PASSPORT HEALTH PLAN

2019
Passport Utilization Management Program Description

Our mission is to improve the health and quality of life of our members

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2019 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Introduction

The purpose of the Passport Utilization (UM) Program is to safeguard our members against unnecessary and inappropriate medical care. The program allows Passport to review member care from perspectives of medical necessity, quality of care, appropriateness of decision-making, place of service, and length of hospital stay.

Utilization Management includes or involves the evaluation of the medical necessity, and the appropriateness and efficiency of the use of healthcare services, procedures and facilities under the provisions of the benefit plan. The UM Department implements comprehensive processes to monitor and control the utilization of health care resources. These programs assist in ensuring services are available in a timely manner, provided in the appropriate settings, and services are planned, individualized and evaluated for effectiveness**.**

Program Goals, Objectives and Functions

Program Goals

The goals of the UM Department are to:

- Ensure Contractual Service Level Agreements are met on a consistent basis
- Ensure regulatory compliance
- Evaluate the appropriateness, medical need and efficiency of healthcare services according to established criteria and policies
- Monitor and report practice patterns of participating providers
- Evaluate for program modification based upon data and health care trends
- Ensure consistency amongst reviewers and Medical Director's aptitude at applying criteria and protocols in a consistent manner through auditing
- Evaluate provider satisfaction with the Utilization Management program
- Evaluate subcontracted activities as it relates to Utilization Management
- Implement training initiatives
- Facilitate integration and communication between all departments within Passport to include:

Department	Integration Points
Care Coordination / Complex Case Management	Member identification; Case collaboration; Training initiatives
Condition Management (Disease Management and Behavioral Health)	Member identification; Case collaboration; Training initiatives
Pharmacy	Member identification; Case collaboration; Training initiatives
Compliance	Regulatory requirements; Policy development; Contractual obligations; Confidentiality
Quality Improvement	Data exchange; Clinical initiatives
Member Services	Member inquiries; Questions regarding prior authorization, denials and appeals
Provider Services / Claims Reimbursement	Provider issues; Provider appeals
Marketing	Member and provider communications
Delegation Oversight	Sub-contractor processes and collaboration

Program Objectives

The objectives of the UM Program are to:

- Ensure compliance with the State contractual and Department of Medicaid Services (DMS) regulations and NCQA guidelines
- Develop policies to maintain compliance with the State contractual and Department of Medicaid Services (DMS) regulations and NCQA guidelines
- Evaluate, monitor and oversee healthcare services for quality and medical necessity
- Review utilization data, identifying over-and under-utilization practices, and identifying and implementing programmatic improvements encouraging appropriate utilization
- Ensure subcontracted activities are within compliance with all state, federal, regulatory and contractual obligations
- Evaluate and implement new systems / technology
- Manage training and education initiatives
- Maintain documentation consistency

Program Functions

The functions of the UM Department are to:

- Conduct clinical review for:
    - Prospective/prior authorization review
    - Precertification review
    - Concurrent review
    - Retrospective review
    - Appeals
- Conduct internal auditing
- Conduct inter-rater reliability/consistency review testing and reporting
- Review, revise and develop policies and procedures
- Evaluate, test and implement medical management systems
- Develop clinical initiatives
- Conduct data analysis for potential over-and under-utilization and provider trending
- Evaluate satisfaction with the UM Program using member and provider input
- Approve and monitor subcontracted activities
- Evaluate for program effectiveness

The UM Department's activities are evaluated annually. The annual evaluation is designed to:

- Evaluate the overall effectiveness of the UM Program
- Assure systematic re-evaluation of the policies and procedures currently in force
- Evaluate consistency amongst Medical Management associates
- Evaluate compliance with policies, procedures and regulations related to the appeals process
- Evaluate documentation consistency amongst Medical Management associates
- Evaluate clinical initiatives efficiency and effectiveness
- Evaluate program objectives, activities, and targets for the coming year
- Results are included in the annual evaluation of the UM program.

The UM Department program description and the annual evaluation are reviewed and approved by the Passport Health Plan Quality Medical Management Committee (QMMC). The program is subject to continuous review to assure it meets the needs of Passport Health Plan. Select data from the evaluation is also submitted to the Quality Department on a quarterly basis for submission to DMS' (Department for Medicaid Services) Quality Work Plan.

QMMC is a committee including actively participating physicians who have professional knowledge or clinical expertise in the area(s) being reviewed.

Modifications to any program are reviewed and approved by the Chief Medical Officer, Vice President of Utilization Management, Quality Medical Management Committee (QMMC) and the Department of Medicaid Services / Medicaid Commissioner as applicable. Modifications to the Utilization Review program / review requirements will be submitted to DMS for informational purposes and / or approval.

Passport does not discriminate or treat members differently on the basis of race, color, national origin, age, disability or sex. Passport follows federal civil rights laws; provides free aids and services to members with disabilities such as qualified sign language interpreter and provide free language services to members whose primary language is not English.

I. Program Staffing

Staff

The UM Department is comprised of the following staff:

- Executive Management Team
  - Chief Medical Officer
  - Market President
  - Vice President Utilization Management
- Senior Management Team
  - Senior Director of Utilization Management
  - Clinical Managers
  - Non-Clinical Manager
  - Medical Directors
  - Appeals Director
- Clinical Team
  - Utilization Review Nurses
  - Tiny Tots Nurses
  - Emergency Room (E.R.) Navigators
  - Appeals Nurse
- Non-clinical Team
  - Intake Specialists
  - Research Appeals Coordinators
  - Emergency Room (E.R.)Coordinators
- Support Team
  - Medical Systems Analyst
  - Data / Business Analyst
  - Medical Management Trainer
  - Medical Management Auditor

