TheHealthPlan

Chapter 9

Clinical

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 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 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
- 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 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
- 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 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 Utilization Review Accreditation Commission (URAC) or National Committee for Quality Assurance (NCQA) accredited vendor for specialty medical review services by board-certified practitioner reviewers with the same or similar background.

Medical Prior Authorization & Notification Requirements

Practitioners 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, practitioners are required to request prior 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) practitioners 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 practitioners.

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

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	7 calendar days	3 calendar days
Self-Funded/ASO	15 calendar days	3 calendar days

If a PA request is incomplete:

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

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

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

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

If services are required in less than 48 hours due to medically urgent conditions, please submit an urgent prior 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 prior authorization will be denied and are not subject to member responsibility. 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 MHT, Medicare Advantage and Commercial Fully Insured product lines.

- Sleep Studies
- 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

Nurse Information Line

A nurse navigator is available 24 hours a day, 7 days a week to assist with medical management questions but 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 practitioner (PCP) or referring participating specialists. This includes acute care, rehabilitation, skilled nursing facilities, and long-term acute care facility (LTACF).

Notification of urgent or emergent admissions by the admitting practitioner or facility, is required at the time of 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.

Non-participating and tertiary non-emergent requests require prior authorization. Clinical information is reviewed for availability of service within the plan 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 involves communication with practitioner(s), hospital utilization review staff, social workers, and family members, as necessary.

Upon discharge from an acute care stay, members receive 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 it is 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 members healthy and out of the hospital. Highly driven by Utilization Management, this program focuses on early identification of members that are high risk for admissions or readmissions by using an iPro admission risk score.

Members can be referred to this program by THP staff. The goal of this program is to keep members healthy and out of the hospital while also assisting with other transition of care needs including but not limited to exhaustion of benefits, finding participating practitioners 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 risk stratification.

InterQual® Review

THP utilizes InterQual® criteria as a screening guideline to assist reviewers in determining medical appropriateness for 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®.

THP uses InterQual® guidelines for most procedures and services other than for MHT where BMS has mandated the 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.

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 prior authorization.

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 rendering practitioner should send the report to the referring practitioner who will discuss findings with the member.

Specialist Coordination of Health Care Services

THP facilitates ongoing specialist care and coordination of benefits for members with special health care needs. This would apply when the PCP, 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, specialist, and 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) practitioner 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 Practitioner

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 Practitioner" 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.

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

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

The completed Request Form: Specialist as Primary Care Practitioner, 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 co-payment 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. The members and specialist practitioner will not be required to complete the Request Form: Specialist as Primary Care Practitioner; however, the specialist practitioner is still required to fulfill all THP PCP requirements.

Member Wellness, Prevention, & Health Promotion

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

THP provides and promotes health risk screening, wellness information, clinical guidelines, and other self-management tools. These tools are available on THP corporate website, secure member portal, or interactively by telephone with a 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 THP CoreWellness Program. Certified Health Coaches can be reached by calling 877-903-7504 Monday through Friday from 8am to 5pm.
- 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 877-903-7504 Monday through Friday from 8 am to 5 pm.
- Social Determinant of Health (SDoH) 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 1.877.221.9295 Monday through Friday from 8 am to 5pm.
- Tobacco Cessation with American Lung Associated certified Freedom from Smoking facilitators. Facilitators can be reached by calling 877-903-7504.

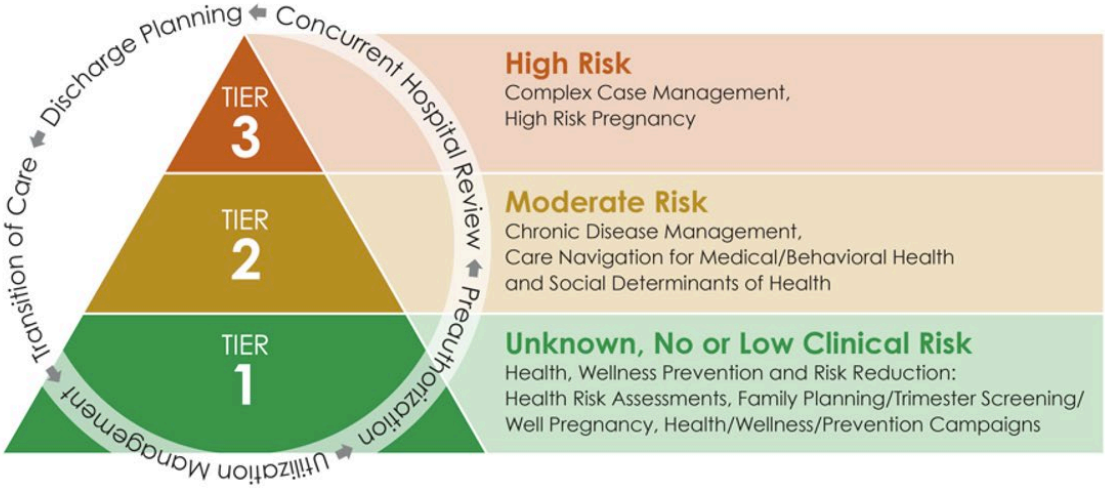
Practitioners may refer members to THP's free Member Wellness, Prevention and Health Promotion or Clinical Programs via our website at **http://www.healthplan.org/providers/resources/physician-case-management-referral**.

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.

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 less risk but have 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 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 needs are addressed along with social determinants of health (SDoH) needs to provide the best possible member outcomes.

