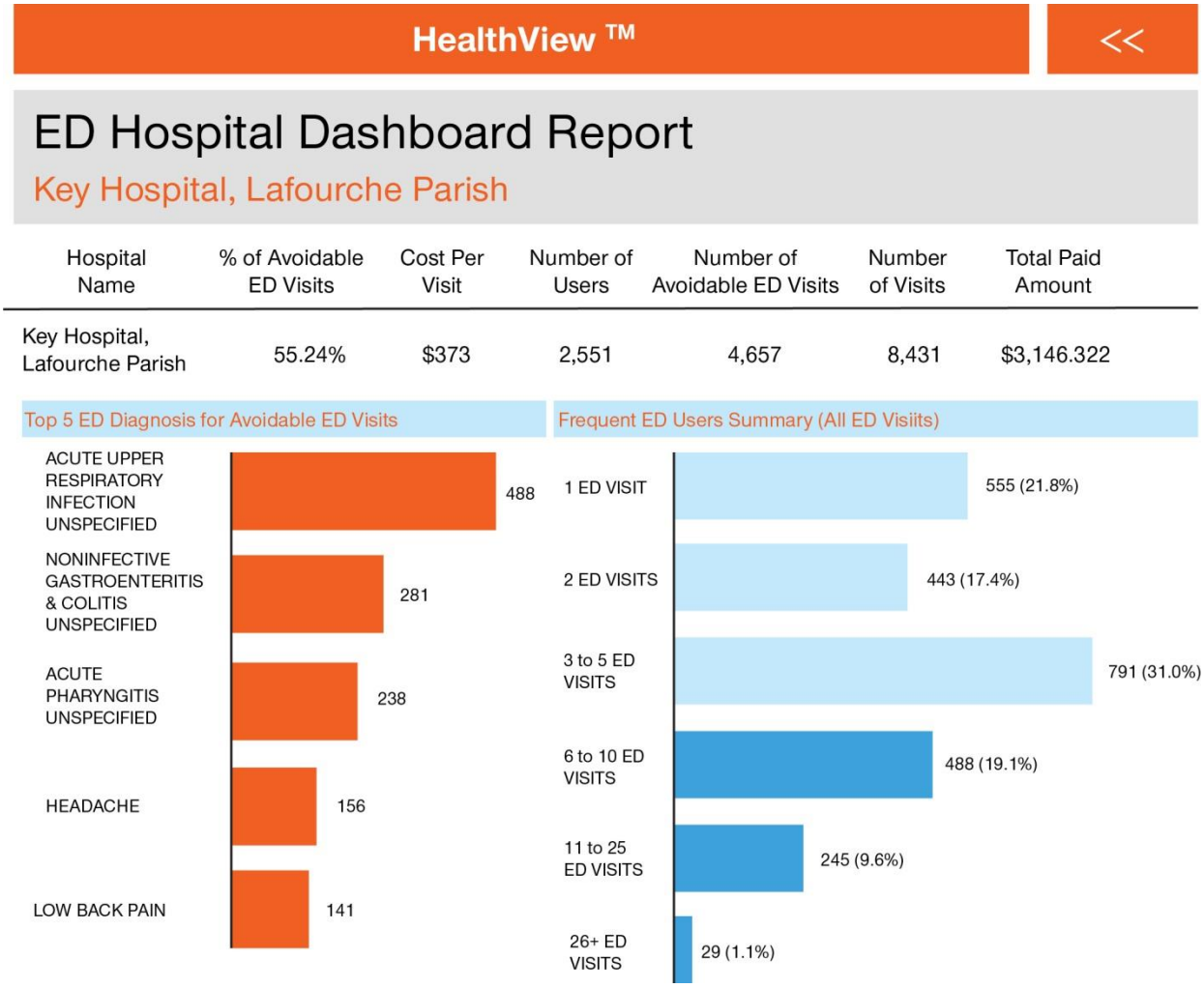

Figure 12. HealthView Analytics ED Hospital Dashboard. We used the dashboard to help a key hospital understand the causes of its high avoidable ED utilization, such as the top five diagnoses leading to avoidable ED visits or the enrollees with the highest avoidable ED utilization. Using this and other dashboards, we helped hospital leadership better target their reduction efforts.

Results: We helped the hospital better target their reduction efforts and develop effective strategies to reduce inappropriate ED use. Some of the strategies included:

- *Identifying and engaging enrollees who may benefit from case management.* Core to helping our enrollees appropriately access services is identifying those enrollees who may benefit from case management and engaging them in case management programs appropriate to their needs
- *Providing tools and programs to help enrollees appropriately access services,* such as providing whole person care to address the needs of enrollees with inappropriate ED use, increasing enrollee access to care through telehealth and providing telephonic support to help enrollees use health care services appropriately

Example 3

Negative Trend: Increasing readmission rates at six designated facilities in Texas

Initiatives Undertaken: We developed and implemented the Reducing Admissions with Collaborative Interventions (RACI) Program to decrease readmission rates at designated facilities using the expertise and resources across UnitedHealthcare in conjunction with facility and community partners. Providing a forum for the facility and the RACI team to review enrollees with high readmission rates and generating solutions for increasing tenure in the community are the goals of the program. Tenure in the community is defined as the number of days an enrollee stays out of the hospital. The program follows target enrollees with behavioral conditions (mental health or co-occurring substance use disorders [SUDs]); more than three admissions in 6 months; or enrollees identified by the facility as a re-admission risk. We developed a catalogue of in-person services and interventions, including online tools such as *My Whole Health Tracker* self-management workbook; cognitive behavioral therapy; and Question, Persuade and Refer (QPR) suicide prevention training on our enrollee portal and information on recovery apps that meet the needs of our enrollees wherever they are in their recovery journey. We made this information available from the RACI team and used community resources to educate enrollees and providers on how to access the services.

Results: The program started in Texas (2017) with one facility and then expanded to six facilities by the end of Q3 2017 with a 15.9% total decrease in 30-day admit rate and a 14.5% total decrease in the 90-day admit rate. The initial 2017 RACI program ultimately resulted in 970-day total increase in days enrollees successfully remained in the community by individuals identified in the cohort.

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)?

