Section 14
Utilization Management Program

Table of Contents—Utilization Management Program

Section 14

Introduction

It is the responsibility of the utilization management department at Capital District Physicians' Health Plan, Inc. (CDPHP®) to ensure that value-based care is available to all members across the full continuum of care. This is accomplished through planning, coordinating, monitoring, and managing health care services to ensure appropriate, cost-effective care while contributing to the overall goal of member wellness. Annually, the health plan evaluates the needs of its enrolled population and uses that information to assess whether current programs need modification to better address the needs of its membership.

In 2019, CDPHP transitioned to a fully integrated and cohesive population health management (PHM) model. Front-end analytics will allow for a proactive approach to finding members who may need support, and tailored interventions will be offered at each health stage. PHM will enhance the adaptability of our current day programming and thus increase our ability to offer services to all our members. This strategy will allow for continued focus on improving quality of care and health care outcomes for our members.

The utilization management department activities are established in accordance with the CDPHP mission statement.

Mission Statement

We provide quality health care at a reasonable cost for our subscribers and operate CDPHP as a model for the delivery, financing, and administration of health care services.

Program Goals:

- To promote healthy lifestyles and improve health outcomes.
- To engage members in programs to mitigate risk factors that negatively affect their health.
- To promote preventive health services.
- To ensure timely and equitable access across the continuum of care for all members.
- To promote judicious use of health care resources across all levels of care.
- To provide an integrated approach to managing the health care needs of our most complex members.
- To incorporate process improvement principles and methods into utilization management department activities.
- To systematically measure, assess, analyze, and evaluate the effective utilization of the medical care delivery system and services provided to members.
- To promote optimal utilization of health care services while protecting and acknowledging members' rights and responsibilities, including the members' rights to appeal utilization management denial decisions.
- To support appropriate care delivery by primary care practitioners (PCPs) to their full scope of practice, using consultation and treatment by specialists when medically necessary and clinically appropriate.

Program Objectives:

- Develop a comprehensive strategy for population health management that addresses our members' needs.
- Include comprehensive care management programming that will include high-risk health management services, inpatient care coordination and concurrent review, prior authorization, member appeal and complaint resolution, and chronic condition support.
- Collaborate with high-volume hospital partners to provide a unique experience for CDPHP members, while ensuring appropriate utilization, quality transitions of care, and appropriate care management as needed.
- Provide a well-structured utilization management (UM) program and make utilization decisions affecting the health care of members in a fair, impartial, and consistent manner.
- Expand the reach and efficiencies of our care management programs through the use of our highly integrated, member-centric information technology systems.
- Provide efficient management of care through the implementation of sound, clinically based medical necessity criteria, including InterQual; Care Advance Enterprise Standard Clinical Content Package; Hayes Medical Technology Directory; Health Technology Brief; Genetic Test Evaluation Program and Technology Prognosis; CA/LOCUS; NYS LOCADTR 3; American Psychological Association; and internally developed medical necessity/medical appropriateness criteria.
- Provide oversight and evaluate effectiveness of the utilization management and care management programs of our delegated partners.
- Meet established performance goals for all utilization management activities while ensuring compliance with regulatory and accreditation standards and requirements.
- Engage the utilization management committee (UMC) in assisting CDPHP to develop and implement policies and programs to reach utilization goals.
- Enhance member awareness and participation in CDPHP population health programs.

- Establish targeted member outreach to impact Healthcare Effectiveness Data and Information Set (HEDIS) measures.
- Offer care management services to targeted employer groups based on group size to assist members in optimizing their health plan benefits.
- Evaluate and implement programs that enhance the ease and efficiency of medical practice and improve the quality of care for members.
- Use a standardized methodology to identify potential utilization outliers (both over- and underutilization) and design interventions as needed.
- Enhance efficiencies in all utilization processes.
- Engage our participating acute care hospitals and skilled nursing facilities in reducing the inpatient readmission rate.
- Audit for coding compliance and educate providers as appropriate.
- Expand our partnerships with community-based organizations to better serve our Medicaid members.
- Expand the scope of our Medicaid programs to include newly carved-in populations.
- Expand the provider network to increase medication-assisted treatment (MAT) for members with substance use disorders.
- Expand access to quality, culturally competent care and support for our most vulnerable populations.
- Continue a multifaceted approach to improving the health literacy of our members.
- Continue focus on keeping utilization in-network whenever possible based on medical appropriateness.
- Partner with local performing provider systems (PPSs) to support the Delivery System Reform Incentive Payment (DSRIP) initiatives.
- Engage CDPHP members in health risk mitigation activities.

Governance and Accountability

CDPHP is a not-for-profit corporation. The board of directors is the governing body responsible for managing the affairs and business of the corporation, as well as maintaining overall accountability and responsibility for the quality management program.

The president and chief executive officer of CDPHP reports directly to the board of directors. The board of directors has assigned the utilization management committee (UMC) the responsibility to develop, review, implement, and recommend enhancements to the utilization management program. The committee reports through the quality management committee (QMC) to the board of directors.

The overall development, review, and revision of the program description is coordinated by the senior vice president, member health/senior medical director, whose primary focus is utilization management and the UMC.

Quality Management Committee (QMC)

The committee structure of CDPHP includes several committees that contribute to the utilization management department activities. These committees include:

- Quality management committee (QMC)
- Utilization management committee (UMC)
- Policy committee
- Joint health services committee (JHSC)
- Behavioral health UM committee
- HARP-UM committee
- Quality stakeholder advisory group (QSAG)
- HARP-quality stakeholder advisory group (QSAG)
- Pharmacy and therapeutics (P&T) committee

The activities of all committees are reported up through the QMC. The actions of the QMC are then directly reported to the board of directors by the executive vice president, member health/chief medical officer. The executive vice president, member health/chief medical officer then has responsibility to report to the QMC the results of the board of directors' review of the committee report. Each of these committees has been assigned a CDPHP medical director and supporting staff.

Utilization Management Committee (UMC)

The UMC has the responsibility to develop, review, implement, and recommend enhancements to the utilization management program.

