TheHealthPlan

Chapter 8

Clinical

Provider Manual

Introduction

The Health Plan's (THP)'s clinical services program ensures the provision of appropriate health care while addressing the effectiveness and quality of the care. The delivery of health care services is monitored and evaluated to identify opportunities for improvement. The program provides for a systematic process to promote the access of medically appropriate, holistic care in a timely, efficient manner across the network through population health-driven care, complex case navigation, prior authorization, admission and concurrent reviews, health and wellness programs, chronic disease management and pharmacy programs.

The primary goal of the clinical services program is to measurably improve the utilization of care and services to our members in a way that is financially responsible and responsive to their individual health care needs. This goal is achieved by meeting the following objectives:

- Promote and provide appropriate allocation of health care services to members.
- Perform utilization management processes with minimal disruption to the delivery of care and services, including clinical information gathering, documentation review, and communication of utilization management decisions.
- Identify and engage members appropriate for health and wellness/preventive care and clinical programs.
- Assess clinical services program performance by soliciting input from members and practitioners through surveys annually.
- Develop interventions based on input received from members and practitioners to improve the quality of services to all customers.
- Educate practitioners on the scope of the clinical services programs and Clinical Services Division.

Prior Authorization Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness allowing for consideration of the needs of the individual member, their circumstances, medical history, and availability of care and services within THP network. Input is sought annually, or as needed, in the review of criteria from practitioners in the community and those who serve as members of the Physician Advisory Committee (PAC). In cases where specific clinical expertise is needed to perform a review, or an appeal is presented, reviews are sent to a contracted URAC or NCQA accredited vendor for specialty medical review services by board-certified physician reviewers with the same or similar background.

Medical Prior Authorization & Notification Requirements

Providers are required to request prior authorization before a service is rendered. This requirement includes both outpatient and inpatient services. If service is rendered after hours, over the weekend or on a holiday, providers are required to request authorization the next business day. Prior authorization requests received after the next business day will not be processed. Failure to follow prior authorization guidelines will result in denied claims.

To comply with West Virginia prior authorization regulations (Senate Bill 267) providers requesting prior authorizations for MHT, WV Commercial, and WV PEIA members are required to submit prior authorizations through THP's secure provider portal.

Effective July 1, 2024, fax and phone prior authorization requests will not be accepted from providers.

To register for THP's provider portal, please visit **myplan.healthplan.org** to begin.

Effective January 1, 2024, THP will follow these Prior Authorization (PA) Response Timelines from receipt of PA, if complete information received:

Line of Business	Standard PA	Urgent PA
Mountain Health Trust (WV Medicaid and CHIP)	5 business days	2 business days
Commercial	5 business days	2 business days
PEIA	5 business days	2 business days
Medicare Advantage	14 calendar days	3 calendar days
Self-funded/ASO	15 calendar days	3 calendar days

If a PA request is incomplete:

- THP will notify provider of the deficiencies within 2 business of receipt.
- Provider will have 3 business days to respond with complete information.
- If provider responds within 3 days business with complete information, THP will have 2 business from receipt of complete information to render decision.
- If provider does not respond within 3 business days, the PA is denied, and a new PA request must be submitted.

If a peer review is requested, then THP must complete peer review process and render decision within 5 business days of the request.

If an official PA appeal is submitted, then THP must render an appeal decision within 10 business days from appeal submission.

The Medical Prior Authorization Requirements are available on THP's corporate website and secure provider portal.

Urgent Requests:

If services are required in less than 48 hours due to medically urgent conditions, please submit an urgent pre-service authorization.

This prior authorization and review process does not include services provided to participants in self-funded plans. Please check plan benefits for coverage and prior authorization requirements.

Services performed without authorization will be denied and you may not seek reimbursement from members.

eviCore healthcare

THP partners with eviCore healthcare to manage medical necessity and prior authorization for the following services for all MHT, Medicare Advantage and Commercial Fully Insured product lines.

- Sleep Studies
- Durable Medical Equipment (DME)
- Radiology/Cardiology
  - CT / CTA
  - MRI / MRA
  - PET / PET CT
  - Myocardial Perfusion Imaging (Nuclear Stress)
  - Echo / Echo Stress
  - Diagnostic Heart Cath
  - Cardiac Imaging (CT, MRI, PET)
  - Cardiac Rhythm Implantable Device (CRID)
- Musculoskeletal Conditions
- Spine Pain Management
- Chiropractic care – the first 20 visits do not require prior authorization
- PT and OT – the first 20 combined visits do not require prior authorization

Service(s) performed in conjunction with an inpatient stay, 23-hour observation, or emergency room visit is not subject to authorization requirements.

Nurse Information Line

A nurse navigator is available 24 hours a day, 7 days a week to assist with medical management questions. However, a nurse navigator does not provide prior authorizations after normal business hours.