We continually review trends and patterns of utilization to verify our UM practices continue to deliver the most value to our customers and enrollees and reduce unnecessary burden to our providers. We may add review of services and procedures when medical necessity review delivers value (e.g., high-cost diagnostics) and remove services or procedures from review when it does not deliver value (e.g., hyperbaric oxygen treatment). Input from our annual Provider Satisfaction survey and our Kentucky PAC provides an opportunity for us to apply feedback from external providers to identify improvement opportunities.

Listening to Stakeholders and Making Adjustments Based Upon their Feedback

In 2017, the Iowa program experienced a massive influx of new enrollees, including a 5-fold increase in those needing private duty nursing (PDN) services. At that time, the policy in place to manage PDN was not as robust as it is today. This created initial disruption for enrollees in obtaining the services necessary to match their needs. Some enrollees required skilled care, which aligned with PDN; however, for other unskilled care needs, PDN was not the right option. The health plan engaged with enrollees and families to understand their current care needs. In addition, UnitedHealthcare met with community agencies and medical practices with a high volume of special needs children requiring PDN. We incorporated their feedback and developed a program using evidence-based tools, consistent guidelines with a tight connection to case management to make sure we provide the right services for the right needs in the right setting. This work helped to inform the more robust PDN policy implemented by UnitedHealthcare nationally.

Our dedicated, local UM team meets weekly to review prior authorization opportunities to add, replace deleted codes, or to remove services and codes from the prior authorization requirements. Our National Medical Care Management Committee (NMCMC) and Kentucky HQUM conduct a comprehensive review of medical necessity and medical appropriateness

guidelines to confirm the data is up to date and effective. Criteria may undergo review more frequently if a new version is published before the annual review date.

Additionally, our NMCMC approves preventive service guidelines, medical policies and clinical practice guidelines at least quarterly. Under the auspices of the NMCMC, we have established a national committee structure focused on reviewing and updating specific aspects of our UM program, including the services requiring prior authorization. These committees include:

- Our Medical Technology Assessment Committee (MTAC), which develops, reviews, updates and approves UM criteria, guidelines and new medical policies specifically for emerging technology or new treatments
- Our Clinical Operational Procedures and Standards Policy group, which reviews, updates and approves our internally developed behavioral health guidelines. We have adopted American Society of Addiction Medicine (ASAM) criteria for SUD services

After considering Kentucky-specific mandates and guidelines, the committees collaborate to review services requiring prior authorization using eligibility criteria, federal and state requirements, MCG criteria and criteria for behavioral health services. Once the NMCMC approves the list of services requiring prior authorization, our Kentucky HQUM reviews it for acceptance and adoption for Kentucky MCO enrollees.

Our chief medical officer coordinates this review with DMS to verify the list of services is appropriately tailored to the Kentucky-specific or mandated guidelines, policies or regulatory requirements and the requirements of the Kentucky MCO program. Additionally, our Kentucky clinical leadership team monitors our UM program through our Quality Improvement Committee (QIC) and our HQUM, which collect, monitor, analyze, evaluate, trend and report utilization data to monitor utilization patterns.

UnitedHealthcare has created these committees and this infrastructure to make sure we can assess and respond to changes in medical evidence. This team of experts monitors and detects the need for adjustment based upon changes in practice as observed in our utilization data. We use claims, cost data and approval and denial data to add or remove services to make certain we are meeting the needs of our enrollees while addressing cost and efficiency. For example, services with low denial rates may be removed from the prior authorization list to improve efficiencies. Complex or high cost services may be added to the review list.

Recently, we purposefully reduced prior authorization requirements for over 300 services based upon feedback from providers and our own detailed data analysis. Categories affected were DME/orthotics/prosthetics, home health, nutritional and experimental/investigational.

We keep a close focus on recent changes in policy, particularly changes in prior authorization policy. We reduce provider burden by removing prior authorization hurdles, which do not improve care. However, we also know removing prior authorization, even in an area where no prior excesses occurred, can trigger increases in utilization that will require restoration of the prior authorization. For example, our experience on therapies demonstrates that we took the appropriate step of removing prior authorization because we had minimal denials. Yet, when we began to observe a rise in utilization, we assessed this pattern, created new policies and programs to address it, and partnered with states to approve the new policies. This deeper analysis also revealed new aberrant patterns, resulting in referrals to OIG. Because of these lessons, we reduced the time to launch new medical policy from over 6 months, to under 30 days — all while preserving the review and analysis necessary to validate good policy. We are continually seeking areas of improvement for prior authorization processes from staffing to automation to provider relations.

If our Kentucky clinical leadership team identifies modifications to the national committee-designed list of services requiring prior authorization, the team makes a recommendation to the appropriate national committee. The national committee reviews the recommendation and determines if the national list of services requiring prior authorization should be updated based upon our hierarchy of clinical evidence confirming only appropriate changes are created. Any modification of the national recommendation will be reviewed locally in Kentucky. Our Kentucky health plan will choose to either implement the policy or create an exception to the national list of services requiring prior authorization based upon Kentucky-specific considerations.

We know the importance of facilitating alignment with our providers, particularly helping them understand our medical policies. We have created webinars and our provider advocates have met with clinicians directly when necessary to share our knowledge and intended goals. Beyond provider advocate support, our providers have access to ongoing training and educational resources via *UHCprovider.com*. For example, through *UHCprovider.com*, we offer live events and on-demand education created specifically for providers. Providers can log in from their computer or mobile device at their convenience.

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:

Our proposed UM program addresses all requirements outlined in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 20.0, Utilization Management.

Our UM program focuses on helping individuals receive the right care in the right setting at the right time by evaluating the quality, continuity, timeliness and outcomes of health services. Our medical directors and nursing staff work closely with health care providers to confirm treatment plans are consistent with evidence-based guidelines, are clinically appropriate, cost effective and improve health care outcomes. Through our UM services, we:

- Address rising health care costs by eliminating waste and confirming medical appropriateness
- Manage over- and underutilization of services to promote optimal outcomes and improve the enrollee experience
- Prevent avoidable hospital readmissions by carefully managing care transitions
- Reduce variation in care by making sure treatment plans are consistent with evidence-based medicine

Our policies, procedures and workflows related to UM decisions are consistent with DMS's definition of medically necessary services. They promote quality of care and validate adherence to standards of care, including clinical appropriateness, closing gaps in care and promoting recovery principles. Our UM program is based upon integrated UM, quality management and care management principles, policies and processes. We manage the appropriate use of health care resources in amount, duration and scope necessary to achieve desired health outcomes. We use innovative approaches to support proper engagement with health care services.