Committee responsibilities include, but are not limited to, the following:

- Develop, review, revise, and approve resource coordination policies.
- Monitor utilization trends for institutional, professional, and ancillary practitioners.
- Identify and ensure implementation of appropriate interventions to address opportunities for improvement identified through monitoring activity.
- Develop or select industry-standard medical necessity/medical appropriateness screening criteria used for UM decision making.
- Monitor consistency of application of medical necessity criteria, including inter-rater evaluation process for physician and non-physician reviewers, to develop and oversee implementation of interventions to address identified opportunities for improvement.
- Monitor timely resolution of UM determinations and service indicators.
- Evaluate for potential over- and underutilization on a plan-wide, product-specific, and practitioner-site level, with recommendations for corrective action when appropriate.
- Evaluate results to recommend interventions and corrective actions for plan-wide and practitioner-specific opportunities for improvement. These are identified through ongoing monitoring of care, service, and utilization indicators.
- Evaluate requests for new technology and/or new uses for existing technology.
- Recommend revisions to the member benefit package.
- Monitor progress toward achieving established performance goals.
- Monitor member and provider satisfaction with the utilization management services and processes.
- Serve as a liaison between participating practitioners and CDPHP on all clinical and utilization-related issues.
- Report on delegated vendor activity and impact on utilization.

A medical director, who has a primary focus on UM, chairs the committee. Membership is appointed by the executive vice president, member health/chief medical officer, subject to the approval of the CDPHP board of directors, and consists of participating board-certified physicians representing primary care and high-volume specialties. The committee meets bimonthly, and minutes are reported through the QMC to the board of directors. The senior vice president, member health/senior medical director serves as chair to the utilization management committee. Additional Plan employees serve as ad hoc staff to the committee as needed.

Policy Committee

The policy committee is charged with the development, review, revision, and implementation of medical, behavioral health, pharmacy, utilization management, and reimbursement policies. Industry norms and clinical research are included in the evaluation of each clinical issue. The committee reviews and researches potential and actual coverage and contract issues, provides continuity in contract interpretations, and ensures the implementation of associated policies (e.g., technology assessment and policy development). New practice patterns and member and provider requests for new services are evaluated to determine potential benefit and contract coverage and related policy changes. The committee ensures consistency between member health programs and utilization policy.

The committee is an interdepartmental team consisting of a medical director and representatives from: finance, government programs, configuration, internal operations, member health, health care network strategy, pharmacy services, business development, special investigations unit, application management, and utilization management.

Minutes are reported to the UMC and upward through the QMC to the board of directors. The committee is supported by provider consultants and workgroups as needed to lend clinical or operational expertise to the review activities.

Behavioral Health Utilization Management Committee

The behavioral health utilization management committee consists of participating providers, representing the behavioral health specialties, who provide advice and recommendations concerning utilization management related to behavioral health, as well as expert opinions on behavioral health issues. The committee discusses the development, approval, and review of policies; recommends procedures for benefit coverage by assessing technologies, medical interventions, and drugs in terms of efficacy and safety; recommends revisions to the member benefit package; monitors utilization trends; develops/selects industry-standard medical-necessity/clinically appropriate screening criteria used for UM decision making; and monitors timely resolution of UM determinations and service indicators.

The committee members are responsible for sharing information relative to trends in the behavioral health industry and exchanging ideas on how to effect better outcomes with specific populations. Their scope includes all CDPHP lines of business except Medicaid HARP.

The primary goal is to impact the behavioral health community by moving them toward the fulfillment of the CDPHP health value strategy. The committee meets four times a year, is chaired by the CDPHP vice president, behavioral health and medical integration, and includes representatives from the following specialty areas: psychiatry, psychology, social work, pediatrics, and substance abuse treatment. Committee minutes are reported to the UMC, QMC, and then to the board of directors.

HARP Utilization Management Committee

The HARP-UM committee consists of participating providers, representing behavioral health specialties, and offers advice and recommendations concerning utilization management related to behavioral health for the members of the CDPHP Medicaid HARP product. The committee also provides expert opinions on behavioral health issues. The committee discusses the development, approval, and review of policies; recommends procedures for benefit coverage by assessing technologies, medical interventions, and drugs in terms of efficacy and safety; recommends revisions to the member benefit package; monitors utilization trends; develops/selects industry-standard, medical-necessity/clinically appropriate screening criteria used for UM decision-making; and monitors timely resolution of UM determinations and service indicators. The committee meets four times a year, is chaired by the CDPHP vice president, behavioral health and medical integration, and includes representatives from the following specialties: psychiatry, psychology, social work, pediatrics, and substance abuse treatment.

The committee shall submit results of its activities to the utilization management committee, which reports through the quality management committee to the board of directors.

HARP Quality Stakeholder Advisory Group

The HARP quality stakeholder advisory group (QSAG) is chaired by the vice president, behavioral health and medical integration, and is led by the behavioral health quality manager. Stakeholders in an advisory capacity are: members, family members, peer specialists, providers, plan subcontractors, regional planning consortiums (RPC), and/or other member-serving agencies. The committee meets at least quarterly, reports to the HARP-UM committee, and maintains records documenting attendance, findings, recommendations, and actions. It is responsible for carrying out the planned activities of the HARP behavioral health quality management program and is accountable to and reports regularly to the HARP behavioral health UM committee concerning behavioral health (BH) quality management (QM) activities for the Medicaid HARP line of business only.

The HARP QSAG members review and provide input on service or clinical quality monitors, preventive and clinical practice guidelines, and care management activities. They provide expert opinions on behavioral health issues; encourage and promote communication between CDPHP and the BH provider network; review and provide input for satisfaction surveys; share information relative to trends in the behavioral health care industry; and share ideas and recommendations for effecting better outcomes with specific populations. The committee's mission is to exchange ideas on how to effect better treatment outcomes and review the findings of BH-specific quality improvement initiatives, performance improvement projects, and focused studies.

Quality Stakeholder Advisory Group

The quality stakeholder advisory group (QSAG) is chaired by the vice president, behavioral health and medical integration, and is led by the behavioral health quality specialist. The committee meets at least quarterly, reports regularly to the behavioral health UM committee, and maintains records documenting attendance, findings, recommendations, and actions. It is responsible for carrying out the planned activities of the behavioral health quality management program and is accountable to and reports regularly to the behavioral health UM committee concerning BH QM activities for all lines of business except HARP.

The QSAG members are responsible for sharing information relative to trends in the behavioral health industry and exchanging ideas on how to effect better outcomes with specific populations. The QSAG shall review the findings of BH-specific quality improvement initiatives, performance improvement projects, and focused studies.

Children's Advisory Committee

The children's advisory committee (CAC) is responsible for advising and assisting CDPHP in identifying and resolving issues related to the management of children's health and behavioral health benefits. The CAC is co-chaired by the behavioral health medical director for children and the CDPHP pediatric medical director, and led by the CDPHP director of care management and BH clinical director for children's services; meets at least quarterly; reports regularly to the utilization management committee; and maintains records documenting attendance, findings, recommendations, and actions.