Admissions/Concurrent Review Process

Prior authorization of elective admissions is performed to confirm eligibility, benefits, and medical appropriateness of services to be rendered and level of care to be utilized. The process is initiated by the member's primary care provider (PCP) or referring participating specialist with the Clinical Services nurse navigators. This includes acute care, rehabilitation, skilled nursing facilities and long-term acute care facility (LTACF).

Notification of urgent/emergent admissions, by the admitting practitioner or facility, is required at the time of, or as soon as practically possible after admission into an acute care facility. This activity is performed for early discussion of member's needs as related to the admission or alternative health care services.

All out-of-network and tertiary non-emergent requests require prior authorization. Clinical information is reviewed for availability of service within the plan's network, clinical complexity, or other extenuating circumstances and should be supplied by the PCP or appropriate in-plan specialist (if referring within their specialty). This includes acute care, long-term acute care facilities (LTACF), rehabilitation, and skilled nursing facilities.

Concurrent review is the process of continued reassessment of medical appropriateness for inpatient care. Any member identified with potential discharge planning needs is referred by the Clinical Services inpatient nurse navigator to the Medical Transition of Care Team to evaluate care needs.

Concurrent review is performed by portal submission and involves communication with practitioner(s), hospital utilization review staff, social workers, and family members, as necessary.

Upon discharge from an acute care stay, all members received a follow discharge call and assessment to identify discharge planning needs. If members are identified and opt-in to a program, a referral is sent to care coordination or the Medical Transition of Care team for transitional care needs depending on risk stratification.

The process of concurrent review utilizes nationally recognized criteria for inpatient admissions and continued stay. It is understood that the criteria cannot be applied to all cases. All factors such as the member's age, living conditions, support systems and past medical/surgical history are considered in applying criteria.

Please indicate if your request is emergent so that we may expedite the review. Simply scheduling the service does not warrant an expedited review. Unless an emergency, scheduling should be done after being approved by THP.

Medical Transition of Care Team

THP implemented a medical transition of care unit to aid in keeping enrollees healthy and out of the hospital. Highly driven from Utilization Management, this program focuses on early identification of enrollees that are high risk for admissions or readmissions by using our iPro admission risk score.

Enrollees can also be referred by THP staff. The goal of this program is to keep our enrollees healthy and out of the hospital while also assisting with other transition of care needs including but not limited to: exhaustion of benefits, assistance in finding in-network providers or transitioning from one plan to another. Once enrolled in the program, the member is periodically contacted for 90 days to ensure all transitional needs are met. If long term needs are identified, the member is referred to care coordination or complex case management dependent on the risk stratification.

InterQual® Review

THP utilizes Change Healthcare InterQual® criteria as a screening guideline to assist reviewers in determining medical appropriateness of health care services. Any participating practitioner, upon request, may review the specific criteria used in an active clinical review process of a procedure requiring the use of InterQual®. You may call THP Clinical Services Department if you have a general InterQual® question or a question regarding a particular type of care.

THP uses InterQual® guidelines for most procedures and services other than for MHT where West Virginia's Bureau of Medical Services has mandated use of other criteria for specific services.

PCPs are responsible for directing care to specialty care practitioners. THP does not require a referral to an in-plan specialist in most instances.

Please refer to the complete listing of in-plan services that require prior authorization and/or notification. Additional services may require prior authorization based on specific plan requirements of some groups. Also, due to changes in medical technology and the accessibility of diagnostic equipment and services in an office/outpatient setting, as well as updated methods or approaches to performing procedures and services, there may be additional services that will require medical review. Contact THP if you have concern regarding a particular procedure or test. The prior authorization list is designed to improve communication to our provider community and to reduce administrative burden. . This feature enables providers to search a CPT code, verify if a prior authorization is required by line of business (Medicare, Medicaid/WVCHIP, Commercial or Self-Funded), and direct you to the applicable vendor.

Requests for Second Opinion

Most "second opinion" evaluations may be achieved within the member's local network. In the event the services requested are not available locally, a tertiary level "second opinion" may be considered.

When requesting a second opinion at a tertiary facility, this request authorizes an evaluation visit only and that any further visits, surgery, treatment, and testing would require additional prior authorization.

Once the evaluation is completed, the consulting practitioner should send the report back to the referring practitioner, who will discuss findings with the member.

Specialist Coordination of Health Care Services

THP will facilitate ongoing specialist care and coordination of benefits for members with special health care needs. This would apply when the primary care practitioner, in consultation with a specialist practitioner, identifies the need for specialty care for a condition that is life-threatening, degenerative, or disabling.

Specialist Referrals

The PCP is responsible for initiating a specialist referral if one is required by plan design and supplying appropriate member history to the specialist. A treatment plan is formulated by the PCP, the specialist, and the member. The treatment plan is reviewed by THP's Clinical Services Department.