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

Our UM program's clinical coverage policies, health care policies, clinical guidelines, review criteria and evidence-based decision support tools will align with DMS's vision to advance integrated and high-value care, improve population health, engage and support providers while maintaining a high-quality, clinically appropriate, highly efficient and cost-effective delivery system.

We have more than 150 clinical coverage policies written specifically for Medicaid and coverage determination guidelines and are prepared to adapt them to make sure they are consistent with and, where possible, enhance DMS's policies. Our local UM team will review UM requirements and clinical coverage policies to make sure we are consistent, compliant and in total alignment with DMS's policies and goals. Our chief medical officer, chief compliance and behavioral health director will work with DMS on clinical coverage policies and make sure any notification of changes are incorporated into policy.

We align UM with the required clinical coverage policies by using them as the source for utilization review. Our clinical coverage policies are available online. We review our policies and guidelines at least annually and more frequently under certain circumstances, such as new scientific evidence; new guidelines issued relevant to our membership; or we have determined the availability of new treatments/technologies or new indications for treatments/technologies. When we update guidelines, our provider and quality committees formally review and approve our national guidelines for Kentucky MCO enrollees' adoption.

In addition, we can quickly adapt our clinical policies where a need has been identified. We have reduced the time it takes to launch a new medical policy to under 30 days, while preserving the review and analysis necessary to validate good policy.

Educating providers on guidelines and prior authorization process: Because UM can be a point of abrasion for providers, we educate them on our UM program, criteria and guidelines during initial and ongoing provider training. Additionally, we conduct education initiatives whenever UM protocols, criteria or guidelines change. We provide guidelines for successful determination on the first submission so our providers do not have to resubmit requests for authorizations. We provide information about our UM program, including the prior authorization process in our *Care Provider Manual*, on our secure provider portal *Link* and in our provider newsletter, *Practice Matters*. Our provider advocates conduct one-on-one training sessions with providers who need assistance or have difficulties submitting requests for prior authorization We make sure the provider receives the education and support needed to follow the prior authorization process.

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

We review services according to Commonwealth and federal regulations using evidence-based medical polices and MCG guidelines, McKesson's MCG (formerly known as Milliman Care Guidelines) are evidence-based guidelines for utilization management and medical necessity, which are used as an industry standard by many managed care companies and providers. The MCG guidelines are reviewed and updated annually by panels of subject matter experts. The MCG- certified trainers provide training to our clinical staff. We conduct interrater reliability testing of our clinicians annually to validate the uniform application of clinical guidelines and the consistency of our determinations.

Along with MCG, we use internally developed clinical practice guidelines, which are evidence-based and written specifically for Medicaid in our medical management program. Additionally, we use evidence-based clinical and preventive health guidelines from nationally recognized sources to guide our quality and health management programs. We make sure our enrollees receive the most appropriate care based upon the expertise of the medical community. While guidelines create a foundation for making decisions, each enrollee's request is reviewed in terms of their own individual needs. The following table lists these physical and behavioral health guidelines:

Condition	Guideline
Acute Myocardial Infarction with ST Elevation	American College of Cardiology Foundation/American Heart Association
Acute Myocardial Infarction without ST Elevation	American College of Cardiology Foundation/American Heart Association
Asthma	National Heart, Lung and Blood Institute
Attention Deficit Hyperactivity Disorder (ADHD)	American Academy of Child and Adolescent Psychiatry
Bipolar Disorder: Adults	American Psychiatric Association
Bipolar Disorder: Children and Adolescents	American Academy of Child and Adolescent Psychiatry
Cardiovascular Disease: Prevention in Women	American Heart Association
Cardiovascular Disease: Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease	American College of Cardiology/American Heart Association
Cholesterol Management	American College of Cardiology/American Heart Association
Chronic Obstructive Lung Disease	Global Initiative for Chronic Obstructive Lung Disease (GOLD)
Depression/Major Depressive Disorder	American Psychiatric Association
Diabetes	American Diabetes Association
Dietary Guidelines	U.S. Department of Health and Human Services
Heart Failure	American College of Cardiology/American Heart Association
Hemophilia and von Willebrand Disease	World Federation of Hemophilia and National Heart, Lung and Blood Institute
Human Immuno-deficiency Virus (HIV)	HIV Medicine Association of the Infectious Diseases Society of America
Hyperbilirubinemia in Newborns	American Academy of Pediatrics
Hypertension	Panel Members Appointed to the Eighth Joint National Committee (JNC8)
Lifestyle Management to Reduce Cardiovascular Risk	American Heart Association/American College of Cardiology
Obesity	American Heart Association/American College of Cardiology/The Obesity Society
Physical Activity	U.S. Department of Health and Human Services
Preventive Services	Agency for Healthcare Research and Quality
Schizophrenia	American Psychiatric Association/PsychiatryOnline Guideline Watch
Sickle Cell Disease	National Heart, Lung and Blood Institute
Spinal Stenosis	North American Spine Society
Stable Ischemic Heart Disease	American College of Cardiology/American Heart Association et al.
Substance Use Disorders	American Psychiatric Association/PsychiatryOnline
Tobacco Use	U.S. Department of Health and Human Services

Behavioral health guidelines: We will use MCG for behavioral health criteria. If MCG does not cover a behavioral health service, we will adopt standardized tools to inform medical necessity determinations. These tools include the following, LOCUS, CASII, CANS or ECSII guidelines for behavioral health authorization decisions as required by DMS in addition to the care

guidelines from the American Society of Addiction Medicine (ASAM) for substance use and DMS's clinical coverage policies for both behavioral health and SUD services, as applicable. We train providers on required policies, behavioral health level of care guidelines, ASAM criteria, and UM behavioral health and SUD protocols. If medical necessity criteria guidelines for services not addressed through DMS's identified guidelines are needed, we will obtain DMS review and approval before implementing with providers. All guidelines and protocols are derived from accepted standards of behavioral health practice. Maintaining these guidelines and providing consistent and reliable education to our network providers makes the system of care more engaging, effective and affordable.