The CAC provides expert opinions on children's health issues, including but not limited to: service or quality monitors, including home and community based services (HCBS) for medically fragile children and children with serious emotional disturbance; preventive and clinical practice guidelines; medical/behavioral health integration and care management activities; suggestions for medical policies and procedures; and member and provider satisfaction surveys.

The CAC shall be composed of representatives with expertise in children's services and familiarity with children eligible for HCBS, including children with medical fragility, developmental disability, or serious emotional disturbance, and children in foster care. The members will be responsible for sharing information relative to trends in the delivery of health care for children, and exchanging ideas on how to effect better outcomes for the various subpopulations of children.

Roles, Reporting, and Resources

Senior Vice President, Member Health, Senior Medical Director

The senior vice president, member health/senior medical director is responsible for providing direct oversight of the other medical directors, as well as of the medical policy manager. The senior vice president provides oversight of utilization management, including resource coordination policy development via the pre-policy development and policy committees, and retrospective review of UM determinations for consistency and corrective action where applicable. The senior vice president, member health, senior medical director also provides oversight of the training and mentoring of the UM staff in order to promote consistency and ensure inter-rater reliability. Additionally, she/he serves as the chairperson on the utilization management committee, which is composed of participating providers from various medical specialties who provide input and recommendations regarding medical policy and utilization management activities. As part of the UMC, the senior vice president, member health, senior medical director monitors utilization trends to address both over- and underutilization of resources, and uses this information to contribute to strategic planning for CDPHP and the overall evaluation of the utilization management program.

Medical Directors

Medical directors are responsible for assisting with ensuring compliance with the plan's quality management, pharmacy, and utilization management programs. Responsibilities are carried out by participating as an active member in medical advisory committees, providing leadership to and serving as a liaison between the physician community and the plan's management.

All medical directors share actively in day-to-day UM case review and determinations, as well as the appeals process. This includes clinical oversight of complex cases, interfacing with providers to gather complete information, and making suggestions for care management interventions when appropriate.

Manager, Utilization Review

The manager, utilization review is responsible for overseeing prior authorization, and assessing the medical appropriateness of benefit utilization. This includes services rendered by both participating and non-participating providers. The manager, utilization review has oversight of processes addressing prior authorization review, close review of all out of network requests, and timely closure of all cases to ensure prompt payment of claims. The manager, utilization review collaborates with providers to ensure appropriate utilization of member benefits. They work closely with medical directors to identify a corrective plan of action if aberrancies are identified, and ensure that all processes comply with all regulatory and accreditation standards.

Supervisor, Utilization Review

The supervisor, utilization review is responsible for the execution of day-to-day activities for the prior authorization program and other utilization management activities, including facilitating appropriate and timely review of health care services and overseeing the hospital experience clinical documentation. This includes monitoring of services for participating and non-participating providers and facilities. In addition, the supervisor will assist in regulatory audits, oversee quality review processes and develop new quality initiatives to facilitate continued process improvement. This role is also responsible for overseeing the implementation of all departmental policies, procedures and processes, ensuring adequate coverage and assisting in the planning of ongoing education for team members.

Utilization Review Nurse

The utilization review nurse is responsible and accountable for coordinating prior authorization of services and using established criteria to determine case outcome. The utilization review nurse is also responsible for the clinical documentation of hospital experience cases. Cases that are complex in nature or that do not meet medical necessity criteria are forwarded to a medical director for review and decision. The utilization review nurse's focus includes non-par utilization.

Manager, Member Appeals and Ambulatory Review

The manager, member appeals and ambulatory review is responsible for the evaluation, planning, implementation, coordination, and supervision of the member appeals team operations, functions, and staff, in alignment with corporate and departmental goals as well as applicable regulations and standards. The manager is responsible for overseeing the day-to-day functions of the member complaint, grievances, and appeals team (CGA), as well as leading the functions of the annual NCQA, Department of Health (DOH), Centers for Medicare and Medicaid Services (CMS), and Department of Financial Services (DFS) audits to ensure requirements for regulatory metrics are met. The manager also oversees processes addressing prior authorization review; close review of all out-of-network requests, and timely closure of all cases to ensure prompt payment of claims. The manager ensures appropriate utilization of members' benefits and appropriate coding. He/she also works closely with medical directors to identify a corrective plan of action if aberrancies are identified, and ensures that all processes comply with all regulatory and accreditation standards.

Supervisor, Ambulatory Review and Coding

The supervisor, ambulatory review (AR) and coding leads a team of clinical coding professionals and is responsible for the day-to-day activities of the department. This includes oversight of work queues and quality review of cases to ensure adherence to coding compliance and medical policy guidelines. The supervisor is also responsible for monitoring timely closure of all cases to ensure prompt payment of claims. She/he also works closely with the configuration team to review and make recommendations to ensure appropriate routing of cases to the ambulatory review team.

Clinical Review and Coding Nurse

The clinical review and coding nurse (RN) is responsible to attain procedure and diagnosis coding accuracy and consistency on referred cases. The RN will perform and coordinate the clinical component of the provider appeal function, including communication of the decision on whether to uphold the original payment. The RN will support provider audit functions, including assessment of coding, practice trends, and evaluation of programs, and will recommend areas for improvement. The RN will also research new technology or services and recommend updates to medical policies.

Vice President, Population Health/Hospital Experience

The vice president, population health/hospital experience is responsible for oversight and administration of all medical/surgical inpatient program operations, including policies and procedures and utilization management of inpatient services for hospitals, skilled nursing and physical rehabilitation facilities. The vice president is also responsible for operation of the CDPHP hospital experience program and the interface between that program and all other programs/services.

Manager, Hospital Experience

The manager, hospital experience is responsible for the oversight and assessment of medical appropriateness related to inpatient services, including hospital, skilled nursing, and physical rehabilitation facilities. This includes services rendered by participating and non-participating facilities. Responsibilities include overseeing the inpatient care coordinators; partnering with facility personnel to ensure that members are moving along the continuum of care in a timely manner; monitoring for potential quality of care issues; and identifying and referring members as appropriate to care management. The manager works closely with medical directors to identify a corrective plan of action if aberrancies are identified, and ensures that all processes comply with all regulatory and accreditation standards.