Standing Referral

Ongoing care over an extended period is requested on a standing referral. Standing referrals are used to prior authorize episodes of specialty care, support tertiary care requirements, or for approved single case agreement (SCA) provider referrals. The number of visits shall be based upon the treatment plan and shall be limited to a one-year period. Case management is highly recommended for members requiring standing referrals.

Specialist Acting as Primary Care Provider

THP members have the right to select and change their PCP. If the member would like to request a specialist as their PCP, due to a disabling condition, the specialist practitioner must give their signed consent that they will take over the PCP responsibilities for the member.

THP has a review and approval process that must be completed before a specialist practitioner can be listed as a member's PCP. THP will require a "Request Form: Specialist as Primary Care Provider" to be completed by the member, current PCP, and specialist practitioner. The form includes information regarding the member's demographic information, current PCP information, reason for requesting a specialist as a PCP, and the information pertinent to the specialist practitioner. After confirmation of qualification through a diagnosed disabling condition, chronic illness, or SSI eligibility, reasons given for requesting a specialist practitioner as a PCP are as follows:

- The specialist is already serving as the member's PCP
- The specialist was recommended by the member's current PCP
- The specialist was requested to serve as the member's PCP

The specialist practitioner will need to supply their name, specialty, NPI, taxonomy(ies) code, practitioner practice name, practitioner office information, and the member's care history with the specialist practitioner. The practitioner will need to describe the existing relationship between the member and the specialist practitioner. This should include the time in care and which services are provided. The specialist practitioner will need to provide clinical rationale as well as any supporting documentation.

The specialist practitioner's specialty must be supplied to determine if they have the credentials to support providing PCP services. The specialist practitioner must be board certified and/or have education and training in the field of family medicine, internal medicine, general practice, pediatrics, geriatric medicine, and/or obstetrics/gynecology. The specialist practitioner must also be participating and in good standing with THP.

The specialist practitioner will attest by signature and date that they are agreeing to serve as the PCP for a specific member, and that they will fulfill all the PCP duties described in THP's provider contract, Provider Manual, and policies/procedures.

The Request Form: Specialist as Primary Care Provider can be found in THP's corporate website, healthplan.org, provider portal, myplan.healthplan.org, or by contacting THP's Customer Service department. Once the member, current PCP, and specialist practitioner complete the Request Form: Specialist as Primary Care Provider, it will be submitted to THP Medical Director for review and to approve or deny.

The completed Request Form: Specialist as Primary Care Provider, along with the applicable letters, will be sent to the member, the current PCP, and the specialist practitioner. The designation of the specialist practitioner as the PCP for the member will allow the PCP copayment to be applied for all services rendered by the specialist practitioner.

THP will grandfather any current member who has a specialist listed as their PCP in THP's system as of May 1, 2022. These members and specialist practitioner will not be required to complete the Request Form: Specialist as Primary Care Provider; however, the specialist practitioner is still required to fulfill all THP PCP requirements.

Clinical Programs

Providers may refer members to our free Member Wellness, Prevention and Health Promotion or Clinical Programs via our website at https://www.healthplan.org/providers/resources/physician-case-management-referral

Member Wellness, Prevention & Health Promotion

THP offers of primary preventive health interventions to help decrease the incidence or progression of illness and chronic disease. THP engages the member in wellness and health promotion activities, such as education, physical activity, and health screenings, to encourage a healthy lifestyle.

THP provides and promotes a health risk screening, wellness information, clinical guidelines, and other self-management tools. They are available on THP corporate website, secure member portal, or interactively by telephone with a health coach or outreach member advocate by calling 1.855.577.7124.

Member Wellness and Prevention and Health Promotion initiatives include:

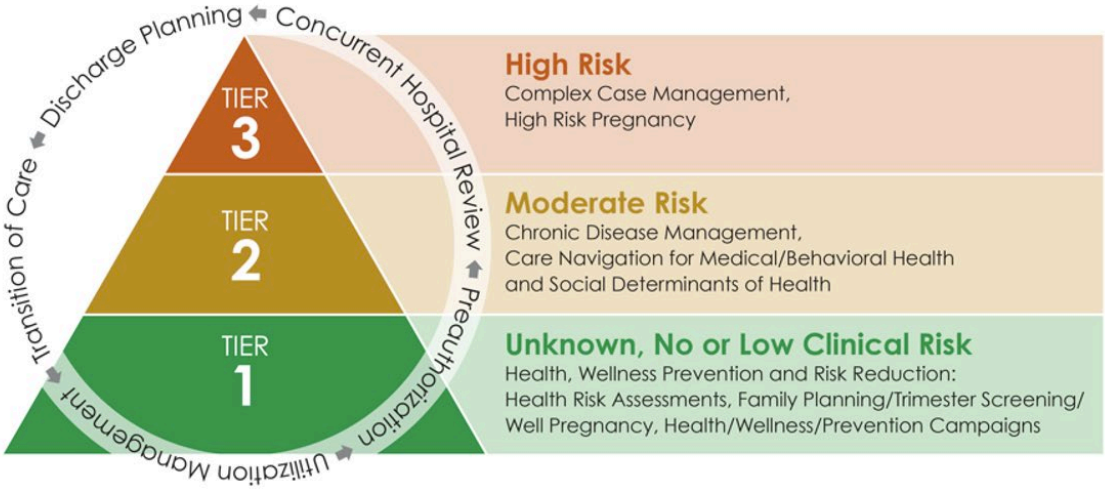
- Outreach/welcome calls
- Health Risk Screening with risk stratification to clinical program referrals
- Screening/Periodicity Reminders/Gap in Care Closure Notification and education to impact Over and Under Utilization of resources with targeted campaigns
- Family Planning Education, Trimester Screening and Well Pregnancy Education Calls
- Risk Reduction Information related to nutrition, exercise, stress management, home safety/falls prevention, safe opiate use and disposal, etc. provided to population health driven focus groups via health fairs, wellness program, email blasts and targeted campaigns
- Personal Wellness with Certified Health Coaches providing care planning towards individualized goals through engagement in our CoreWellness Program
- Certified life coaches to assist with self-actualization, inclusive of educational resources/job training, managing finances/budgeting and assistance with family resources. The life coaches may be reached by calling 877-236-2293 Monday through Friday from 8 am to 5 pm.
- Social Determinant of Health screening and resource referrals to outside supports/community- based organizations: Women, Infants and Children (WIC), Food Banks, Birth to Three, Workforce, etc. THP Social Workers may be reached by calling 1.877.221.9295Monday through Friday from 8 am to 5pm.
- Tobacco Cessation

Care Coordination

Care Coordination is promoted through a series of supportive services and programs offered to THP members to facilitate quality care planning and improve access to care. Care Coordination is made up of a three- tiered risk-based stratification system that includes opportunities for members to engage in programs based on a Low, Moderate or High-Risk level.

Anyone may request evaluation for participation in a Care Coordination Program at any time. Members with any identified needs related to end of life issues, functional deficits, personal resource deficits, benefit issues, poor linkage to care, caregiver issues, or medication issues to name a few, are appropriate to refer or may self-refer to a care coordination program. THP's clinical analytic tools and health risk assessment results are used to stratify members to a program that is correct for them. Members with high clinical risk and actionable opportunities may be appropriate for Complex Case Management or High-Risk Pregnancy if they are pregnant. Those with lesser risk but identified needs may be enrolled in Care Navigation. Members requiring specific education to manage chronic conditions such as diabetes, cardiac, respiratory, or high-risk perinatal conditions may be appropriate for Disease Management or Perinatal Care Programs. Members with low risk or unknown risks may benefit from engagement in Health and Wellness, Prevention and Risk Reduction Programs such as CoreWellness or by receiving information through an educational campaign to aid in prevention or promote wellness and routine screening.

THP Clinical Care Coordination Programs form a pyramid with high-risk members enrolled in Tier 3 Programs at the top of the pyramid and Tier 1 or Health and Wellness programs forming the base of the pyramid. Each program includes educational aspects of the information included in the programs below. For example, Complex case management includes health and wellness/preventive information as well as chronic disease management information for members with relevant diagnoses. Utilization management programs encircle the care coordination programs and provide another layer of support and service to provide access and promote comprehensive care across all settings and risk levels.



Care Navigation

Care Navigation is a program for the moderate risk member requiring support or education to achieve personal health goals on a short-term basis. It is intended to be episodic or situational and care is facilitated by a care navigator. Care navigators can be registered nurses, licensed practical nurses, social workers, licensed professional counselors or medically trained member advocates depending on the nature of the case and member's need. A THP care navigator coordinates resources to support members and minimize costs while improving total quality of care. Care navigation focuses on service access, health maintenance, education, and member empowerment through promotion of self-management skills. Medical and behavioral health issues are addressed along with social determinant of health needs to provide the best possible member outcomes.

Complex Case Management

The Complex Case Management Program is a service that helps provide appropriate care and supportive services to high-risk individual members, their families and/or caregivers via a personalized care plan. Members are identified as high-risk due to severity of illness or injury and complexity of services and are enrolled in this program based on a clinical analytic defined risk score comprised of clinical risk and actionable opportunities or a high score on a health risk assessment. Members receive a comprehensive HRA and/or disease specific assessment performed by a complex case navigator to develop a member centric care plan. Assessments are performed on enrollment and at minimum annually for as long as the case remains open. Complex case navigators are registered nurses with Certified Case Manager credentials (CCM), or they are registered nurses supervised by a CCM. They have a variety of specialty backgrounds and are trained to address medical, behavioral, and social needs.