Qualifications & Responsibilities

Title	Reports to:	Qualifications	Responsibilities
Executive Management Team			
Chief Medical Officer	CEO	Physician licensure in the state of Kentucky Board certification 5 years Medical Management / 5 years of progressive business experience A Primary Care discipline	Direct the implementation and oversight of all programs under Medical Operations including the Utilization Management Program
Market President	CEO	14 years progressive experience in business 10 years management experience required 6-8 years Managed Care experience Bachelor's degree in business or health related discipline	Direct the implementation and oversight of all programs under Medical Operations
Vice President Utilization Management	Sr. VP Product Health Plan Ops	Registered Nurse 14 years progressive experience in business 10 years management experience required 6-8 years Managed Care experience Bachelor's degree in business or health	Direct the implementation and oversight of all programs under Utilization Management

		related discipline	
Senior Management Team			
Senior Director of Utilization Management	Market President Clinical Operations	8-10 years progressive experience in healthcare delivery 5 years' experience in managed healthcare preferred 5 years managerial experience Registered Nurse	Direct the implementation and oversight of Utilization Management Department
Manager Clinical	Senior Director	8 years progressively responsible experience in a clinical environment 3 + years of management experience Registered Nurse	Oversee daily operations of the Utilization Management Department
Manager Non-Clinical	Senior Director	5 years progressively responsible experience in a clinical environment 3 + years of management experience	Oversee daily non-clinical operations of the Utilization Department
Medical Directors	CMO	Physician Licensure in the State of Kentucky Board Certification 5 years of Medical Management experience Primary Care discipline in Internal Medicine, Pediatrics or Family Practice	Serve as consultant to the Medical Management associates Conduct denials when serving as a clinical reviewer
Appeals Director	Senior Director	8 years progressively responsible experience in a clinical environment 5 years' experience in managed healthcare appeals preferred 5 years managerial experience Registered Nurse	Direct the implementation and oversight of the Appeals process
Clinical Team			
Utilization Review Nurses	Manager	Active, unrestricted Kentucky Nursing License 3 year clinical experience Experience in Utilization Management preferred	Perform medical necessity review Ensure compliance with policies, procedures and regulations Refer for higher level of care Identify potential fraud, waste and abuse
Tiny Tots Nurses	Manager	Active, unrestricted Kentucky Nursing License 5 years' experience in NICU, or appropriate specialty area. Experience in Utilization Management preferred	Conduct concurrent review and care coordination Acts as a member of the healthcare team to coordinate activities with physician, NICU staff, and caregiver
E.R. Navigators	Manager	Active, unrestricted Kentucky Nursing License 5 years' experience in Emergency Room Experience in Utilization Management preferred	Conduct member interviews Evaluate the member's discharge needs Provide member education Track and trend E.R. utilization
Appeals Nurse	Appeals Director	Active, unrestricted Kentucky Nursing License 5 years' experience in Medical Management	Perform clinical oversight of appeal decisions Ensure compliance with policies, procedures and regulations Identify potential fraud, waste and abuse
Non-Clinical Team			
		3-5 years of experience in the medical	

Intake Specialists	Supervisor	field 3-5 years progressively responsible administrative experience	Provide non-clinical support to the clinical staff
Research Appeals Coordinators	Appeals Director	3-5 years of experience in the medical field 3-5 years progressively responsible administrative experience	Provide non-clinical support to the clinical staff
Emergency Room (E.R.)Coordinators	Manager	3-5 years of experience in the medical field 3-5 years progressively responsible administrative experience	Provide non-clinical support to the clinical staff
Support Team			
Medical Systems Analyst	Appeals Director	High School Degree College degree or equivalent experience preferred Demonstrates knowledge of medical terminology, ICD-10and CPT-coding, principles and practices of health information record systems, medical records and office procedures	Maintain a current knowledge base with regards to rules, all Federal and State regulations, DMS contract requirements Develop, edit and maintain multiple Medical Management systems Assist with the development and delivery of system training programs and processes
Data / Business Analyst	Appeals Director	High School Degree College degree or equivalent experience preferred Demonstrates knowledge of medical terminology, ICD-10 and CPT-coding, principles and practices of health information record systems, medical records and office procedures Demonstrate knowledge of medical data reports	Assist in the development of reporting and analysis of medical data, metrics and measures Assist with clinical and physical data modeling to support medical management initiatives Develop weekly, monthly, quarterly and annual medical management reports and results
Medical Management Trainer	Appeals Director	Current KY RN license or Social Worker license 4-5 years clinical experience 4-5 years Managed Care experience	Assess training needs and methods of instruction Develop, implement and maintain training strategies for both short-term and long-term training goals and initiatives Develop and maintain training material Serves as the training liaison between Medical Management and other departments within Passport Health Plan
		Active, unrestricted Registered Nurse	Perform internal chart audits on Medical Management associates for completeness and accuracy Perform internal chart audits on Medical Management associates to ensure compliance with criteria, regulations, NCQA requirements and policy and procedures Develop and maintain clinical and non-clinical audit tool Prepare audit reports Assist in the development of

Medical Management Auditor	Appeals Director	license 2-years progressively responsible experience in medical records or chart auditing	individual / team corrective action plans based upon audit results

Non-clinical and Support Staff are restricted from making any medical necessity review determinations.

Utilization Review Staff are available at a minimum 40 hours per week during normal business hours and extended hours on Monday and Friday until 6pm including federal holidays and Saturdays.

II. Medical Policy

The following are utilized during the review process to evaluate for medical necessity of a proposed service:

- InterQual™ Guidelines.
- Internally developed medical policies
- Medicare and Medicaid criteria/guidelines
- Statutory / Regulatory Guidelines

InterQual™ Guidelines is the clinical decision support tool, approved and required for use by DMS, utilized by Passport for medical necessity review of requested adult and pediatric services; and is the criteria supporting clinical decision-making, reviewer consistency, efficient operations and reporting.

Passport utilizes the American Society of Addiction Medicine (ASAM) for substance use. If InterQual does not cover a behavioral health service, Passport adopts the following standardized tools for medical necessity determinations -- for adults: Level of Care Utilization System (LOCUS); for children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children; Early Childhood Service Intensity Instrument (ECSII).

If it is determined that one of the DMS approved medical necessity criteria is not available or not specifically addressed for a service or for a particular population, Passport UM Department will submit its proposed medical necessity criteria to DMS for approval. "Approval of Department", except that the submissions involving medical necessity criteria will not be deemed approved after thirty (30) days.
DMS may also, at its discretion, require the use of other criteria it creates or identifies for services or populations not otherwise covered by the named criteria in the above paragraph. The Contractor will be given ninety (90) days to implement criteria the Department may otherwise require.

Internal medical policies are developed by Passport Health Plan Medical Directors when no other criteria exist within InterQual™ Guidelines. Internal medical policies are derived from one or more of the following:

- Current approved medical literature and peer reviewed publications
- Commercially available policy models
- Physician comments and/or recommendations
- Community standards of medical practice
- Accepted standards of practice of health contractors
- Medicaid Guidelines

Internal policies are submitted to the Quality Medical Management Committee (QMMC) for final approval.

Once internal approval has been issued, Passport will submit the internal medical policy to the Department of Medicaid Services (DMS) for review and approval.