Inpatient Care Manager

The inpatient care manager is responsible for assessing the medical necessity of inpatient admissions and continued stay by adhering to InterQual. She/he collaborates with the hospital experience manager and medical directors as necessary to meet care coordination needs for CDPHP members, as well as with facility personnel to ensure that members are moving along the continuum of care in a timely manner, monitoring for potential quality of care issues and identifying and referring members as appropriate to care management. He/she is also responsible for on-site and/or telephonic utilization at inpatient hospital, skilled nursing, and physical rehabilitation facilities.

Medical Policy Manager

The medical policy manager reports to the senior vice president, member health/senior medical director for the overall development, monitoring, implementation, and evaluation of policies and procedures for resource coordination. She/he is responsible for developing policies and procedures for external resource coordination; ensuring compliance with documentation standards; reviewing dates and regulatory requirements; researching evolving medical and behavioral health technologies and new applications to existing technologies; actively participating on the policy committee; maintaining an annual review schedule for existing external resource coordination policies; and staying up-to-date with current medical trends, technology, and treatment modalities. The medical policy manager interfaces with internal departments to ensure that policies can be operationalized and to provide continuity in policy interpretation.

Director, Clinical Pharmacy Operations

The director, clinical pharmacy operations is responsible for assisting the senior vice president and chief pharmacy officer in the management of pharmacy benefits and clinical functions, including supervision of managed care pharmacists, certified pharmacy technicians, and technical staff in the prior authorization request and medical exception process.

Managed Care Pharmacists

Managed care pharmacists are responsible for performing utilization review of all drugs requiring prior authorization and formulary exceptions.

Managed Care Pharmacy Technicians

Managed care pharmacy technicians are responsible for utilizing algorithms created by New York State licensed pharmacists to initially determine if a prior authorization or medical exception request meets criteria for benefit coverage.

Supervisor, Pharmacy Benefit Specialist

The supervisor, pharmacy benefit specialist is responsible for the oversight of day-to-day activities within the pharmacy operations department. This includes training staff and monitoring daily pharmacy turnaround times and phone statistics to meet regulatory requirements, enforcing policies and procedures, and generally ensuring that the needs of CDPHP members are met while conducting prior authorization/medical exception duties.

Vice President, Behavioral Health and Medical Integration

The vice president, behavioral health and medical integration is a medical director who is responsible for directing all clinical aspects of the administration of the behavioral health benefit, including policies and procedures and utilization management of inpatient and outpatient services to treat psychiatric and substance use disorders.

Director, Behavioral Health Operations

The director, behavioral health operations is responsible for budget; direct and indirect supervision of employees; strategic partnering with behavioral health providers to ensure a robust network for both inpatient and outpatient services; oversight of utilization of services with special attention to preventing over- and underutilization; and integration of behavioral health into all facets of medical management activities. The director, behavioral health operations provides strategic operational oversight of: clinical administrative operations of the program, quality control, utilization management, customer service, and workflow. Their role is to monitor clinical performance of the unit through regular reviews of clinical documentation, regular clinical supervision meetings, and attendance at psychiatric reviews.

Manager, HARP Utilization Management and Care Management

The manager, HARP utilization management and care management reports to the director, behavioral health operations, and is responsible for the oversight of day-to-day activities of the HARP and behavioral health care management program, including compliance of all regulatory requirements and departmental metrics. Additional responsibilities include tracking and trending of all reporting for HARP care management and utilization management, as well as the administrative and clinical leadership of the behavioral health services provided to Medicaid and HARP recipients 21 years of age and older.

The manager of HARP utilization management and care management also provides direct oversight to the behavioral health inpatient care managers to ensure the execution of day-to-day utilization review and care coordination of members' behavioral health needs during hospitalization. Responsibilities include identifying potential quality of care issues and developing plans at health care facilities that will reduce the potential for unplanned readmissions and provide access to services along the health care continuum; overseeing the training and education of the inpatient behavioral health care coordinators and monitoring their daily activity; enforcing policies and procedures; and ensuring appropriate application of InterQual; CA/LOCUS and NYS LOCADTR 3, patient placement criteria. The manager, HARP utilization management and care management works collaboratively with many departments within CDPHP to meet the needs of members during and immediately following inpatient confinement.

Manager, Behavioral Health Clinical Intake Unit and Children's Medicaid

The manager, behavioral health clinical intake unit and children's Medicaid reports to the director, behavioral health operations, and is responsible for the administrative and clinical leadership of the behavioral health services provided to Medicaid recipients under age 21. Additional responsibilities include oversight of the behavioral health clinical intake unit/access center, including monitoring of phone metrics, authorizations, outpatient behavioral health services and daily program activity; training staff; and enforcing policies and procedures. In addition, the manager, behavioral health clinical intake unit and children's Medicaid is responsible for the coordination of crisis services within the community to ensure that resources are available for all CDPHP members, and specifically, CDPHP Medicaid members (including HARP and under age 21). This manager also works with internal departments and oversees the crisis training for CDPHP.

Clinical Intake Specialist

The clinical intake specialist reports to the manager, behavioral health clinical intake unit and children's Medicaid. The clinical intake specialist serves as the entry point for members, providers, and internal behavioral health inquiries, and uses established guidelines to conduct telephonic assessments, collect information, create authorizations, and assist with appropriate referrals. Under the clinical supervision of the manger and behavioral health medical directors, the clinical intake specialist reviews and processes requests for outpatient behavioral health services, and is also responsible for oversight of outpatient behavioral health programs, including personalized recovery oriented services (PROS), assertive community treatment (ACT), home and community based services (HCBS), and children and family treatment and support services (CFTSS).

Behavioral Health Inpatient Care Manager

The behavioral health inpatient care manager is responsible for assessing the medical necessity of inpatient admissions and continued stay using InterQual and NYS LOCADTR 3, patient-placement criteria; as well as assessing discharge planning needs for CDPHP members. In addition, the behavioral health inpatient care manager is responsible for on-site and/or telephonic utilization review duties at inpatient psychiatric and substance abuse facilities for concurrent review and medical necessity. In addition, the behavioral health inpatient care manager is responsible for ensuring that a comprehensive discharge plan is in place prior to discharge.

Vice President, Member Health Operations

The vice president, member health operations is responsible for the overall management and strategic direction of the member and provider complaints, grievances, and appeals (CGA); credentialing; utilization management; and ambulatory review departments. The vice president, member health operations is responsible for ensuring that processes are effectively implemented for all CDPHP products including management of daily operations, performance management of staff, achievement of regulatory timelines, and oversight of critical issues, as well as for ensuring that regulatory requirements are met in accordance with state, federal, and National Committee for Quality Assurance (NCQA) accreditation. The vice president, member health operations oversees delegation management and ensures that delegation oversight is completed within CDPHP requirements. The vice president will provide expertise and a point of escalation in reviewing issues for each department. This position is also responsible for communicating with appropriate parties such as state, federal, NCQA accreditation, and HEDIS as it relates to utilization review, ambulatory review, CGA, credentialing, and re-credentialing functions.