A key aspect of the Complex case navigator's job is to assess the needs of the member from a holistic point of view. A comprehensive assessment helps identify any potential medical/behavioral health needs, safety needs, gaps in care or applicable social determinants of health such as housing or food security that must be addressed in a care plan to help the member to achieve defined goals. Opportunities, goals, and interventions are identified and agreed upon by the member in collaboration with the complex case navigator and their care team members. Care team members may include pharmacists, social workers, counselors, psychologists, THP medical directors, providers and/or family members/caregivers identified by the member or the Complex Case Navigator and added to the care team. The Complex case manager serves as the direct contact to coordinate care with all involved care team members and is responsible for scheduling follow up calls and/or visits at routine agreed upon intervals to guide care coordination along with the primary care provider. Timing of interventions and call frequency is based on individual need, member acuity and agreed upon schedule of interventions.

Complex Case Examples May Include:

- Transplants—organ and bone marrow/stem cell; includes evaluations, pending and post transplants
- Catastrophic neuromuscular diseases such as multiple sclerosis, myasthenia gravis, amyotrophic lateral sclerosis
- Brain injury in active treatment
- Cystic fibrosis
- New spinal cord injury
- Critical or major burns (1st or 2nd degree burns) covering more than 25% of adult's body or more than 20% of child's or 3rd degree burns on more than 10% body surface area or burns involving hands, feet, face, eyes or genitals
- Immunodeficiency
- Ventilator cases in home setting
- Major congenital anomalies – atrial septal defect, valve stenosis and atresia, pulmonary artery stenosis, patient ductus arteriosus, craniofacial deformities, myelocystocele, myelomeningocele (such as spina bifida)
- Premature birth (extreme) 28 weeks or less
- Complex cancers in active treatment; with anticipated ongoing high-cost care, including myelodysplasia
- Children with special health care needs (CSHCN)
- Hemophilia
- Genetic abnormality with ongoing care, treatment, or monitoring
- Trauma – Complex needs in active treatment
- Serious and persistent mental illness as evidenced by recurrent non-substance use related psychosis or mania with multiple emergent admissions

Chronic Disease Management Program

THP's Chronic Disease Management (CDM) Program is an education and support program developed to proactively identify populations with, or at risk for, chronic medical conditions. Populations currently being managed include members with diabetes, chronic cardiac conditions such as coronary artery disease, congestive heart failure (CHF),and chronic obstructive pulmonary disease (COPD) or asthma. The focus of chronic disease management is early identification and educational engagement with a nurse navigator for newly diagnosed or risk based members to learn life skills needed to prevent disease progression and knowledge to support self-management. THP CDM Program also uses a remote patient monitoring (RPM) vendor for additional supports for appropriate members. The RPM program is tablet based educational materials and surveys with attached digital monitoring tools that include blood pressure cuffs, pulse oximeters, scales and

glucometers as appropriate based on the member's condition for enrollment. The RPM vendor shares biometric information of concern with THP CDM staff and the provider of record.

The Chronic Disease Management Program supports the practitioner-patient relationship and plan of care and emphasizes the prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies.

Program Content

- The program includes **condition monitoring** relevant to the identified disease state or states that is ongoing and proactive.
- **Member adherence** to the provider treatment plan is integral. Members are followed to determine their success with self-management, self-monitoring activities, and medication compliance. Providers are made aware of their member's enrollment in the program and information is shared with providers on the Care Team. Members are called at periodic intervals. Detailed questions are asked about the member's condition and information is gathered regarding health status, treatment plan adherence, functional status, and quality of life.
- **Member education** is targeted at areas of concern based on the findings from a clinical assessment and functional inventory which is used to build a care plan. Ongoing monitoring ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to participants by the nurse navigator is determined by the severity of symptoms. This may result in daily contact in times of elevated-risk or concern.
- **Closure of care gaps** is a program goal and Disease Management Nurse Navigators work collaboratively with Population Health, members and providers to facilitate preventive screens, routine tests and recommended ongoing monitoring related to particular disease states.

Members are stratified to Disease Management Programs based on the Impact Pro Population Health Category of Chronic Big Five Conditions, identified needs, moderate health risk assessment scores, a moderate clinical risk score, actionable opportunity levels, and their propensity to engage as well as members identified with newly diagnosed Chronic Big Five Conditions.

THP's Chronic Disease Managers may be reached by calling 800-776-4771 Monday through Friday from 8 am to 5pm.