We have also adopted behavioral health clinical best practice guidelines from the American Psychiatric Association (APA) and American Academy of Child & Adolescent Psychiatry (AACAP) as decision support tools. The APA practice guidelines provide evidence-based recommendations for the assessment and treatment of psychiatric disorders and AACAP practice parameters address a broad range of topics in child and adolescent psychiatry and behavioral health, including autism, eating disorders, child welfare, reactive attachment disorder and disinhibited social engagement disorder. These guidelines are available to providers for use as well through our provider portal.

Clinical practice guidelines: Our implemented clinical practice guidelines inform UM decisions for conditions prevalent in Kentucky's population. They cover conditions, such as ADHD, asthma, autism, depressive disorders, diabetes, eating disorders, jaundice in the newborn, PTSD, sickle cell disease, SUD, neonatal service guidelines (including neonatal abstinence syndrome) and many other practice guidelines. Our specialized Neonatal Resource Services unit uses their own robust clinical guidelines for conducting utilization management for infants in the Neonatal Intensive Care Unit (NICU).

Coverage determination guidelines: We follow the American Academy of Pediatrics Bright Futures recommendations in our preventive services coverage determination guidelines. We also use Commonwealth and federal mandates; the enrollee's certificate of coverage, evidence of coverage or summary plan description; UnitedHealth Group medical policy; medical technology assessment information; and CMS National Coverage Decisions (NCDs) and Local Coverage Decisions (LCDs) for evidence-based decision support.

Our UM system s supports the consistent application of our guidelines by providing UM clinicians with a standardized set of evidence-based UM tools to make medical necessity determinations. The system allows the UM clinician to determine if prior authorization for the requested service is required, provides the UM clinician with access to the enrollee's clinical information for review, allows the UM clinician to review the enrollee's benefit data and provides the mechanism for the UM clinician to review the service request against our guidelines. The system also allows the UM clinician to document the medical necessity determination, including the information the UM clinician reviewed to make the medical necessity determination.

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

Our approach to reduce administrative burden for providers is rooted in our extensive experience collaborating with and providing support for providers. We use innovation and automation to minimize prior authorization concerns. We continually review trends and patterns of utilization to verify our UM practices deliver the most value to our clients and enrollees in addition to reducing unnecessary administrative burden for our providers. We may add review of services and procedures where medical necessity review delivers

value (e.g., high-cost diagnostics) and remove services or procedures from review when they do not deliver value (e.g., hyperbaric oxygen treatment).

In addition to obtaining recommendations and feedback on reducing administrative burden from our PACs, the health plan CMO will further explore opportunities to reduce the burden on Kentucky providers. Our CMO is responsible for ongoing provider engagement including education and discussions about medical necessity determinations and level of care, leading regularly scheduled review sessions, mitigating process gaps and driving clinical improvements through data sharing with providers and facilities. Payment integrity resources will review performance regarding clinical documentation, coding and discussion of disputes. Leadership will interface with other markets, including the provider call center, claims processing and provider relations. Through continuous quality improvement and associated initiatives, we continue to streamline authorization processes to remove barriers and engage enrollees in the right care when they need it. More than 1,000 codes do not require prior authorization and can be approved administratively.

> We will use DMS's common prior authorization form to streamline the prior authorization process and reduce administrative burden for providers. We know collaboration with other MCOs is necessary, and we are more than willing to engage in discussions with other MCOs to reach consensus on its use.

Provider Advocates: We have a team of Kentucky-based provider advocates, our provider service representatives, with clearly defined territories and provider assignments. They take a hands-on, in-person approach to educating providers education identifying issues. These advocates tailor their support relationship to fit each network provider group's specific needs. They have established relationships with Kentucky providers in our commercial and Medicare lines of business and will build upon these existing provider relationships to increase network capacity in the Commonwealth.Our provider advocates will help implement, train and educate provider groups and health systems for UnitedHealthcare's MCO program.

Initially, our provider advocates call to welcome new providers, share basic education and respond promptly to provider requests and inquiries — within 2 business days. On an ongoing basis, providers with a large UnitedHealthcare membership receive touchpoints (in-person, by email or telephonically) at least monthly. During the course of these visits, the provider advocates promote self-service tools, such as our provider portal (*Link*), instruct on new or updated products or processes and discuss challenges the providers are experiencing. By providing this outreach and training for providers reluctant to embrace *Link*, provider advocates play a critical role in increasing provider adoption of *Link's* enhanced electronic claims payments and prior authorization capabilities.

Link Dashboard: Through our provider portal, *Link*, providers can submit and manage prior authorization requests electronically for medical and behavioral health services. *Link* helps reduce the provider's administrative burden when submitting requests for authorizations. Available 24 hours a day, seven days a week, it helps the provider submit all information required for a medical necessity review, provides access to our guidelines/review criteria and allows the provider to track the status of prior authorization requests.

INNOVATE

Streamlined Prescription Authorization: *PreCheck MyScript*, available to medical and behavioral health providers via our *Link* provider portal, reduces the need to fax or call for prescription coverage information. Physicians can see and offer lower-cost alternatives, simplifying the process and reducing frustration and delays at the pharmacy when prior authorization is needed. ***Since its launch in July 2017, there have been more than 8 million***

transactions with over 99% successful benefit check transactions.

UHC On Air is our online source for live recordings and on-demand videos created specifically for providers. Providers can log in from their computer through our provider portal, be part of the experience and chat live with presenters. Providers can watch our recorded presentations at their convenience. They can also "Ask a Question" and get an answer within 48 hours. A number of trainings qualify as continuing education for professionals' continuing medical education and continuing education units. Behind-the-scenes reporting allows us to track the number of people (e.g., total views for each program). We conduct surveys at the end of each program so providers can rank the content and give input on other topics they would like to see.

Behavioral Health

To remove barriers to accessing the right care when needed, we streamline and minimize authorization processes. A few examples include:

Platinum Designation: Our Platinum Designation program, which assesses our behavioral health network facilities and outpatient providers, supports the delivery of high-quality behavioral health services with reduced authorization requirements for facilities who achieve preferred status as Platinum providers. We maintain outlier identification and treatment thresholds to confirm we will continue to meet quality metrics without requiring authorizations, but still allow a quality facility to do what they do best — treat the enrollee and spend less time on paperwork.