Project Oversight Manager, Appeals

The project oversight manager, appeals is responsible for the preparation and presentation of regulatory audits. Additional responsibilities include the implementation of policy and procedure updates as well as appeal/complaint reference tools. The project oversight manager, appeals provides staff education and delegation oversight; manages regulatory reports; submits appeals quarterly reports; maintains appeals correspondence library; implements NYS mandates; and monitors staff workload.

Clinical Appeals Specialist

The clinical appeals specialist reports to the manager, appeals and is responsible for ensuring that the member/provider appeal and grievance process meets state, federal, accreditation, and other regulatory requirements. Using knowledge of clinical nursing and medical practice, the clinical appeals specialist reviews medical necessity and renders determinations about appropriateness of care and expedited cases within established criteria and contract requirements. Cases that are complex in nature or that do not meet medical necessity criteria are forwarded to a medical director for review and decision. The clinical appeals specialist is responsible for tracking, trending, and monitoring appeals and grievances and external reviews and making recommendations for change, as well as oversight of the external review process.

Senior Quality Complaints Coordinator and Delegated Vendor Analyst

The senior quality complaints coordinator and delegated vendor analyst reports to the manager, appeals and is responsible for the timely research, documentation, grade determination, and response letters to members and providers for administrative quality-of-care and quality-of-service member complaints, according to regulatory processing timelines. In addition, responsibilities include oversight of complaints, grievances, and appeals of the delegated dental vendor.

Medicare Appeals Analyst

The Medicare appeals analyst is responsible for the timely and accurate triage, research, investigation, and documentation of Medicare appeals and grievances. In addition, the Medicare appeals analyst is responsible for tracking, trending, and monitoring Medicare appeals and grievances and coordinating responses to CDPHP internal departments and external regulatory agencies as they relate to determinations made within the Medicare process.

Manager, Medicaid LTSS and HIV Programs

The manager, Medicaid LTSS and HIV programs reports directly to the Director of Care Management and is responsible for day-to-day oversight of the case management and utilization program activities for the Medicaid LTSS team. He/she is also responsible for the evaluation, planning, implementation, coordination and general management of the Care Management Department and Medicaid Long Term Services and Support (LTSS) program operations, functions, and staff in alignment with corporate and departmental goals as well as applicable regulations and standards. The manager oversees regulatory requirements for the Medicaid LTSS programs, regulatory audits, and planning, implementation, and oversight of new State-required benefits and services. She/he represents CM and attends meetings for assigned committees, work groups and teams, in addition to participating in required CM department data collection, documentation audits, reporting and analysis.

Utilization Management Program Scope

The utilization management program includes the monitoring and evaluation of services delivered across the health care continuum. This includes behavioral health care and substance use disorder services. Below is a list of services included in the scope of the CDPHP utilization management program:

- Prior authorization and review
- Admission review/concurrent review
- Retrospective review
- Member appeal and complaints
- Member outreach and engagement
- Medical and behavioral health care management
- HARP care management
- Long Term Supports and Services Program (LTSS)
- Care transitions
- Chronic condition support
- Technology assessment and medical policy development
- Ambulatory review and code auditing
- Behavioral health services
- Appropriateness of plan-wide, product-specific, and individual practitioner/practice site utilization
- Pharmacy and formulary management
- Consistent application of medical necessity/medical appropriateness criteria in UM decision making
- Member and practitioner/provider satisfaction with the utilization management department and related services and processes
- Clinical criteria development and/or selection
- Delegation oversight

Program Components

Requests for authorization of care and clinical services are performed by the CDPHP utilization management department staff using approved CDPHP policies; InterQual; Care Advance Enterprise Standard Clinical Content Package; Hayes: Medical Technology Directory, Health Technology Brief, Genetic Test Evaluation Program, and Technology Prognosis; CA/LOCUS, LOCADTR 3 patient placement criteria; and the clinical experience of the professional nursing staff, licensed mental health clinicians, pharmacists, medical directors, physician consultants, and the utilization management committee.

After review of medical information provided by the requesting physician, hospital, and/or office medical records, and when appropriate, physician-to-physician communication, the member's individual needs and the limitations of the local delivery system are considered and a medical necessity determination is made. UM determinations may be made on a prospective, concurrent, or retrospective basis for services requested or rendered by participating and non-participating practitioners and facilities.

Prior Authorization

Participating CDPHP physicians are required to obtain prior approval for certain elective medical and surgical services by contacting utilization management for medical or behavioral health services prior to scheduling the services. Each request is reviewed for compliance with the CDPHP resource coordination policies and/or InterQual and CA/LOCUS or NYS LOCADTR 3 patient placement criteria, to ensure medical appropriateness and benefit availability.

CDPHP-participating hospitals are required to notify the plan of all admissions within 24 hours of admission, unless otherwise indicated in the provider's contract, or the next business day for admissions that occur on a holiday or weekend.

Inpatient Review Process

The inpatient care managers are responsible for conducting a comprehensive review of all elective, urgent, and emergency dmissions to participating and non-participating acute care, rehabilitation, and skilled nursing facilities. The focus of the inpatient review process is to determine the most appropriate level of care and setting by reviewing medical information related to the admission and continued stay. The organization adheres to the appropriate time frames for UM decision making, in accordance with the review process for resource coordination policy. Staff assists in coordinating discharge planning; researching and identifying alternatives to current care for medically necessary services; and coordinating and referring cases to care management, chronic condition program, readmission avoidance, and other specialized programs as appropriate. Discharge planning and care coordination discussions with the PCP, attending physician, specialty consultants, ancillary service staff, hospital care management staff, and/or medical director occur as needed. Inpatient care managers are also responsible for identification and referral to the quality management department when potential quality of care issues are identified.

Admission Review

Review of inpatient admissions at both participating and non-participating facilities is conducted either on-site at the facility or by telephonic review. Inpatient care coordinators review clinical data and compare against established criteria, which include the CDPHP resource coordination policies, and InterQual, CA/LOCUS and NYS LOCADTR 3 patient placement criteria. Cases not meeting defined criteria are referred to a medical director for review and determination of the medical necessity of care in the current setting.