The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate. The Medical Director and Behavioral Health Director shall supervise the UM program and shall be accessible and available for consultation as needed.

All internal medical policies and guidelines are reviewed and approved at least annually.

Once the policy has been approved by DMS, prior to implementation of criteria, the Medical Management staff participates in educational programs related to the approved policies and protocols, guidelines, and review criteria as needed. Member and provider education regarding additions/changes to the criteria, medical policy or protocols, or guidelines is provided as needed through member newsletters and provider newsletters/manuals as well as direct mailings, community outreach, and postings on the Passport Health Plan website.

Supplementary Information

Along with the use of approved criteria, when evaluating requests for services, at a minimum, the following information is considered during the review process:

- Patient demographics and eligibility information
- History of symptoms and results of physical examination
- Results of clinical evaluation including appropriate lab and radiology results
- Cultural diversity
- Other information as required by criteria

Criteria based on individual needs assessment of the local delivery system is also applied during the review process. When applying the guidelines to a specific request for service for a member, the following factors are considered:

- Age
- Co-morbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Cultural diversity

Characteristics which are specific to our local healthcare delivery system when considering a specific request for services are also applied during the review process. These include:

- Availability of skilled nursing or sub-acute care facilities or home care in the organization's service area to support the patient after hospital discharge
- Coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care where needed
- Local hospitals' ability to provide all recommended services within the estimated length of stay

Cultural Competency

Medical Management Associates are responsible for assuring members receive from all providers' effective, understandable, and respectful care that is provided in a manner compatible with their cultural beliefs and practices and preferred language.

- Effective health care is care that successfully restores the member to the desired health status and takes steps to protect future health by incorporating health promotion, disease prevention, and wellness interventions.

- Understandable care focuses on the need for members to fully comprehend questions, instructions, and explanations from clinical, administrative, and other staff.
- Respectful care includes taking into consideration the values, preferences, and expressed needs of the member.

Medical Management Associates may refer to Cultural Competency policies and procedures for guidance in ensuring members receive effective, understandable and respectful health care.

III. New Technology

Passport is responsible for identifying new technologies and new applications of existing technologies when they provide a demonstrable benefit for a particular illness or disease; are scientifically proven to be safe and efficacious; and there is no equally effective or less costly alternative.

Passport Health Plan evaluates and approves coverage of new technologies and new applications of existing technologies when they demonstrate an improvement in health outcomes, health risk and health benefits when compared with established procedures and products. Passport also reviews to determine the new technologies are scientifically proven to be safe and effective.

The technology assessment process includes the reviewing of pharmaceuticals, biological, devices, diagnostics, or procedures. Emerging and innovative technologies are monitored by Passport Health Plan Medical Directors through review of trend reports from technology assessment bodies; government publications; medical journals; and information provided by providers and professional societies.

New technology assessments are reviewed by the Medical Directors, Chief Medical Officer and the Quality Medical Management Committee (QMMC) for approval. Any changes or modifications to the UM program are submitted to the Department of Medicaid Services (DMS) for review and approval.

Once final approval is achieved, the UM Department:

- Develops or modifies an applicable policy
- Forwards to Public Affairs Department to be placed on Passport's website for provider review and feedback for 30-days, if applicable
- Trains all Medical Management associates

IV. Clinical Criteria Requests

Passport is responsible for monitoring and tracking provider or member requests for clinical criteria utilized during the review determination process.

Members or providers may request, at any time and free of charge, the clinical criteria utilized during the review process. The UM Department monitors all requests for clinical criteria. Copies of all documents, records, and other information relevant to a determination, including medical necessity criteria and any processes, strategies, or evidentiary standards relied upon shall be provided upon request.

Members or providers may request statutory / regulatory guidelines, InterQual™ Guidelines, internally developed medical policies, or Medicare and Medicaid criteria/guidelines.

If a member or provider requests a copy of InterQual™ Guidelines, the Department is to send only the smallest increment or portion feasible under the circumstances, or as legally required for disclosure. In connection with each disclosure/distribution, all clinical content related to a specific medical necessity decision or any copies of the clinical content from the book or software shall prominently display on the cover page and/or introductory screen InterQual™ Guidelines, the InterQual™ Guidelines Statement of Disclosure, and copyright notices and Proprietary Notice.

Statement of Disclosure – "The Clinical Content reflects clinical interpretations and analyses and cannot alone either resolve medical ambiguities of particular situations or provides the sole basis for definitive decisions. The Clinical Content is intended solely for use as screening guidelines with respect to medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient; all ultimate care decisions are strictly and solely the obligation and responsibility of your health care provider.

The Clinical Content you are receiving is confidential and proprietary information and is being provided to you solely as it pertains to the indication discussed with your healthcare provider. Under copyright law, the Clinical Content may not be copied."

All clinical criteria requested are tracked and trended on an annual basis.

V. Inter-rater Reliability (IRR)

An annual consistency review is conducted to demonstrate the Nurse Reviewers and Medical Directors' aptitude at applying criteria and protocols in a consistent manner.

The Senior Director, Manager, Trainer and Auditor identify the method used to ensure consistency among associates concerning the application and utilization of medical policies, protocols, criteria and guidelines.

The Senior Director, Manager, Trainer and Auditor define the process utilized to monitor the application of decision-making compared to Utilization and Care Coordination policies, medical policies, guidelines and protocols, criteria such as InterQual™ Guidelines.

The Senior Director, Manager, Trainer and Auditor identifies both global and individual areas requiring improvement and assist in the development of a correction action plan to address areas of deficiency.

Annual analysis of results is presented by the Senior Director to the Quality Medical Management Committee (QMMC).

VI. Training and Education

A formal orientation and training program is provided for all positions within the UM Department.

The new associate orientation and training program is initiated with the Human Resources Department in conjunction with the UM Department.

Ongoing educational opportunities are provided and/or offered to all associates within Passport. The UM Department provides education, development and training for all medical and non-medical Passport associates. Website trainings are also available to all associates.

The Trainer oversees the ongoing education for Passport associates. Ongoing education include educational forums with associated Continuing Education (CE) credits and training sessions (clinical and nonclinical), which are formulated by analyzing the needs of the staff and the relativity of the content of the training.

The Trainer develops and deploys ongoing education opportunities for Passport Associates as applicable. The proposed educational / training sessions are reviewed and approved by the following:

- Director
- Clinical Programs Manager
- Supervisor

The Trainer designs/plans trainings and approves the educators and their curriculum. The Clinical Programs Manager reviews feedback and evaluations of current trainings and review ideas and qualifications of future trainers for upcoming professional development offerings.