Family Planning, Well Pregnancy, and High-Risk Pregnancy Programs

Family planning, well pregnancy and high-risk pregnancy programs are designed to improve access to family planning, early and routine prenatal care, improve pregnancy outcomes, reduce neonatal hospitalizations, and reduce all costs associated with preterm birth and other complications of pregnancy. This is accomplished by providing education for family or pre-pregnancy planning, perinatal education, promoting safe health behaviors, and enhancing the management of care for women identified as interested in family planning, planning for a healthy pregnancy, pregnant and well or currently identified as high-risk for premature labor and delivery. The Family Planning, Well Pregnancy and High-Risk Pregnancy Programs are administered by THP Perinatal Nurse Navigators with a background in Obstetrics, Gynecology, Labor/Delivery/Post-Partum Recovery or care of neonates.

Program goals include:

- Reduction in the incidence of preterm births
- Reduction in the incidence of low-birth-weight babies
- Reduction in the number of neonatal intensive care unit days
- Early Identification of Substance Use Disorder in Pregnancy and Referral to Appropriate Treatment Support
- Provision of improved family planning and perinatal education, promotion of safe health behaviors including depression screening, and enhanced management of maternity care for women identified as high-risk for premature labor and delivery

Program Enrollment

- Referrals may come from the practitioner, THP outreach program during new member welcomes or annual HRAs, Monthly Comment Files, PRSI reports, self-referral, and claims data. Practitioners are provided with a perinatal risk screening tool (PRSI) to fill out and forward to THP.
- The targeted time for enrollment of members is during pre-pregnancy planning or early in pregnancy depending upon the program of interest.
- Early pregnancy is defined as between 12 to 15 weeks gestation for the perinatal program. A telephonic assessment of the clinical and psychosocial status, including depression screening, of the member is completed by Perinatal Nurse Navigator at enrollment, during each trimester and during the postpartum period.
- Family planning members are engaged until their personal care goals are achieved, be it achieving a healthy pregnancy or obtaining appropriate birth control or family planning.
- Consideration is given to other health conditions during care planning for Family Planning, Well and High-Risk Pregnancy Programs.

- For pregnant members, the assessment tool, along with the perinatal risk screen completed by the practitioner, is reviewed by the nurse navigator. The mother-to-be is placed in the appropriate low-risk pregnancy group or the high-risk pregnancy group to be case managed dependent on identified risk factors. Relevant information is shared, and care is coordinated with involved providers including PCP and obstetricians throughout the program.
- A late referral education component is available for those women enrolled after 34 weeks gestation. A partial program is offered for those individuals who decline to enroll in the complete program but who want to receive educational materials.
- Members in well and high-risk pregnancy programs are provided with education/information and self-management tools to promote parenting and newborn care during the postpartum period. Sample educational materials are available to participating providers.

A successful perinatal care program is dependent on the coordination of health care services. The role of the practitioner is vital, and this program is intended to complement the medical care the member is receiving from her practitioner. The goal of THP is to foster a collegial relationship between the practitioner and the Perinatal Nurse Navigator to coordinate the necessary health care to promote a healthy mother and a healthy baby.

THP's Perinatal Program Case Managers may be reached by calling 877-236-2288 Monday through Friday from 8 am to 5 pm.

What the Member and Provider May Expect with Care Coordination Program Enrollment

- Members are identified by risk level and offered the opportunity to engage in a relevant care coordination program. A Care Navigator/Nurse Navigator performs a telephonic assessment to determine the member's specific needs and opens a case.
- The member receives an introductory call and letter explaining the program. The provider receives a copy of the member letter as well.
- A plan of care is established based on the member assessment. The care plan identifies prioritized opportunities, goals, and interventions to facilitate personal goal achievement. The care plan is available on the secure member portal to the member and their designated care team members. The care plan is available to the provider on the provider portal if they are the PCP or SCP on record, or if they have formally been added to the "Care Team" in THP's care coordination platform.
- A Care Team is identified/constructed in the platform. It may include the member, their designated support people, and relevant providers. The member has control over who is on their external care team. The PCP is always a care team member with full access to member records on the Secure Provider Portal.
- Agreed upon interventions are carried out by the care team members as discussed during phone interactions and documented in the care coordination platform.

- Agreed upon interventions are carried out by the care team members as discussed during phone interactions and documented in the care coordination platform.
- Reminders are set for telephonic, or messaging follow up at agreed upon intervals. Interventions may take the form of providing education, making/facilitating provider appointments, coordinating transportation, explaining benefits, referring to community agencies, transitional care support, caregiver resources, medication adherence and medication reconciliation among others.
- A care coordination program may be closed 1) when all goals are met, 2) if the member chooses to terminate participation in care coordination, 3) if the member becomes non-compliant with the program and no longer participates actively in calls and interventions. All care coordination programs require that a member opts into the program and remains actively engaged throughout the course of the program.

Advance Care Planning

Advanced Care Planning allows for effective communication between providers and patients to plan for the patient's future care.