Concurrent Review

Concurrent review of inpatient admissions at participating and non-participating facilities is also performed, using CDPHP resource coordination policies, and InterQual, CA/LOCUS and NYS LOCADTR 3 patient placement criteria to determine the need for continued inpatient services. In addition, concurrent review is performed on other ancillary services including, but not limited to: home care, hospice, and other services that require intensive care management intervention. Discharge planning and care coordination decisions may be discussed with the PCP, attending physician, specialty consultants, ancillary service staff, hospital care management staff, and/or medical director. If the inpatient care coordinator does not have sufficient information to justify the continued services, the case will be referred to a medical director for further evaluation and determination.

Retrospective Review

Retrospective review of health care services rendered in participating and non-participating facilities is conducted in cases of non-notification and select provider services to ensure medical necessity. Medical information related to the case is evaluated against CDPHP resource coordination policies and InterQual, CA/LOCUS and NYS LOCADTR 3 patient placement criteria to determine the appropriateness of services and level of care. In addition, all reviews assess the quality of health care services rendered. Cases not meeting criteria are referred to a medical director for review and determination.

Health and Recovery Plan (HARP)

CDPHP has an integrated team consisting of both behavioral health and medical care managers to assist members with physical health, mental health, and substance use services. Care managers conduct face-to-face assessments and develop individualized care plans tailored toward member-centric interventions that address medical needs, behavioral health needs, and social determinants of health.

Care Management

This is a collaborative function within CDPHP that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a member's health needs. A dedicated team of medical care managers works collaboratively with BH care management to assist members with physical health, mental health, and substance use services in an integrated way. Care managers conduct face-to-face assessments and develop individualized care plans. Education, coordination, and communication in relation to available resources are used to promote appropriate and cost-effective outcomes.

Member Appeals and Complaints

The appeals process provides the member or the member's designee, physician, ancillary service provider, or facility an opportunity to have a medical necessity or benefit denial reviewed in compliance with the member contract. CDPHP ensures that all member complaints, grievances, and appeals are documented, acknowledged, investigated, tracked, handled, and resolved in a timely and fair manner, and in compliance with the member contract and regulatory requirements.

Ambulatory Review and Coding

The CDPHP ambulatory review and coding process includes pre- and post-payment review of complex hospital and physician claims to evaluate for medical health, behavioral health, and substance use services. It also involves conducting periodic provider/specialty targeted audits to analyze coding abnormalities, report findings, and identify opportunities for improvement.

Over- and Underutilization

As a managed care organization, CDPHP relies on resources to monitor and identify potential over- and underutilization. These plan resources include utilization data from data management, enrollment, HEDIS, and other sources, including member and provider satisfaction survey results. When potential over- or underutilization is identified, CDPHP will implement appropriate plan-wide, product-specific, or practitioner-specific actions to address the identified issues, and will re-measure to ensure resolution of the identified issues.

CDPHP has established reporting packages to assist with identifying variation in practice patterns. The reports are monitored monthly, and findings are reported to the UMC annually. The UMC approves recommended corrective actions.

CDPHP has systems in place to identify out-of-network (OON) utilization for all product levels. Analysis is based on the requests to trend and compared across all product lines.

CDPHP has policies and procedures describing its system controls for utilization management denial notification dates which are specific to NCQA requirements.

Behavioral Health Services

The CDPHP behavioral health department administers a comprehensive behavioral health care program inclusive of triage, referral, assessment, prospective, concurrent, and retrospective review for benefit determination, as well as episodic and complex care management services.

The behavioral health department is led by a psychiatrist board-certified in general psychiatry and addiction, as well as a psychiatrist board-certified in child and adolescent psychiatry. The department operations are directed by a licensed master social worker. The department is composed of master's-prepared licensed clinicians, as well as clinicians with bachelor's degrees.

The behavioral health staff uses approved resource coordination policies and InterQual, CA/LOCUS and NYS LOCADTR 3 patient placement criteria when reviewing for sites of service and levels of care to determine medical necessity. Clinical rounds are held Monday through Friday to review coverage determinations. All mental health services take into consideration patient need and risk factors in all the following domains:

a. For adults:
   i. Risk of harm;
   ii. Functional status;
   iii. Co-morbidity;
   iv. Level of stress and support in the recovery environment;
   v. Treatment and recovery history; and
   vi. Engagement and recovery status.

b. For children/adolescents (information from all of the following domains must be considered in a developmentally appropriate context):
   i. Risk of harm;
   ii. Functional status;
   iii. Co-morbidity;
   iv. Environmental stress and support in recovery environment;
   v. Resiliency and treatment history; and
   vi. Acceptance and engagement in child/adolescent *and* caregivers.

All cases not clearly meeting the established criteria are reviewed by the behavioral health medical director or clinical peer reviewer. All determinations are made in accordance with established turnaround time and member/provider notification standards.

Program Components

- **Triage and assessment** – CDPHP has established a behavioral health access center to assist members and providers with securing behavioral health services inclusive of mental health services, as well as substance use services. The access center is staffed from 8 a.m. to 6 p.m., Monday through Friday, with after-hours on-call staffing seven days per week. Staff verify eligibility, collect relevant clinical information, and determine the urgency of the situation to ensure that members are directed to the most appropriate provider/setting. Department protocols are in place to ensure that callers in crisis are appropriately handled.
- **Elective behavioral health services** – All requests for elective, outpatient behavioral health services are reviewed for medical necessity and contractual limitations by the clinical intake specialist under the supervision of a licensed behavioral health clinician and the behavioral health medical director. Clinical intake specialists will review requests for coverage against resource coordination policies; many requests for elective behavioral health services do not require authorization.
- **Admission review** – Elective inpatient and residential behavioral health services are subject to concurrent review at various time frames as outlined in CDPHP resource coordination policies. The behavioral health care coordinator is responsible for completing reviews as outlined in the policy. Emergency admissions require notification by the admitting facility within 24 hours of the admission.
- **Concurrent review** – CDPHP has resource coordination policies that describe in which circumstances inpatient treatment is reviewed concurrently versus retrospectively. Both types of review are the responsibility of the behavioral health care coordinator. For cases that are reviewed concurrently, the behavioral health care coordinator will collaborate with facility personnel to develop and execute comprehensive discharge plans for the member. Discharge plans are designed to address all aspects of the member situation that may result in relapse and/or readmission. Discharge plans are shared with behavioral health care managers, who may follow the member post-hospitalization. In addition to inpatient services, concurrent review is performed on additional ancillary services that require intensive care management intervention.
- **Retrospective review** – CDPHP conducts post-payment review of specified services to evaluate for medical necessity, benefit availability, quality of care, and appropriateness of coding. In addition, periodic targeted audits may be conducted.