VII. Response Standards and Service Level Agreements (SLAs)

The following response standards have been established per Kentucky State statute and/or NCQA guidelines for case determinations and notifications:

- The decision for urgent requests must occur and the decisions communicated via telephone, voice mail, or fax within 24 hours of receipt of the request including federal holidays but excluding weekends.
- The decision for non-urgent requests must occur, and the decision communicated to the requestor via telephone, voice mail, or fax within 2 business days of the receipt of the request. These requests are considered for scheduled / non urgent requests.
- The decision for a covered member's continued hospital stay must occur, and the decision communicated to the requestor via telephone, voice mail, or fax within 24 hours of receipt of the request for review, and prior to the time when a previous authorization for hospital care expires including federal holidays but excluding weekends.
- The decision for a retrospective review must be completed and the decision communicated within 14 calendar days of the receipt of the medical information.
- If the review results in an adverse determination, a letter must also be sent within the time frames indicated above.
- The decision for an expedited appeal must be completed no later than 3 working days from the request.
- The decision for a standard appeal request must be completed within 30 days of the receipt of the request.

The UM Department is responsible for ensuring all contractual service level agreements related to the Utilization Management Program are met.

Service level agreements for the Utilization Management are:

	Description	SLA
Telephone		
ASA	Average speed to answer inbound calls	2 minutes or less
AR	Abandonment Rate on inbound calls	10 % or less
Case Turn Around Times for Review Determination		
Urgent	Case Types	24 Hours
Non-Urgent		2 Business Days
Retrospective		14 Calendar days

* Includes federal holidays; weekends

A request for authorization or preauthorization for treatment of an enrollee with a diagnosis of substance use disorder shall be considered an expedited authorization request by the provider

In the event a SLA is not met on a quarterly basis, the Senior Director will develop and submit to the Passport Executive team a Corrective Action Plan (CAP) to assess and correct the deficiencies.

VIII. Utilization Analysis

The UM Department is responsible for evaluating data, analyzing trends and modifying program requirements as applicable.

Data is evaluated in the following areas:

	Description
Inpatient Admissions per 1,000 members	An indicator calculated by taking the total number of inpatient admissions for a specific period of time (usually one year), dividing it by the average number of covered members in that group during the same period, and multiplying the result by 1,000.
Inpatient days per 1,000 members	An indicator calculated by taking the total number of inpatient days for a specific period of time (usually one year), dividing it by the average number of covered members in that group during the same period, and multiplying the result by 1,000.
Average length of stay (ALOS)	Average length of stay is computed by dividing the number of days stayed (from the date of admission by the number of discharges during the year.
Utilization by Category of Aid (CoA)	Resource utilization by eligibility type under Medicaid
Utilization by MDC / DRG	Resource utilization by Major Diagnostic Category / Diagnostic Related Grouper
Outpatient	Analysis of outpatient trends

Data is analyzed and tended to evaluate for program efficiency and effectiveness and over / under- utilization trends. Modifications to the Utilization Management Program and Program recommendations are made to improve outcomes and manage costs and ensure quality healthcare for our members and providers.

Passport may establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members; may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan, and applicable regulations, such as medical necessity; and place appropriate limits on a service for utilization control, provided the services furnished can reasonably be expected to achieve their purpose, services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the Member's ongoing need for such services and supports, and family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning.

Any modifications to the Utilization Management Program are reviewed and approved by the Chief Medical Officer, Market President, Quality Medical Management Committee (QMMC) and the Department of Medicaid Services / Medicaid Commissioner as applicable.

IX. Utilization Management Activities

The Utilization Management (UM) program, processes and timeframes are in accordance with 42 CFR 456, 42 CFR 431, 42 CFR 438 and the private review agent requirements of KRS 304.17A as applicable (Managed care organization requirements and policies related to utilization management and quality).

Medical Necessity

Utilization Management is responsible for the medical necessity determination of select services.

The State of Kentucky's definition of "medical necessity":

Passport Health Plan reviews all requests for services pursuant to the authority granted to it in accordance with Kentucky Regulations: 907 KAR 17:025 (Managed care organization requirements and policies related to utilization management and quality) and 907 KAR 3:130 (Medical necessity and clinically appropriate determination basis). Passport Health Plan is required to provide only medically necessary health services as defined by the Kentucky Administrative Regulations. 907 KAR 3:130 states "medical necessity means a covered benefit is: Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; Clinically appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice; Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons; Provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided; Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 U.S.C. 139d(r) and 42 CFR Part 441 Subpart B for individuals under twenty-one (21) years of age; and Provided in accordance with 42 CFR 440.230."

Inpatient Pre-Admission Review

The Utilization Review Nurse conducts pre-admission review for all elective admissions requiring review to determine the medical necessity and appropriateness of inpatient stays. Evaluation is made using authorized clinical criteria to determine the medical necessity of all requests and whether the treatment could be rendered in an alternative level of care. Pre-admission review authorizations are completed by the First Level Reviewer (Utilization Review Nurse) and if required, the case may be referred to the Medical Director if criteria are not met. Only the Medical Director can make medical denial determinations.

In evaluating each inpatient admission request, the following standards should be met:

- The services are medically necessary
- The services can be provided for the member safely and effectively only in an inpatient hospital setting
- The services cannot be provided in an alternative setting
- The member's medical condition and treatment require daily or more frequent physician contact

- The medical condition and treatment requires constant availability of medical services and equipment ordinarily available only in the inpatient setting
- The type of diagnostic test, observation, equipment, etc., needed to perform a work-up cannot be done on an outpatient basis
- Discharge planning is initiated
- Opportunities for case management and disease management intervention are identified

The review completion time for Inpatient Pre-admission review request is 2 business days or as expeditiously as the member's health warrants.

Inpatient Urgent Review

The Utilization Review Nurse conducts reviews for all urgent admissions that require a review. The review is to determine the medical necessity and appropriateness of urgent inpatient stays. Evaluation is made using authorized clinical criteria to determine the medical necessity of all requests and whether the treatment could be rendered in an alternative level of care.

Urgent admissions are completed by the First Level Reviewer (Utilization Review Nurse) and if required, the case may be referred to the Medical Director if criteria are not met. Only the Medical Director can make medical denial determinations.