Provider's Role:

1. Ask each member over the age of 18 if they have an advance directive and document the answer in the member's medical record. If the member does not have an advance directive, that should be noted in the medical record, and the provider and office staff should encourage discussions with the member to help them understand advance directives and the importance of such documents. Provide them with educational material regarding advance care planning. Honor their wishes as outlined by their advance care plan and do not discriminate against any member based on the existence or content of their advance directive.
2. Transfer any member whose advance directive you cannot support based on moral or religious beliefs that may prevent you from full support of the member's decision.

Compliance with advance directive policies is part of THP's quality review process. Annual audits will be conducted to ensure compliance.

If the member has signed an advance directive, a copy should be retained in the medical record.

To comply with guidelines, all members of THP 18 years old or older must have documentation on their chart that advance care planning has been discussed, reviewed, and updated at a minimum of every three years.

Information regarding advance directives is provided at the time of the member's initial enrollment and is included in their welcome packet. In addition, advance directive information for all 50 states is available on THP corporate website. Information is also provided at health fairs and community events.

THP utilizes Five Wishes to provide education regarding advance care planning to all members. The document is available in print and online formats and can be provided by PMC upon request or sent to members by calling the Health Coaches at 877-903-7504 Monday through Friday from 8 am to 5 pm.

Clinical Leadership and Committees

THP's Chief Medical Officer (CMO) and medical directors provide leadership and direction for all utilization management and quality improvement activities. This team plays an important role in the development of the quality management program and supervises quality improvement plans and initiatives. One of the THP physicians serves as chairman for each of the following committees:

- Physician Advisory Committee
- Medical Directors Oversight Committee
- Appeal and Grievance Committees
- Quality Improvement Committee
- Credentialing Committee

THP's medical directors are responsible for all utilization management decisions not delegated to an outside vendor (i.e., denial of authorization decision based on medical necessity). They will communicate with primary care provider, attending practitioner, and specialist reviewers as necessary for case discussions.

THP's medical directors' other responsibilities include:

- Decision making regarding medical appropriateness of care and services
- Review of appeals
- Physician education regarding practice patterns

Physician Advisory Committee

The Physician Advisory Committee (PAC) is a collaborative committee established to receive input from the physician community to guide THP in its decision making related to medical policy affecting coverage and reimbursement for physician services and to discuss issues related to relationships and interactions between and among physicians, their patients, and THP.

These issues may include but are not limited to: (a) improvement of health care and clinical and quality through the establishment of clinical and quality guidelines; (b) improvement of communications, relations, and cooperation between physicians and THP; and/or (c) matters of a clinical or administrative nature that impact the interaction between physicians and THP.

In addition, physicians serving with the PAC may also serve as specialty reviewers, based on board certification and field of expertise. The PAC additionally provides oversight of the Medical Directors' Oversight Committee (MDOC).

Members of the committee shall include a representative sample of specialty areas that may include family practice, behavioral health, internal medicine, obstetrics and gynecology, orthopedics, pediatrics, surgery, and medical sub-specialists. Committee members may be asked to serve consecutive terms.

Meetings may be held as actual onsite meetings at central or regional locations with telecommunications accessibility. PAC members may also review guidelines, InterQual®, and other policy and procedural changes related to his/her expertise via mailings.

Medical Directors' Oversight Committee (MDOC)

The MDOC is comprised of THP CMO, medical directors, and various other department leads in Clinical and Pharmacy Services, Quality Improvement and Population Health. The committee provides internal clinical service program and policy review and ensures clinical questions and issues are dealt with in a timely and appropriate manner. The key functions of the committee are to provide oversight to programs within clinical services, assist in identifying trends and practice pattern variations and develop and initiate programs and interventions as needed.

Appeal and Grievance Committees

The Appeal and Grievance committees are composed of Clinical, Operations, Benefit Services, Quality, Compliance, and other staff as needed. They are line of business specific for THP Commercial, MHT and Medicare lines of business. These committees convene when necessary to impartially discuss and decide upon a request to reconsider coverage determinations when the member and/or provider are dissatisfied. THP's medical director has the final decision-making authority.

Pharmacy and Therapeutics Committee (P&T)

The Pharmacy and Therapeutics Committee is responsible for the formulation and adoption of policies regarding the appropriate evaluation, selection, procurement, distribution, use, and safety of drug therapies. The committee recommends and assists in the development of programs and policies for participating practitioners in all areas pertaining to drug therapy for THP membership. The committee's composition includes practitioners, pharmacists, and representation from THP. The Pharmacy and Therapeutics Committee reports quarterly to the Quality Improvement Committee.

Quality Improvement Committee

The Quality Improvement Committee responsibilities include recommending policy decisions, analyzing and evaluating the results of QI activities, ensuring practitioner participation in the QI program through planning, design, implementation, and review, identifying needed actions and ensuring any follow-up as appropriate.