Complex Case Management

Complex Case Management is a program 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 Health Risk Assessment (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, practitioners 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 practitioner. 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

Chronic Disease Management (CDM) 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 support 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 treating practitioner.

The CDM 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 practitioner treatment plan is integral. Members are followed to determine their success with self-management, self-monitoring activities, and medication compliance. Practitioners are made aware of their members enrollment in the program, and information is shared with practitioners 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 at times of elevated risk or concern.
- Closure of care gaps is a program goal, and Disease Management Nurse Navigators work collaboratively with members and practitioners to facilitate preventive screens, routine tests and recommended ongoing monitoring related to 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 costs associated with pre-term 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:

- 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 a practitioner, , annual HRAs, Monthly Comment Files, PRSI reports, self-referral, and claims data. Practitioners are provided with a perinatal risk screening tool (PRSI) to complete and return to THP
- The targeted time for member enrollment 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 reached by 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 practitioners 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 and self-management tools to promote parenting and newborn care during the postpartum period

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 receives from the practitioner. THP's goal is to foster a relationship between the practitioner and the Perinatal Nurse Navigator to coordinate the necessary health care and 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 Practitioner 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/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 practitioner receives a copy of the member letter
- A care plan is established based on the member assessment. The care plan identifies prioritized opportunities, goals, and interventions to facilitate personal goal achievement
- A Care Team may include the member, their designated representative, and relevant practitioners. The member has control over who is on their external care team
- 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
- Telephonic reminders are set at agreed upon intervals. Interventions may take the form of providing education, facilitating practitioner 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 when:
    - All goals are met
    - Member chooses to terminate participation in care coordination

- Member becomes non-compliant with the program and no longer participates in calls and interventions. All care coordination programs require 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 practitioners and members to plan for the member's future care.

Practitioner's Role:

Practitioners should ask members over the age of 18 if they have an advanced directive and document the information in the member's medical record. If the member does not have an advance directive, it should be noted in the medical record, and the practitioner and office staff should encourage discussions with the member to help them understand advance directives and the importance. . Practitioners should provide members with educational material regarding advance care planning and 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.

Practitioners should transfer any member whose advance directive you cannot support based on moral or religious beliefs that may prevent full support of the member's decision.

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

To comply, 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 (3) years.

Information regarding advance directives is provided by THP 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'scorporate website at healthplan.org.

THP partners with Five Wishes to provide education regarding advance care planning to members. The Five Wishes document is available in print and online formats and can be provided by the practitioner's THP Practice Management Consultant (PMC) upon request or sent to members by calling THP 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 (1) of THP's physicians serves as chairman for each of the following committees:

- Utilization Management Committee (UM Committee)Appeal and Grievance Committees
- Quality Improvement Committee
- Professional Review Committee

THP's medical directors are responsible for all utilization management decisions not delegated to an outside vendor, i.e., denial of prior authorization decisions based on medical necessity. They will communicate with primary care practitioner (PCP), 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

Utilization Management Committee

The Utilization Management Committee exists to promote the effective implementation of THP Utilization Management program and to provide oversight of the development and maintenance of the scope and processes of prior authorization, concurrent review, and post service reviews.

The committee also ensures that all utilization management functions are sufficient to effectively analyze and make recommendations relating to controlling costs, mitigating risk, and assuring quality of care. This includes the review of utilization patterns and trends through data analysis to detect and recommend remediation of over/under or inappropriate utilization.

The Utilization Management Committee is formed through the combination of two pre-existing committees known as the Medical Director Oversight Committee and Physician Advisory Committee in order to fulfill the internal and external requirements

Membership

The committee is comprised of internal and external members including THP's staff, medical directors, and the Chief Medical Officer, who serves as an advisor to the committee, and:

- Include a majority of practicing physicians.
- Include at least one practicing physician who is independent and free of conflict relative to the plan.
- Include at least one practicing physician who is a specialist in geriatrics.
- Include members representing various clinical specialties to ensure a wide range of conditions are considered in the development of UM policies.
- Include at least one (1) member with expertise in health equity.
- Other people by invitation. Such invitation-only attendees should have a clearly defined purpose for attendance. Such attendees are not intended to offer commentary on other agenda topics outside of the reason for their attendance and shall be excused when the purpose for their attendance has concluded. Subject matter experts (SMEs) may be invited by the committee for a specific agenda topic and shall only participate during the related topic.

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 or practitioners 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
- Oversees the analysis and evaluation of the QI program and assesses the results
- 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
- 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
- Reviews and evaluates THP's actions to determine effectiveness

Professional Review Committee

The Professional Review Committee (PRC) serves as the peer review committee responsible for reviewing all information available regarding practitioner credentials as well as character, professional competence, qualifications, and ethical standing of applicants for privileges as practitioners of THP. This committee is also responsible for investigating any breach of ethics reported to the committee, propose changes or restrictions in privilege status, and 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 applicable recommendations are received from the UM work group, 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.

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

Medical Economics

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

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

The medical economic 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. Information obtained from health risk assessments is analyzed to identify social determinants of health (SDoH) and barriers to care. Electronic health records (EHR) may be available through shared portal access with practitioners. Other data points include clinical assessments performed by THP's Clinical Services Department nurse navigators, member outreach, and vendors that provide in-home assessments. Data available through licensed software is 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 and member satisfaction with clinical services programs. Data is reported in aggregate and by line of business 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 SDoH 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 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. THP's vendor may contact practitioners for chart retrieval. THP will coordinate an onsite visit to accommodate the practitioner 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 THP at 740.699.6163. A documentation cover sheet is required and can be found on the provider portal resource library.