Assessments are conducted on-site, by telephone, or fax. In evaluating each review request, the following standards should be met:

- The services are medically necessary
- The services can be provided for the member safely and effectively only in an inpatient hospital setting
- The services cannot be provided in an alternative setting
- The member's medical condition and treatment require daily or more frequent physician contact
- The medical condition and treatment requires constant availability of medical services and equipment ordinarily available only in the inpatient setting
- The type of diagnostic test, observation, equipment, etc., needed to perform a work-up cannot be done on an outpatient basis
- Discharge planning is initiated
- Opportunities for case management and disease management intervention are identified

Additional considerations to evaluate during the review process include:

- Triage or screening for the purpose of determining the urgency of the member's need for care
- Appropriatenss of Site / Place of Service
- Level of care
- Cultural and linguistic barriers
- Member characteristics and information (i.e. educational level that may present barriers to care)
- Information regarding responsible family members; home environment
- Information regarding benefits for services or procedures, if applicable
- Information regarding the local delivery system and alternative services
- Discharge plans

The review completion time for Inpatient Urgent review requests is 24 hours business day or as expeditiously as the member's health warrants including federal holidays but excluding weekends.

Concurrent Review

Concurrent review is performed to determine medical necessity and appropriateness of a continued inpatient stay. Evaluation is made using authorized clinical criteria to determine the medical necessity of all concurrent review requests.

Concurrent review requests are completed by the First Level Reviewer (Utilization Review Nurse) and if required, the case may be referred to the Medical Director if criteria are not met. Only the Medical Director can make medical denial determinations.

Assessments are conducted on-site, by telephone, or fax. In evaluating each review request, the following standards should be met:

- The continued need for hospital level-of-care is medically necessary
- There is not an inappropriate delay of necessary hospital care
- Discharge planning is initiated
- Opportunities for case management and disease management intervention are identified

The review completion time for urgent concurrent review requests is 24 hours after receipt of information and prior to the time upon which a previous authorization for hospital stay will expire or as expeditiously as the member's health warrants including federal; holidays but excluding weekends.

Outpatient Prior and Urgent Authorization

Prior authorization provides an opportunity to determine medical necessity and appropriateness of services, procedures, and equipment prior to utilization. Urgent outpatient review is to determine the medical necessity and appropriateness of urgent outpatient services.
Evaluation is made using authorized clinical criteria to determine the medical necessity of all outpatient prior authorization requests.

Prior / Urgent authorizations are completed by the First Level Reviewer (Utilization Review Nurse) and if required, the case may be referred to the Medical Director if criteria are not met. Only the Medical Director can make medical denial determinations.

Assessments are conducted on-site, by telephone, or fax. In evaluating each review request, the following standards should be met:

- The service, equipment or procedure is medically necessary
- The service, equipment or procedure is clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- The service, equipment or procedure reflects the most efficient and cost-effective application of patient care
- Opportunities for case management and disease management intervention are identified

The review completion time for outpatient prior authorization requests is 2 business days or as expeditiously as the member's health warrants.

The review completion time for outpatient urgent review is 24 hours including federal holidays and excluding weekends.

Retrospective Review (post-service)

The retrospective review process consists of reviewing records for healthcare services rendered for which previous authorization and coverage determinations had not been established. Retrospective review is conducted utilizing InterQual® Criteria, Utilization Management policies and Medical Management policies. The need for retrospective review may be due to a service rendered after business hours, out-of-area care, or it may be due to retrospective eligibility.

The review completion time for Retrospective requests is 14 business days. If the Member, or the Provider, requests an extension, or the Passport UM justifies a need for additional information and how the extension is in the Member's interest, may extend an additional fourteen (14) days to complete the review

Utilization Management decision making is based only on appropriateness of care and services and existence of coverage.

Discharge Planning

Discharge planning supports the continuity of healthcare, between the health care setting and the community, based on the individual needs of the patient.

Discharge planning during the review process functions as a conduit for the discharge planning process within a health facility, providing education and support to hospital staff in the development and implementation of discharge plans. Discharge planning assists to coordinate all services allowing member to transition to the next level of care.

Integration with Care Coordination / Complex Case Management, Disease / Condition Specific Management, and Behavioral Health Management

Care Coordination / Complex Case Management is the process linking members with special health care needs and their families and/or caregivers to services and resources in a coordinated effort to maximize the potential of the member and provide them with optimal health care.

Disease / Condition Specific Management is e an approach to healthcare teachings patients how to manage a chronic disease and to prevent or decrease exacerbation of an illness by a comprehensive, integrated approach to care.

Behavioral Health Management focuses on improving the quality of life for people suffering from mental health or substance abuse issues and is a key aspect of a person's overall health and wellbeing.

Utilization Management will evaluate all members for potential Care Coordination / Complex Case Management / Disease Condition Specific Management / Behavioral Health Management services.

The guidelines to assist in determining if a referral to Care Coordination / Complex Case Management is appropriate are:

- A new diagnosis of a chronic or catastrophic illness

- Non-compliance with medical regimen
- Multiple services / multiple providers
- Frequent hospitalizations and or emergency room use
- Psychosocial issues hindering medical care
- Over/under-utilization of services
- Members at risk for chronic physical, developmental, behavioral or emotional conditions
- Member with special health care needs beyond that required by individuals generally
- Request from providers for intervention by Care Coordination

The guidelines to assist in determining if a referral to Disease / Condition Specific Management is appropriate are:

- Diabetes
- Chronic Respiratory Disease
- Congestive Heart Failure
- Pregnancy
- Obesity
- Coronary Artery Disease

The guidelines to assist in determining if a referral to Behavioral Health Management is appropriate are:

- Children, youth, and adults with multiple health conditions, who are chronically at risk for hospitalization or other out-of-home placement
- Members with histories of behavioral health utilization/diagnoses

Coordination of Services

Passport will ensure the coordination of services for members:

- Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; This will include discharge planning with the provider(s), referrals to Case Management, Clinical Rounds and through the authorization process.
- With the services the Member receives from any other MCO (Managed Care Organization) or FFS (Fee for Service). The UM Department will ensure continuity of care as to not disrupt treatment previously approved through another MCO or FFS plan.
- With the services the Member receives from community and social support providers.

Coordination with Special Programs

The Utilization Management Department works in conjunction with other Passport Health Plan programs to ensure members receive the optimum benefits Passport Health Plan has to offer.