Treatment Milestone Authorization (TMA) Program: This program streamlines authorization processes to facilitate access to care and reduce administrative burden. If a case meets criteria, authorization is given for a predetermined number of days (treatment milestones) without requiring clinical review. Treatment milestones have been calculated across combinations of enrollee and treatment factors using length of stay data from approximately 500,000 recent admissions and nationally sourced admission standards. Each treatment milestone is calculated individually and reflects a length of stay where the majority of cases have either completed their treatment or stepped down to a lower level of care for continued treatment. **Using this method, we have identified 12 diagnosis categories authorized to use treatment milestones and have reduced the number of diagnoses requiring a full initial clinical review from 100% to 40%.** We will use the TMA program for some services in Kentucky to reduce provider administrative burden.

Behavioral Health Outpatient Management Program: Removing potential barriers to accessing routine services aligns our model of care with requirements of Federal Mental Health Parity. We assess service delivery through claims analytics determining if care being delivered aligns with evidence-based guidelines. As a result, services, such as behavioral health therapy and outpatient visits, do not require a referral or prior authorization.

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

We understand the importance of facilitating timely access to care for enrollees while delivering clinically appropriate UM decision-making. Our method and approach includes timely adjudication of prior authorization requests. **We do not require prior authorization for emergency services, traditional outpatient behavioral health services or well-child screenings. Additionally, we will not require authorization of telehealth services** in accordance with KRS 205.5591, Attachment C – Draft Medicaid Care Contract and Appendices, Section 20.5, Service Authorization. Each enrollee's prior authorization request is reviewed in terms of their individual needs to make sure they have access to and receive the most appropriate care based upon the expertise of the medical community. Medical directors for our

Kentucky health plan will assist with this process by helping staff and enrollees identify the right services and providers using their medical expertise and provider relationships.

We use tracking tools to monitor the aging of prior authorization requests and to identify providers who maybe struggling with timely submissions. Our provider advocates can then engage these providers to provide education and guidance. We also have processes in place for receiving requests for expedited reviews based upon urgent access needs.

Timely Approval of Prior Authorization Requests: We will meet DMS's required prior authorization review timeframes: standard prior authorization request within 2 business days of receiving the request (requests may be extended up to 14 days to benefit the enrollee); expedited request within 24 hours; and post-service (retrospective) review request within 14 days. Our compliance rate for timely approval for our Medicaid business exceeds 99% for standard requests and 97% overall.

In addition to managing the timeliness of the review process, we work aggressively to eliminate barriers to effective care transitions through multidisciplinary, integrated care coordination and UM program. For example, our Care Continuum program, driven by our local clinical team and our Kentucky health plan CMO, Dr. Jeb Teichman, focuses on quickly and collaboratively identifying barriers including authorizations of services required to successfully transition enrollees through various levels of care. Additionally, all out-of-network requests are reviewed by Dr. Teichman to determine if out-of-network services are needed clinically and are in the best interest of the enrollee and their family. This allows for a proactive and enrollee-centric approach to the review of requests for out of network services.

We are committed to supporting and advocating for our enrollees by completing a thorough review of prior authorization requests and communicating denials on time, clearly detailing the reason for the adverse determination and the steps enrollees can take to obtain medically necessary services. Our enrollee- and provider-friendly and efficient processes help the enrollee navigate an already complicated process in the health care delivery system.

When we deny a service authorization request, we make every effort to document the reasons for UM decisions in a clear and understandable way for the enrollee. The reasons for decisions clearly describe why the enrollee's condition fails to meet criteria for approval and includes references to the benefit provision, guideline, protocol or other criteria on which we based the denial and instructions for filing an appeal. Making sure each enrollee has information on the reason for the denial helps the enrollee decide whether to appeal the denial. The enrollee also can receive a copy of the benefit provision or criteria we used to make the decision. For example, in all denial letters, we include the following paragraph notifying the enrollee they can request a copy of the information used to make the decision and the instructions for filing an appeal:

"What If I Don't Agree With This Decision? You have the right to request a copy of the criteria/policy used by us to make our decision to deny authorization for the service requested. There is not a charge for this copy. You have the right to appeal. To exercise it, file your appeal in writing within 90 days after the date of this notice. We can give you more time if you have a good reason for missing the deadline. Please refer to Important Information About Your Appeal Rights included with this letter or your Medicaid Handbook."

Quality Commitment: Review of UM Performance through Inter-Rater Reliability (IRR) and Audits: We verify clinical guidelines are applied consistently through annual IRR testing of all licensed UM personnel. Our IRR score averages 98%. We also conduct a formal retrospective

audit to verify UM staff maintains compliance with established policies, processes and guidelines. Our audit performance requirement is 95%.

Continuous Review of Prior Authorization Requirements to Determine their Necessity: We review our standard prior authorization list at least annually and modify it to deliver the greatest value to our clients and enrollees while reducing administrative burden for our providers. Building upon input from our Kentucky PAC, we will incorporate local provider feedback in our ongoing review of prior authorization requirements.

Our UM system (ICUE) is the authoritative source of service authorization and utilization data and provides an integrated, single solution for managing service authorizations for physical and behavioral health services. Our UM clinicians use it to provide integrated prior authorization management and utilization management. Our UM system is highly configurable so we can customize it to meet the Commonwealth's timeliness requirements. It includes a workflow management process allowing our UM clinicians to understand and adhere to relevant turnaround times. Our UM system also helps our clinical leadership team verify that UM clinicians make prior authorization decisions in compliance with Kentucky time frames by monitoring UM clinician adherence to processing turnaround times.

Our secure provider portal, *Link,* has built-in administrative tools and functionalities related to prior authorization and medical necessity reviews. For example, *Link* informs the provider of specific clinical information they need to provide for medical necessity review and allows the provider to submit the required clinical information. Providers can submit prior authorization requests through *Link* provider portal 24 hours per day, seven days per week. Our intake department tasks these requests to our prior authorization team, which is staffed to meet timeliness requirements for both standard and expedited service authorization requests.