- **Care management services** – The CDPHP behavioral health care program has established a systematic approach to identifying members who may benefit from care management services. The goals of care management are treatment-plan adherence and the prevention of relapse. The behavioral health staff work directly within the medical care management department. This whole-person approach empowers members to take responsibility for their care while directing them to the plan and to community services that are available. Behavioral health care managers are embedded in multiple hospital crisis units and community clinics.

In addition to these services, the behavioral health team is working with all aspects of resource coordination and quality enhancement to integrate behavioral health into all facets of our programs.

Pharmacy Services

The CDPHP pharmacy professional services department administers the pharmaceutical benefit to ensure that medication needs of plan members are met in an effective manner. This is accomplished by interfacing with our pharmacy benefits management company, our specialty pharmacy, the P&T committee, and other departments, as well as the practitioner community.

The department manages the plan's formularies. Medical exception requests are processed in the department for drugs not covered on a formulary. The department also reviews requests for drugs requiring prior authorization or exceeding quantity limitations based on department policies that are reviewed at least annually or as necessary for new pharmaceutical technology or treatment guidelines.

As part of the pharmacy services program, authorization requests are reviewed for medical necessity. These requests are reviewed by, or under the supervision of, a pharmacist registered in New York State. In the event that medical necessity cannot be justified, the case will be referred to a medical director for review and determination. The medical director will review individual patient circumstances, capacity of the delivery system, availability to provide care in an alternate setting, available practice guidelines, applicable contract benefits, and supporting pharmacy policies and procedures to render a determination. The medical director may also contact a board-certified physician of the same or similar specialty in the event that clinical peer review of the case is necessary. The medical director or clinical peer reviewer may also speak with the requesting provider. Medical directors are the only staff authorized to deny a service for medical necessity.

Health care services deemed not medically necessary result in an adverse determination. Members and providers are notified of the adverse determination by telephone and in writing. Timeliness of notification is determined by the classification of the request. Denial notifications include the reason for the denial as well as the appeal process available to the member and provider.

Adverse determinations based on medical necessity may be given reconsideration when the medical director was unable to discuss the case with the PCP and/or requesting physician prior to the determination. The medical director who made the original decision may review requests for reconsideration. If no new medical information is provided or the reconsideration review results in an adverse determination, the member may submit a verbal or written request for a first-level appeal.

Medical Necessity Denials

As part of the utilization management program, authorization requests are reviewed for medical necessity. In the event that medical necessity cannot be justified, the case will be referred to a medical director for review and determination. The medical director will review individual patient circumstances, capacity of the delivery system, availability to provide care in an alternate setting, available practice guidelines, applicable contract benefits, and supporting resource coordination policies and procedures to render a determination regardless of the member's financial risk. The medical director may also contact a board-certified physician of the same or similar specialty in the event that clinical peer review of the case is necessary. The medical director or clinical peer reviewer may also speak with the requesting provider. Medical directors are the only staff authorized to deny a service for medical necessity.

Health care services deemed not medically necessary result in an adverse determination. Members, providers, and, when appropriate, facilities are notified of the adverse determination by telephone and in writing. Timeliness of notification is determined by the classification of the request. Denial notifications include the reason for the denial as well as the appeal process available to the member and provider.

Adverse determinations may be given reconsideration when the medical director was unable to discuss the case with the PCP and/or requesting physician prior to the determination. The medical director who made the original decision may review requests for reconsideration. If no new medical information is provided or the reconsideration review results in an adverse determination, the member may submit a verbal or written request for a first-level appeal.

Appeals Process

The appeals process provides the member or the member's designee, physician, ancillary service provider, or facility an opportunity to have a medical necessity or benefit denial reviewed in compliance with the following process:

- A verbal or written request for review of an adverse utilization review (UR) determination is submitted to CDPHP.
- The appeal will be reviewed by a medical director other than the one who rendered the initial adverse determination.
- An appeal that results in a final adverse UR determination may then be further appealed internally or through NYS external review, based on the member's line of business.
- At each level of appeal, the member will be advised of the appeal outcome in writing. The notice will include the detailed reasons for the decision, the clinical rationale, and the procedure for requesting the next level of review.
- If the appeal involves an imminent and serious threat to the health of the member, or the member is a current patient at a facility, the review will be completed in accordance with the time frames specified in the New York State Managed Care Law and the Employee Retirement Income and Security Act (ERISA) for expedited appeals.
- The provider appeal process allows the right for a provider to appeal a medical necessity denial of a concurrent or retrospective adverse determination on their own behalf or to appeal on behalf of a member with the appropriate designation form.

Detailed policies are in effect to define the appeals process for specific member products.

Technology Assessment and Medical Policy Development

The CDPHP member health division is responsible for ensuring the systematic and timely review of evolving medical and behavioral health technologies provided to the CDPHP membership. This includes evaluation of new medical and behavioral health technologies, as well as new applications for existing technologies, using all of the following criteria to reach decisions regarding eligibility for coverage:

- Receives approval from the FDA or other appropriate regulatory agency where required
- Improves health outcomes at least as well as existing technologies
- Is not cosmetic and is required for reasons other than convenience
- Provides greater value than currently available therapies
- Safety and effectiveness has been proven in scientific studies

The CDPHP technology assessment team consists of medical directors (physicians), a medical policy analyst (registered nurse), and additional appointees as directed. The team is chaired by an appointed medical director. The medical policy analyst is responsible for researching and compiling up-to-date information from computerized searches from various sources of evidence—such as evidence-based peer-reviewed literature, government agencies, and professional societies and associations—for review and consideration by the CDPHP technology assessment team. Board-certified consultants in medicine and behavioral health are used during the review process when additional expertise is needed regarding a newly emerging medical technology. A determination of the effectiveness of technology based on scientific evidence from published clinical research, and the need for development of a new policy, are based on consensus from the CDPHP technology assessment team. Draft policies developed to address coverage or non-coverage of a technology are presented to the CDPHP policy committee for approval.

Policies are developed to define benefit availability for existing as well as new technologies or changes in medical care. The CDPHP policy committee is a multidisciplinary team, chaired by a CDPHP medical director, with responsibility for the development, review, and revision of all CDPHP resource coordination, pharmacy, and payment policies. It is supported by provider consultants in medicine and behavioral health and workgroups as needed to lend clinical expertise to the review activities. Addition of new policies, deletion of those outdated, and revision of current policies is based on input from members, providers, and staff, in addition to current trends in medical treatment and review of peer-reviewed literature. All draft policies are forwarded for review to the policy committee. After policy committee approval, the formal utilization management and pharmacy draft is presented to the utilization management committee or the pharmacy and therapeutics committee for review and approval. Revisions are made to the resource coordination and pharmacy policies as recommended by the utilization management and/or pharmacy and therapeutics committee. Minutes from these respective committees are reported to the quality management committee and board of directors for final approval. All resource coordination, pharmacy, and payment policies are reviewed at least annually.