When appropriate, the Utilization Management staff will refer members to the following programs for evaluation and intervention:

- EPSDT Services - all Passport Health Plan members under the age of 21 are eligible for EPSDT services. EPSDT services are defined as Early, Periodic, Screening, Diagnosis and Treatment
    - Passport shall provide Covered Services in an the amount, duration, and scope that is no less than the amount, duration, and scope furnished Medicaid recipients under fee-for-service program, and for members under the age of twenty-one (21) as set forth in 42 CFR 441 Subpart B; that are reasonably be expected to achieve the purpose for which the services are furnished; enables the Member to achieve age-appropriate growth and development; and enables the Member to attain, maintain, or regain functional capacity.
- Care Connectors - rapid triage of the member to identify any urgent needs, both clinical and non-clinical not managed within the Utilization Management Department

Transition of Care

The Utilization Management Department assists with a member's transition when the following circumstances apply:

Transition Scenario	Transition Activity(s):
Another MCO	A Prior Authorization (PA) will be honored by the New MCO for 90 days or until the recipient or provider is contacted by the New MCO regarding the PA. If the recipient and provider are not contacted by the New MCO, the existing Medicaid PA shall be honored until expired.
Hospital Admission Prior to the Member's Transition	If the Member is an in-patient in any facility at the time of transition, the entity responsible for the Member's care at the time of admission shall continue to provide coverage for the Member at that facility, including all Professional Services, until the recipient is discharged from the facility for the current admission. An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a "current admission." The "same diagnosis" is defined as the first five digits of a diagnosis code.
Outpatient Facility Services and Non-Facility Services	Effective on the Member's Transition date, the New MCO will be responsible for outpatient services both facility and non-facility. Outpatient reimbursement includes outpatient hospital, ambulatory surgery centers, and renal dialysis centers.
Transplants	Follow up care provided on or after the Member's Transition that is billed outside the Global Charges will be the responsibility of the New MCO.
Eligibility Issues	For a Member who loses eligibility during an inpatient stay, an MCO is responsible for the care through discharge if the hospital is compensated under a DRG methodology or through the day of ineligibility if the hospital is compensated under a per diem methodology.

Continued service to a member:

During the transition of care, the UM Department will:

- Allow access to services consistent with the access the member previously had, and will be permitted to retain their current provider for a period of time if that provider is not in network. The UM Department will conduct a Medical Necessity review for out of network services and will refer the member to Case Management / Member Services to assist with locating an in network provider.

The UM and Case Management Department will ensure continued access to services to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.

If a member's coverage for services ends and the member continues to require certain care or services, education regarding alternatives for continuing appropriate care and avenues to obtain care are provided to the member. Utilization Management will collaborate with the Care Coordination Department to ensure the member's health care needs are met. If a member's provider terminates a contract, Utilization Management will coordinate with the Care Coordination Department to assist the member in locating a contracted provider. If a member or provider requires assistance to transition a member to a lower level of care, Utilization Management will coordinate with the Care ordination Department to assist the member in locating a lower level of care provider

Referrals

The Primary Care Physician (PCP) is responsible for coordinating the member's entire healthcare. If the member needs to see a specialist, the PCP completes and issues a referral form for the specialist. Referral forms are processed through the Passport claims unit. Utilization Management provides assistance to the Primary Care Physician with any out-of-network referrals that are needed. Prior approval by Utilization Management is not required for referrals to participating providers. Referrals to an out- of-network provider require prior approval through the Utilization Management Department.

There are a number of direct access services covered by Passport for which members can make appointments with network providers without referrals from their PCP.

Direct access services include:

- Basic vision care
- Behavioral health care
- Chiropractic care
- Dental care
- Diabetes eye test
- Family planning
- Maternity care
- Immunizations
- Routine women's care (gynecology)
- Mammogram
- Orthopedic care
- Pap smears
- Sexually transmitted disease screening, evaluation and treatment
- Substance abuse treatment
- Tuberculosis screening, evaluation and treatment
- Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions

Passport shall ensure direct access and may not restrict the choice of a qualified provider by a member for members with special health care needs determined through an

assessment to need a course of treatment or regular care monitoring, allowing members to directly access a specialist as appropriate for the Member's condition and identified needs.

Second Opinion

A member may request a second opinion for a service or may request information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions. The member may choose an in OR out of network provider for the second opinion or the Medical Management Department may assist the member to arrange a second opinion. There will be no cost to the member associated with a second opinion

Emergency Services

Authorization is not required for emergency services. For those services rendered in the Emergency Department, notification to Passport Health Plan is not required.

For those services rendered on an emergency basis in an outpatient or inpatient setting, other than the Emergency Department, notification to Passport Health Plan is required within the next business day.

Non-Compensation for Decision Making

The UM Department does not reward providers, or other individuals, conducting utilization reviews for issuing denials of coverage or service care.

Passport Health Plan's policy on non-compensation for decision makers is communicated to providers and members through the Passport Health Plan Provider Manual, the Member Handbook, and on Passport Health Plan's website. All Passport Health Plan staff are required to sign a Code of Conduct, which addresses this, on an annual basis. Additionally, articles addressing this issue are included in provider mailings and member newsletters annually, at a minimum.

Modifications to Program Requirements

Modifications to the Utilization Management Program requirements must be reviewed and / or approved by DMS (Department for Medicaid Services) / Medicaid Commissioner/

QI (Quality Improvement) Work Plan

On a quarterly basis, the Utilization Management Department submits utilization management data to the Quality Department for submission to DMS (Department for Medicaid Services) in the QI Work Plan.

The data submitted in the QI Work Plan include but is not limited to:

- Inpatient data
- Outpatient data
- Data Analysis
- Data Trends
- Service Level Agreements outcomes
- Program Recommendations
- Barriers

X. Delegated Utilization Management Services

The UM Department assists with the coordination and oversight of delegated activities to ensure the delegated entity is in compliance with health plan standards. If the delegated agreement is not followed, corrective action, up to and including revocation of delegated status may be implemented.

The Department will coordinate services for members with the delegated entities when applicable. The Department assists with pre-delegation assessments and annual assessments of delegated entities to ensure NCQA and contractual compliance for activities related to Utilization Management.