Provider advocates also promote self-service tools such as our provider portal (*Link*). By providing this outreach and training for providers reluctant to embrace *Link*, provider advocates play a critical role in increasing provider adoption of *Link*'s enhanced electronic claims payments and prior authorization capabilities.

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

Our UM program is fully integrated, delivering a simplified experience for enrollees and providers. Our goal is to facilitate greater integration at the point of care through our integrated UM approach.

When we receive a request for prior authorization, whether it is for medical or behavioral health services, the UM clinician reviews the request based upon a comprehensive view of the enrollee. We use the appropriate guidelines to support the expertise of our respective clinicians and then confirm the decision-making process and the platform to document authorizations is the same. We deliver an integrated approach to UM by incorporating medical and behavioral health guidelines and criteria into our program.

Integrating the UM program started with our executive leadership, where medical and behavioral health medical directors, clinical directors and managers work collaboratively to confirm our policies, processes and staff trainings to engage and address an enrollee's total care needs. The UM program includes behavioral health executive directors, behavioral health medical directors, care advocates, quality directors and senior clinical quality analysts. Regardless of their discipline/license, all of our UM staff are trained to review enrollees' care needs comprehensively and to make sure requested and needed medical and behavioral health services are assessed timely and authorizations documented in our integrated platform and

communicated to providers. UnitedHealthcare provides or arranges for training of providers and staff on identifying and screening for unmet medical and behavioral health needs and referral procedures. We evaluate our UM program annually to determine how well resources have been deployed and to improve UM activities, clinical care and services provided to enrollees. The evaluation will be presented to the integrated Quality Oversight Committee for next steps and approval.

Experienced licensed clinicians **conduct utilization reviews based upon the individual needs of each enrollee**, including the treating physician and MCT findings and conclusions, compared to nationally recognized criteria and established clinical practice guidelines. On our single UM platform, clinicians who authorize care for enrollees can view enrollees' comprehensive medical, behavioral, pharmacy, lab and health-related resource needs information. Nationally, we have worked to develop programs that specifically support integrated medical and behavioral health services in UM, including our collaborative care model to expand value-based payment (VBP) models and resources for integration.

Our network personnel work with providers to promote, educate and assess requirements for integration (e.g., screenings and referrals). We use our quality oversight processes to address any need for improvement. Examples of this work include provider scorecards to educate providers on how they compare to predefined metrics, such as the medical provider screen for behavioral health and substance use and the use of quality audits for behavioral health providers on whether they identify if enrollees have a PCP and refer them to a PCP if they do not have one. We will review provider performance meeting integration measures and mechanisms quarterly through Joint Operation Committee (JOC) meetings with medical and behavioral health executive leadership to improve integration across the Commonwealth.

Accessing and sharing enrollee-level information is important for clinical integration at all levels. One way we share enrollee-level information with providers, enrollees and the enrollees' identified support systems is through *CommunityCare*, our integrated care management platform. *CommunityCare* includes a shared enrollee care plan and important data, including gaps in care with alerts; ED and inpatient admissions and discharges, medical health, behavioral health and pharmacy utilization; referrals made; initial HRA and Enrollee Needs Assessments; messaging functionality for care team enrollees; and health-related resource needs. We conduct ***UM for medical and behavioral health on a single platform, our Integrated Clinical User Experience (ICUE) system.*** With a daily system interface between *CommunityCare* and ICUE, our UM staff are aware of assessments and updated information documented by the enrollees' MCT to help inform UM decisions.

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

We design a parity-compliant UM program and policies at implementation. We then maintain compliance through an annual review of the process and evidentiary standards used to administer medical/surgical and mental health/substance use disorder (MH/SUD) benefits to ensure any medical management techniques applied to MH/SUD benefits are comparable to, and applied no more stringently than, those for medical/surgical benefits. Simply put, behavioral health benefits must be consistent with or less restrictive then medical benefits in both policy and administration. Examples of mental health parity include:

- Benefits for MH/SUD are delivered and administered on a basis that is comparable to, or similar to, how medical/surgical benefits are delivered and administered
- MH/SUD benefits cannot be more stringent than medical/surgical benefits

- In addition to the benefits themselves, the way the benefits are administered and the methods used to create and implement limitations must also be comparable

We conduct annual compliance reviews of parity for behavioral health benefits in all UnitedHealthcare's Community & State markets. In line with the requirements of the Mental Health Parity Law, we use Non-Quantitative (NQTL) Treatment Limitation data collection tools that support analysis and alignment of the non-quantitative treatment limitations applied to MH/SUD benefits. We use the *NQTL Collection Tool* to gather policies and procedures, process standards, evidentiary standards and other factors used in designing the treatment limitation. With this data, we can provide expert consultation and recommendations regarding compliance with the Mental Health Parity Law customized to those techniques established and provided by the medical/surgical plans. To ensure our UM program is complaint with mental health parity:

An Example of Mental Health Parity in Pharmacy
Our pharmacy prior authorization program uniformly applies evidence-based guidelines to evaluate and assist with clinical decision-making for behavioral health and physical health needs. For example, prior authorization for behavioral health medications, such as the use of different types of anti-psychotics or stimulant medications in children is comparative to prior authorization for physical health drugs, such as biologics in various autoimmune drugs. We evaluate these guidelines annually to ensure we are in alignment with nationally recognized standards of care in the use of pharmaceuticals for our enrollees.

- We participate in Commonwealth inquiries or mandated annual reporting requirements regarding non-quantitative elements of UM and our analysis of comparability and stringency against the medical plan.
- We make certain criteria for medical necessity determinations for MH/SUD benefits used during the UM process are available online to any current enrollee or contracting provider.
- We provide clear reasons to enrollees and providers for any denial of reimbursement or payment with respect to MH/SUD benefits as the result of the UM process.
- We provide a clear and easily accessible process for filing appeals and complaints regarding denials or other processes provided during UM that comply with established requirements, including NCQA and URAC accreditation requirements.

It is important that our staff understand our commitment to behavioral health; therefore, we offer Mental Health Parity training to UnitedHealthcare employees through our enterprise-wide learning platform. Additionally, the following mental health parity resources and toolkits are available to our health plans: *Understanding Parity, Your Role in Parity, Benefit Change Parity Checklist, Parity Contacts and Resources* and *Glossary of Parity Related Terms*.