- The committee recommends and revises, or oversees recommendations and revisions to, policies for effective operations of the QI program and achievement of the QI program objectives.
- The committee oversees the analysis and evaluation of the QI program and assesses the results.
- The QI committee facilitates participating practitioner involvement in the QI program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings or on ad hoc task forces.
- The committee identifies actions to improve quality, prioritizes them based on their significance and choose which to pursue, or oversees these functions if performed by an associated committee or subcommittee.

- The QI committee reviews and evaluates The Health Plan's actions to determine their effectiveness.

Credentialing Committee

The Credentialing Committee serves as the peer review committee responsible for reviewing all information available regarding provider credentials as well as character, professional competence, qualifications, and ethical standing of applicants for privileges as providers of THP. This committee is also responsible to investigate any breach of ethics reported to the committee, to propose changes or restrictions in privilege status, and to recommend or reject new appointments and reappointments.

Annual Utilization Management Program Description and Evaluation

An annual written Clinical Service UM program evaluation that includes the Medical, Behavioral Health, Pharmacy and Appeal & Grievance Units is prepared in collaboration with Clinical Service management staff. The evaluation includes data from the work plans which include barriers encountered, opportunities for improvement, final analysis, and recommendations for the upcoming year. The evaluation is complete after recommendations (if applicable) are received from the UM work group, the Continuous Quality Improvement work group and approved by the Medical Directors Oversight Committee (MDOC).

Once the UM program evaluation is finalized by MDOC the recommendations are incorporated into a revised annual UM Program Description for the upcoming year. When the updates are completed the revised UM Program Description is discussed with the UM workgroup and MDOC for recommendations.

The finalized Utilization Management Program Description is effective after the Statement of Approval is completed by the MDOC representative and the Chief Medical Officer.

Population Health

THP's population health team identifies and stratifies our enrollment population based on medical conditions, risk factors, and social determinants of health.

Data is reviewed to assist in developing programs to meet the needs of various risk groups and engage both members and providers in improving the overall health of the populations.

The population health management team completes a population assessment by evaluating trends of prevalence and financial burden of medical conditions, both chronic and episodic, utilizing analytical software, claims data, business intelligence reporting and care navigation engagement reporting and outcomes.

The intent of the analysis is to develop specific programs to support the four focus items of population health management:

- Keeping members healthy
- Managing members with emerging risk
- Managing outcomes across healthcare settings
- Managing multiple chronic conditions
- Integration of data for this assessment includes medical and behavioral claims and encounter information, pharmacy claims data, laboratory claims, lab values and results. Additionally, information obtained from health risk assessments is analyzed to identify social determinants of health and barriers to care. Electronic health records (EHR) may also be available through shared portal access with providers. Other various data points include clinical assessments performed by THP's Clinical Services Department nurse navigators and member outreach as well as vendors who may be providing in-home assessments. Data available through licensed software are also incorporated into the analytical process.

The population assessment is completed to determine:

- Needs across THP service area
- Members that should be targeted for various care navigation programs
- Appropriateness for disease management and social services programs
- Whether the current programs are meeting the needs of the population

Included in the assessment is the review of gaps in care related to evidence-based practice as well as member satisfaction with clinical services programs. Data are reported in aggregate and by product line to facilitate an understanding of similarities and differences in health needs and status according to geographical influences. Additionally, further analysis of specific high-risk groups, such as children with special healthcare needs, members with disabilities, and those with severe and persistent mental illness, is completed to ensure the needs of those members are identified.

Examples of social determinants of health that are identified as barriers to care include:

- Transportation and/or lack of transportation
- Mobility issues
- Food insecurity
- Social isolation

Quality Measures and HEDIS®

Healthcare Effectiveness Data & Information Set (HEDIS®)

The HEDIS audit contains a core set of performance measures that provide information about customer satisfaction, specific health care measures, and structural components that ensure quality of care. THP is required to report quality performance measures set forth by HEDIS, to NCQA, CMS, and BMS annually.

The HEDIS audit takes place annually between January and June and administrative (claim) data is used when applicable. THP contracts with an outside vendor to assist with medical record retrieval needed for each of the applicable performance measures. A representative from our vendor may contact the office for chart retrieval. THP will coordinate an onsite visit to accommodate the provider and office staff.

To support performance measurement, care gap reports to identify members with gaps in care according to HEDIS quality measures specifications are available through the secure provider portal. Gap reports are run monthly based on a proactive review of members' claim history.

Coding by measure is outlined in the Quality Measures and HEDIS Coding Guide that is available on THP's corporate website.

In addition to utilizing care gap reports and the appropriate HEDIS related ICD-10 codes to capture the services rendered, practitioners can submit clinical documentation for HEDIS measures via fax to the Population Health team at 1.304.433.8208. A documentation fax cover sheet is required and can be found on the provider portal resource library.