Passport Health Plan delegates the following activities:

Vendor Name	Delegated Activities
Avesis	General Dentistry Services
Superior Vision	General Vision Services
CVS	Pharmacy Benefit Manager
EviCore	High Dollar Radiology / Outpatient Therapy / Chiropractic / Pain Management Injections
Beacon Health Strategies	Behavioral Health
Magellan	High Cost Medication

XI. Adverse Benefit Determinations

Medical Necessity Denial

The process of medical necessity review encompasses an initial first level review performed by the Utilization Review Nurse, followed by a second level review performed by a Medical Director for those requests not meeting criteria. The Utilization Review Nurse refers any request not meeting criteria to a Medical Director for review determination. Decisions resulting in an adverse benefit determination are only made at the Medical Director (physician) level. The adverse benefit determination process consists of the following:

- In the first level medical necessity review, a Utilization Review Nurse reviews the information against approved criteria. If the request does not meet criteria or if the criterion specifically requires a Medical Director review, the Utilization Review Nurse submits the information to a Medical Director.

- The second level of medical necessity review consists of a medical review of the information and a determination made at the Medical Director level. Passport Health Plan makes available physician-to-physician discussion of any denial decision. Decisions resulting in an adverse benefit determination are only made at the Medical Director (physician) level. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, is made by a physician who has appropriate clinical expertise in treating the Member's condition or disease. Physician consultants from appropriate medical, surgical and psychiatric specialties are accessible and available for consultation as needed.

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

Members are not responsible for payment, reimbursement or recoupment by the provider for a medical denial; member must be held harmless for the denied service(s).

Administrative / Benefit Denial

All requests for authorization of services must be received during normal business hours. Those requests must be within 1 business day of an emergency admission or observation and prior to an elective service being performed. Failure to provide this notification will result in an administrative denial of the requested admission, observation, or elective service.

Administrative denials will only apply to those days between the admission date and the date Passport Health Plan was notified. Administrative denials are also administered for services that are not a covered benefit under Passport Health Plan.

On retrospectively enrolled members, providers have 60 days from the notification of eligibility to request a review. If no card issue date is available in state system, or no documentation provided by provider, then the State segment date and claims payment history is used. If notification is not received timely, Passport Health Plan will issue an administrative denial.

Members are not responsible for payment, reimbursement or recoupment by the provider for an administrative denial; member must be held harmless for the denied service(s).

Denial Notification

Passport UM provides the Member written notice that meets the language and formatting requirements for Member materials, of any adverse Action benefit determination (not just service authorization actions) within the timeframes for each type of Action adverse benefit determination pursuant to 42 CFR 438.210(c) and in compliance with 42 CFR 438.404 and other provisions of the DMS Contract. The notice must explain in easily understandable language:

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

The written notification will contain specific and detailed information as to why the service did not meet medical necessity, if the adverse benefit determination related to a denial in whole or in part of a service due to lack of medical necessity.

Passport Health Plan, in recognition of the diversity of its membership and in compliance with Title VI of the Civil Rights Act of 1964, provides for oral interpretation and written translation of member communication sent to and/or received by Passport Health Plan's members with communication barriers when requested. All written communication sent to members is accompanied by a Language Translation Insert.

Written Notification is available in the state-established prevalent non-English languages in the Passport service area; is available in alternative formats for persons with special needs; and is in easily understood in language and format (6th Grade Level; 12 Point Font). Passport reviewers may utilize the Passport Marketing Team for assistance in obtaining material translations.

XII. Appeals

An appeal is a request for review of an adverse benefit determination or a decision related to covered services or services provided. An adverse benefit determination is defined as the denial or limited authorization of a requested service, including:

- A denial of a request to obtain services outside the network for specific reasons
- A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit;
- Reduction, suspension, or termination of a service previously authorized by the Department, its agent or Contractor;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined by Department;
- Failure of an MCO or Prepaid Health Insurance Plan (PHIP) to act within the timeframes required by 42 CFR 438.408(b); or
- For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside a Contractor's Network; or
- Denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

The Passport UM Department has an organized system that includes an appeals process, and access for Members to a State Fair Hearing pursuant to KRS Chapter 13B and 42 CFR 438 Subpart F. DMS may provide a standardized form for Passport UM to utilize for a Member to begin the appeal process.

The appeals system has processes in place for assuring that files contain sufficient information, as outlined at 42 CFR 438.416, to identify the appeal including:

- Date the appeal was received
- Nature of appeal
- Notice to the member of the receipt of the appeal
- All correspondence between Passport and the member
- Date the appeal is resolved
- Notices of the final decision
- All pertinent information

All members have 60 calendar days from the date of receiving a notice of an adverse benefit determination to file an appeal either orally or in writing. If an appeal request is received after the expiration of 60 calendar days from the date of receiving the notice of adverse benefit determination, the appeal request shall be denied and a letter advising the member is sent and the provider copied as appropriate. The 60 day timeframe for resolution of the appeal may be extended by 14calendar days if:

- The member requests the extension; or
- The UM and Clinical Programs Departments demonstrate to the DMS there is need for additional information and the extension is in the member's interest

For an appeal or expedited appeal, and the extension was not at the request of the member, reasonable efforts are made to give the Member prompt oral notice of the delay; and give the Member written notice within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance

if he or she disagrees with that decision; and resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

The Appeals Department will notify the member orally of the Plan's intent to extend the appeal time frame and provide the member with the right to file a grievance if they disagree with decision to extend.

If the appeal request was made orally, the oral appeal must be followed up with a written appeal signed by the member, or authorized representative, within 10 calendar days of the oral appeal. In the event a written appeal is not received within 10 days of an oral appeal, the appeal shall be dismissed and the member or provider notified in writing of the dismissal. Passport will provide oral inquiries seeking to appeal an adverse benefit determination are treated as appeals to establish the earliest possible filing date for the appeal and will be confirmed in writing

If an appeal is received from anyone other than the member or his or her authorized representative, the UM Department shall provide oral notification to the requester that an appeal may only be initiated by a member or his or her authorized representative. A provider shall not be an authorized representative without the member's written consent for the specific adverse benefit determination being appealed or is the subject of a State Fair Hearing. The written consent shall be signed and dated by the member no earlier than the date of the adverse benefit determination taken by the UM Department.

Passport will provide for continuation of services, in accordance with 42 CFR 438.420, while the appeal is pending; A member may request continuation of benefits during the appeal process if all the following are met:

- The member or the service provider files a timely appeal of the adverse benefit determination OR
- The member asks for a State Fair Hearing within one hundred and twenty (120) days from the date on the notice of action
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized service provider
- The time period covered by the original authorization has not expired; and
- The member requests extension of the benefits

If Passport continues or reinstates the Member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The Member withdraws the appeal or request for a State Fair Hearing
- The Member does not request a State Fair Hearing with continuation of benefits within ten (10) days from the date the Contractor mails an adverse appeal decision,; or
- A State Fair Hearing decision adverse to the Member is made

If the final decision is adverse to member, the member may be required to pay for services while the appeal was pending.