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.

Utilization review activities are supported by evidence-based, nationally recognized medical policies, clinical guidelines and criteria, including MCG and appropriate levels of care. Internally developed clinical policies in addition to Commonwealth and federal coverage determination guidelines (CDGs) complement these guidelines.

These policies, guidelines and criteria influence care decisions to promote the delivery of appropriate care in the most appropriate setting at the right time. Medical directors, nursing and pharmacy staff work closely with health care providers to enhance health care outcomes. Clinical guidelines are available in both installed and web-based formats for staff to use whether they are office based or working on-site in health care facilities.

Ensuring Accountability for Consistent Application of Criteria

Consistently applying UM guidelines is a critical aspect of the UM process. To make certain each reviewer maintains the same utilization review standards and promotes consistent decision-making, our policy requires clinical staff to make medical necessity decisions based upon national evidence-based guidelines. We use evidence-based, nationally recognized MCG criteria for physical health care services and for behavioral health services. However, if MCG does not cover a behavioral health service, we will adopt the following standardized guidelines — LOCUS, CASII, CANS or ECSII guidelines for behavioral health authorization decisions as required by DMS in addition to the care guidelines from the American Society of Addiction Medicine (ASAM) for SUDs and DMS's clinical coverage policies for both behavioral health and SUD services, as applicable — to assist us in administering health benefits and to help clinicians make informed decisions in many health care settings. These tools are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Confirming Services are Not Arbitrarily or Inappropriately Denied: Clinical leadership, medical directors and UM clinicians make sure services are not arbitrarily or inappropriately denied or reduced by:

- Relying on evidence-based, nationally recognized criteria to determine medical necessity and appropriateness of care
- Developing standardized Coverage Determination Guidelines (CDG) policies that facilitate accurate and consistent coverage decisions
- Reviewing service requests using benefit plans, CDGs, medical necessity criteria and internal medical policy to determine medical necessity and appropriateness of care
- Confirming medical directors and UM staff are qualified to determine medical necessity
- Conducting consistent, evidence-based medical necessity reviews that result in fair and impartial utilization review activities and outcomes
- Continuously monitoring, evaluating and seeking to improve our approaches, methods and UM process to validate our UM policies and procedures, management and oversight to promote fair and consistent application of our review criteria
- Providing staff training for clinical reviewers and conducting inter-rater reliability (IRR) reviews to establish consistent training and guideline application
- Implementing a formal retrospective audit process to validate UM staff maintains compliance with established policies, processes and guidelines

Confirming Consistent Application through our UM System: Our comprehensive UM system supports our person-centered approach to care management. Our UM system provides a 360-degree view of our enrollees' care management information, such as utilization of authorized services and prescription history. It is the authoritative source of service authorization data and provides an integrated, single solution for managing service authorizations for physical and behavioral health services.

Confirming Consistent Application through Ongoing Monitoring: Our QIC, our Kentucky HQUM Committee conducts an annual review of national UM

We conducted staff MCG IRR testing in 2018 to establish consistent training and guideline application among clinical reviewers. The results of our assessment, for each MCG product, included:

- Inpatient and surgical care: 1,684 participants = 99% passed
- Ambulatory care: 1,084 participants = 98% passed
- Recovery facility care: 833 participants = 100% passed

and QM policies and procedures and evaluates the consistency of the UM decision-making process through IRR reports. Our HQUM Committee monitors all clinical quality improvement and UM activities within UnitedHealthcare. This includes extensively reviewing our care management and disease management programs and reviewing utilization metrics from pharmacy, HEDIS indicators for behavioral and physical health as well as grievances and appeals.

Confirming Consistent Application through IRR Testing: To verify consistent application of medical necessity guidelines, we conduct annual IRR reviews on all licensed UM personnel. IRR reviews compare decisions among UM staff for uniform cases and then use statistical measures to assess consistency and identify potential sources of inconsistency. When the assessment is complete, management reviews the results and reports them to our QIC for possible corrective actions, as indicated. Our systematic IRR testing process determines consistency in outcomes among clinical peer reviewers. We evaluate evidence-based guideline criteria application, guideline navigation, understanding of workplace policies and procedures, and knowledge of regulatory agencies requiring compliance and timeliness guidelines as part of this process.

Confirming Consistent Application through our Audits of UM Staff: We use a formal retrospective audit process to validate UM staff maintains compliance with established policies, processes and guidelines. Clinical auditors perform audits on cases from each nurse and physician reviewer's caseload. They conduct audits using a standardized tool that evaluates appropriate documentation of data and compliance using contractual time frames and processes. Each clinician reviewer and their manager receive their individual audit results. Audit thresholds are 95%. Those clinicians falling below the threshold must complete a remediation plan, which includes additional training on policies and procedures, guidelines and the application of criteria. All clinicians receive a formal performance evaluation annually.

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

Our UM program is supported by evidence-based, nationally recognized health care policies and UM review criteria, which influence care decisions to support delivery of appropriate care in the most appropriate setting at the appropriate time. Our guidelines standardize UM decisions regarding the most appropriate and available level of care needed to treat an enrollee's presenting problems, while remaining flexible to address individual needs. These resources include MCG and the industry guidelines listed previously in response to10.b.ii. The MCG guidelines are reviewed by MCG annually with a new edition released each year.

Our Medical Technology Assessment Committee (MTAC) and Operational Procedures & Standards (OPS) Committee report to the National Medical Care Management Committee (NMCMC) and review and update specific aspects of our UM program, including promoting consistent clinical decision making regarding safety and efficacy of medical care. Our MTAC meets at least 10 times each year to develop new policies in response to emerging technology or new treatments based upon scientific evidence. The OPS Committee meets monthly to review submissions of new, revised and updated policies and determines which policies to retire. We share MTAC and OPS updates with our health plan and other stakeholders through our Quality committee and Kentucky PAC.

We engage contracted providers to develop our guidelines through our Kentucky PAC, which includes acute, dental, physical health, behavioral health and pharmacy providers and experts. Our PAC provides input, as appropriate, reviews nationally endorsed guidelines and review criteria and may make recommendations to modify the guidelines through our Kentucky HQUM Committee.