All policies are reviewed and/or revised on an annual basis and then communicated both internally and externally. Participating providers are notified through bimonthly publication through our secure physician interface at www.cdphp.com and with individual policy mailings upon provider request. Copies are also available to CDPHP members at www.cdphp.com.

Clinical Criteria

CDPHP uses industry-standard, clinically based, medical necessity criteria, and develops internal criteria based on current industry standards. The information sources used to determine benefit coverage and medical necessity include industry-standard criteria such as InterQual; CA/LOCUS; LOCADTR 3; Hayes: Medical Technology Directory, Health Technology Brief Service, Genetic Test Evaluation Program, and Technology Prognosis; Care Advance Enterprise Standard Clinical Package; or internally developed CDPHP resource coordination policies. When the utilization management department receives a request for authorization, eligibility and benefit packages are verified. Staff with the appropriate licensure and/or credentials review the request, the required clinical information and medical reports, the member's individual needs, and the services available through the local delivery system, and the appropriate medical necessity criteria are applied. The member's age, co-morbidities, complications, treatment progress, psychosocial situation, and home environment are considered when applying criteria to an individual case. When clinical criteria are clearly met, the nurse issues the authorization and completes the appropriate notifications and documentation within the required time frames. If the request does not meet the applicable criteria, or questionably meets the criteria, or the clinical reviewer is unable to determine if criteria are met based on the individual case specifics, the request is referred to a medical director for evaluation and decision. The medical director may seek further evaluation by a specialty clinical peer reviewer if additional clinical expertise is required. Medical director decisions are returned to clinical review staff for documentation and notification within defined turnaround times.

All industry-standard and internally developed clinical criteria are reviewed, revised, and approved at least annually by the UMC. The UMC membership consists of participating board-certified physicians representing primary care and major specialties.

Practitioners/providers are notified of the availability of clinical criteria through the *Provider Office Administrative Manual*, provider newsletter, and individual determination letters. Practitioners/providers and members may also obtain a copy of the specific medical necessity criteria used to make individual decisions upon request. Physicians may discuss individual medical necessity determinations with a CDPHP medical director by calling the utilization management department during regular business hours (8:30 a.m. to 5 p.m., Monday through Friday, excluding holidays).

Consistency of applying medical necessity criteria is evaluated at least annually. All staff involved in utilization determinations, including but not limited to nurses, social workers, pharmacists, and plan medical directors, are evaluated for inter-rater reliability to establish the consistency with which they are applying criteria in decision making. The organization acts on opportunities to improve consistency, if applicable.

Delegation

CDPHP entrusts others to deliver specified activities to its members and thus has entered into mutual agreements to perform precise activities. CDPHP has entered into contracted agreements relative to utilization management services for the following:

- Pharmaceutical safety, benefit management, and member connection activities
- Dental service for Child Health Plus, Essential Plan, and Medicaid members
- Intensive in-home care management for Medicare Advantage members

Separate documents clearly delineate both the delegate's and the plan's responsibility for the delegated activities. These documents describe the methodology used to evaluate and assess the delegated activities on a regular basis in accordance with the CDPHP delegation policies and procedures.

Strict adherence to accreditation and regulatory standards demonstrates our commitment to the highest standards of member care and service. CDPHP performs thorough assessment of external entities before delegating clinical or service activities to determine the ability of each entity to perform the activities. In addition, CDPHP maintains responsibility for ensuring that each delegated function is performed appropriately. CDPHP conducts monitoring and annual evaluation of delegates to ensure adherence to CDPHP policies, procedures, QI goals, and utilization activities. Delegates also report to the joint health services committee on a quarterly and annual basis. Failure to meet CDPHP standards will result in termination of a delegated activity.

CDPHP has entered into mutual agreements with its customers to perform specific activities as outlined in the CDPHP *Quality Management Program Description 2020.*

Incentives

CDPHP does not compensate medical directors or other individuals conducting utilization review for denials of coverage or service. UM decision-making is based only on appropriateness of care and service and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Confidentiality

CDPHP utilization management program activities are privileged and confidential and are conducted in a manner that ensures the confidentiality of member and provider information. Staff and committee members are required to handle data responsibly and carefully and take the necessary steps to protect the privacy of the involved individuals in compliance with HIPAA regulations. Member and provider identifiers will be coded in any presentations, reports, and/or committee minutes. All plan employees are subject to a confidentiality agreement as a term of employment with CDPHP. Any breach in confidentiality will result in disciplinary action as described in the employee manual. In addition, committee members are required to sign a confidentiality statement upon appointment to the UMC and on an annual basis thereafter.

Program Evaluation

The utilization management program is formally reviewed and revised on an annual basis. The evaluation includes the assessment of the overall effectiveness of the program and the progress toward achieving established goals and objectives. (Reference the *Quality Management Program Evaluation 2020*, *Section III*, *Utilization Management Program Evaluation*.) The revised program description is presented to the UMC for review and approval and then forwarded to the QMC and board of directors for final approval.

In addition to the annual evaluation, all components of the program, including compliance with external accreditation and regulatory requirements, are monitored and reported to the UMC throughout the year to ensure that the program continues to be effective.

New: 11/15/94
Revised: 11/21/95, 12/17/96, 04/21/98, 12/15/98, 01/04/00, 01/30/01, 01/02/01, 12/30/01, 11/01/02, 02/17/04, 02/15/05, 03/21/06, 04/17/07, 03/18/08, 1/13/09, 01/12/10, 03/08/11, 03/13/12, 3/12/13, 3/11/14, 9/9/14, 3/10/15, 3/8/16, 3/14/17, 3/13/18, 3/12/19, 3/10/20, 3/9/21

The 2020 Utilization Management Program Description has been reviewed, revised, and approved:

Signed: _____ Date: _____
Elizabeth Warner, MD, FACS
Senior Vice President, Member Health, Senior Medical Director

Signed: _____ Date: _____
Julie Keohan
Vice President, Member Health Operations

Date Approved by Quality Management Committee . . . . . Date: _____

Date Approved by Board of Directors . . . . . Date: _____