We review our criteria at least annually and more often as needed. Ad hoc reviews are conducted if a guideline has been updated or if new scientific evidence has been issued. Our national UM committees collaborate to determine when our guidelines need to be reviewed and updated and when changes are made to the guidelines. They communicate revisions to our UM clinicians via bulletins, training classes and through online resources. If our national UM committees update the guidelines, our Kentucky HQUM Committee will review, edit and recommend adoption of the updated guidelines. This includes obtaining input and recommendations from contracted providers in the Kentucky PAC.

Provider advocates, UM staff and RN clinical consultants provide education to providers on our UM program, criteria and guidelines during initial provider training, when UM protocols or criteria and guidelines change and when we identify providers who need assistance (e.g., difficulties submitting requests for prior authorization). We convey information regarding our UM program through our *Care Provider Manual*, provider portal, *Link* (available 24 hours a day, seven days week), and provider newsletter, *Practice Matters*.

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.

UnitedHealthcare is committed to making sure our enrollees get the right care in the right setting. We look first to direct enrollees to access care in our network but understand that sometimes the enrollee's best interest may be served outside that network. We look at each request for out-of-network care individually. We take into consideration the clinical and social needs of each enrollee when making a determination and strive to do the right thing for every enrollee and their family.

Prior authorization is required for non-emergency services provided by non-participating providers. Out-of-network providers can contact our UM team or our care managers to request authorization, standard or expedited, for out-of-network services. We accept standard and expedited prior authorization requests through the provider portal and phone. Our online tools for providers can be used by both in-network and out-of-network providers to facilitate open communication and access to provider tools as needed. Upon receipt of a prior authorization request, the UM team conducts clinical review for medical necessity in accordance with the enrollee's benefit plan and in compliance with state, federal, government and accreditation requirements. The UM clinicians can authorize referrals for out-of-network services based upon approval criteria, which considers local provider availability. When review staff cannot approve the referral, they forward it to the medical director or a designated physician reviewer for a decision. Their review considers the enrollee's individual health needs when making a determination on whether to cover out-of-network care. Standard prior authorization decisions and notices are completed within 2 business days of receipt of needed clinical information. Non-participating providers are generally approved for, but not limited only to, continuity of care or medically necessary services not available within the network.

Transitions of Care: We employ continuity of care and transition of care processes for new enrollees and those receiving medically necessary covered services and transfer from another

contractor. Enrollees receiving medically necessary services, in addition to prenatal services, have up to 90 calendar days continuation with a non-participating provider or until the enrollee can be reasonably transferred to a participating provider, whichever is less. During the 90 days, we do not require prior authorization. We contact the treating provider to discuss the care plan, educate them about our care management program, determine their interest in working with us as a contracted provider and, if needed, provide notice of our intent to transfer enrollees to participating providers. If a terminating participating provider provides the services, we follow the same 90-day process.

Expedited prior authorization requests require a faster review because the time frames for a standard resolution may seriously jeopardize an enrollee's life, health or ability to attain, maintain or regain maximum function. Our expedited prior authorization process complies with the requirements in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 20.6, Service Review and Authorization Timeframes, including resolving the request within 24 hours of receipt. Request for authorization or preauthorization of treatment for an enrollee with a diagnosis of SUD is considered an expedited review.

Following the determination, we notify the provider as quickly as possible based upon the enrollee's health condition, but no later than 72 hours following receipt of the expedited authorization request.

UnitedHealthcare will outreach to provider organizations within the Commonwealth, including the Kentucky Medical Association, local Medical Group Management Association chapter to notify them of our contract, which will help make sure non-participating providers are aware of our new business in the Commonwealth.

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

At UnitedHealthcare, we realize that health care is constantly changing and we want to lead the way. Our leadership team, led by our chief medical officer, Dr. Jeb Teichman, continuously monitors our UM program using data gleaned from our QM department and input from local providers who sit on our Kentucky Physician Advisory Council to lead proactive change and better serve our enrollees, our providers and the Commonwealth. The Physician Advisory Council is a forum for providers to share external feedback related to our UM program and the impact on clinicians and enrollees will be shared with the HQUM and QIC Committees to inform change and innovation. The leadership team also receives input from our QM department and QM committee structure, which includes our QIC and our HQUM Committee through comprehensive analytics. At least quarterly, our QIC and HQUM Committee evaluate the effectiveness of care management interventions, detect and correct utilization variances against UnitedHealthcare benchmarks and national standards, and identify opportunities for improvement. The committees:

- Oversee and approve, at least annually, updates to UM and QM program descriptions, work plans, program evaluations, responsibilities and policies and procedures that conform to industry standards
- Evaluate analyses of quality measures, prior authorization data, medical and behavioral claims, social determinants data, lab results and utilization data developed by our health care economics team
- Analyze trends to identify opportunities for improvement and develop interventions that include measurable outcomes so we can determine the intervention's effectiveness
- Monitor provider service authorization requests for health care services provided to enrollees through provider quality and utilization profiling

- Monitor medical appropriateness and necessity of health care services to enrollees
- Monitor consistent application of medical necessity criteria and CPGs
- Evaluate the consistency of UM decision-making through review of IRR reports and identify overutilization and underutilization issues related to UM decision-making
- Review, edit and recommend adoption of updated clinical guidelines and utilization review policies and practices based upon input and recommendations from various sources, including our national clinical resources and our Kentucky PAC
- Monitor quality reports across all clinical areas; review performance metrics, trends and outcomes related to care management; establish data driven interventions to improve performance in identified areas; monitor progress on clinical performance improvement programs; and conduct targeted quality and performance improvement studies
- Monitor actions taken to investigate and confirm resolution of quality-of-care incidents, including UM issues
- Monitor and correct utilization variances, including over- and underutilization of services
- Conduct and monitor medical record review of enrollee medical records to verify providers deliver high-quality health care to enrollees
- Monitor access to specialty care and coordination with network on any concerning network related UM trends
- Review date on appeals and grievances to identify trends for possible UM/prior authorization improvements
- Review trends by provider to determine the need for education and/or coordination to improve the response to enrollees throughout the UM process