For a post-service medical necessity appeal and provider administrative appeal, the appeal must be received within 60 calendar days from the date of the notice of action, or 60 calendar days from the date of discharge from an inpatient setting. If an appeal request is received after the expiration of 60 calendar days from the date of receiving the notice of adverse benefit determination, the appeal request is denied.

All appeals are logged in the appeals system upon receipt. Within 5working days of receipt of an appeal the member is provided with written notice the appeal has been received and the expected date of its resolution, unless an expedited resolution has been requested. The letter includes an explanation of the appeal process and informs the member of his or her right to present evidence of the facts or law, testimony and allegations of fact or law, in person as well as in writing. The Passport Appeals Coordinator will inform the Member of the limited time available for this sufficiently in advance of the resolution time frame for appeals and expedited appeals as specified in 42 CFR 438.408(b) and (c);

A board-certified physician with clinical expertise in treating the member's condition or disease who was not involved or a subordinate of the physician involved in the initial denial reviews all member medical appeals. The Medical Director is not the subordinate of any person involved in the initial determination. A member, or representative of the member with member written consent, may examine or request copies of the member's appeal case file free of charge. The Medical Director will take into account all comment, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

The appeal decision is final and all appeal options with Passport have been exhausted. A State Fair Hearing through the Department for Medicaid Services (DMS) may be requested within 120 calendar days of notification of an appeal decision. The member must exhaust all Passport appeals prior to requesting a State Fair Hearing. The member may also contact Kentucky's Ombudsman or Passport Member Services for assistance at any time during the appeal process. If Passport fails to resolve an appeal within this time frame, the Member is deemed to have exhausted Passport's internal appeal process and may initiate a State Fair Hearing;

Passport will allow the member or the Member's representative prior to and after the appeal to review the member's case file free of charge and sufficient in advance of the resolution time frame for appeals as specified in 42 CFR 438.408(b

Members can refer to their Passport Health Plan Member Handbook for complete details about filing an appeal. Members may also call Passport's Member Services for help filing a medical appeal. Passport will provide assistance to Members in filing an appeal if requested or needed including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability;

Appeal Types

Appeal Type	Description	Requirements
Pre-service Medical Necessity	Available for covered services not yet received by the member	The member, an authorized representative for the member, or a provider acting on behalf of the member, may file a pre-service appeal
		An expedited appeal is available when the Passport determines or the provider indicates taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function

Expedited Medical Necessity Appeals	Available for prospective and concurrent services	The member, an authorized representative for the member, or a provider acting behalf of the member, may file a pre-service appeal
Provider Post-Service Medical Necessity Appeals	Available for covered services received by the member, but for which the provider has not received payment due to a medical necessity or administrative denial	The member, an authorized representative for the member, or a provider acting behalf of the member, may file a post-service Medical Necessity appeal
Provider Administrative Appeals	Available for review of an adverse benefit determination by Passport to administratively deny a service based upon the provider's contract and Passport Health Plan's Provider Manual.	The member, an authorized representative for the member, or a provider acting behalf of the member, may file an administrative appeal
Member Administrative/Benefits Appeals	Available for member administrative/benefits appeals include, but are not limited to, appeals for non-covered services and appeals for removal from the lock-in program.	The member, an authorized representative for the member, or a provider acting behalf of the member, may file an Administrative/Benefits Appeal

If Passport denies a request for an expedited resolution of an appeal, the appeal shall be processed in accordance with the standard appeal resolution timeframe of 30 calendar days with the time period commencing on the original date of the receipt of the request for appeal. The member is notified in writing within 2 business days with an acknowledgement letter. The acknowledgement letter contains the statement the expedited appeal was denied and a standard appeal initiated.

Timeliness of Appeals

Appeal Type	Passport to complete within:
Pre-service Medical Necessity	30 calendar days from the request
Expedited Medical Necessity Appeals	72 Hours
Provider Post-Service Medical Necessity Appeals	30 days calendar from the request
Provider Administrative Appeals	30 days calendar from the request
Member Administrative/Benefits Appeals	30 days calendar from the request

The 30 day timeframe for resolution of the appeal may be extended by 14 calendar days if:

- The member requests the extension; or
- Passport demonstrates to the DMS there is need for additional information and the extension is in the member's interest

For an appeal or expedited appeal, and the extension was not at the request of the member, reasonable efforts are made to give the Member prompt oral notice of the delay; and give the Member written notice within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

If the extension is requested by Passport, Passport sends the member written notice of the extension and the reason for the extension within 2 working days of the decision to extend.

Passport provides written notice of its decision to the member or provider, if the provider filed the appeal. The notice advises the member of the right to request a State Fair Hearing in writing postmarked or filed with DMS within 120 days from the date of the date on the notice of appeal decision.

Passport will provide written notice of the appeal decision in a format and language that, at a minimum, meet the standards described in 42 CFR 438.10 and for notice of an expedited resolution. Passport will also make reasonable efforts to provide oral notice.

Definitions:

Authorized Representative – The legal guardian of the member for a minor or an incapacitated adult, a representative of the member for a minor or an incapacitated adult, a representative of the member as designated in writing to Passport, or a provider acting on behalf of the member with the member's written consent. A provider shall not be an authorized representative without the member's written consent for the specific adverse benefit determination being appealed or is the subject of a State Fair Hearing. The written consent shall be signed and dated by the member no earlier than the date of the adverse benefit determination taken by Passport. Passport shall consider the member, representative, or estate representative of a deceased Member as parties to the appeal.

Medical Necessity - (State of Kentucky's definition of "medical necessity")
Passport Health Plan reviews all requests for services pursuant to the authority granted to it in accordance with 907 KAR 17:025. Passport Health Plan is required to provide only medically necessary health services as defined by the Kentucky Administrative Regulations. 907 KAR 3:130 states "medical necessity means a covered benefit is: Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; Clinically appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice; Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons; Provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided; Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 U.S.C. 139d(r) and 42 CFR Part 441 Subpart B for individuals under twenty-one (21) years of age; and Provided in accordance with 42 CFR 440.230."

XIV. Member State Hearing and Provider Third Party Review

Member State Hearing

A member may request a State Hearing if he or she is dissatisfied with an adverse benefit determination taken by the Passport within 120 days of the final appeal decision provided for in CFR 438.408. The member must complete all Passports internal appeal processes before requesting a State Hearing. A member may request a State Fair Hearing for an adverse benefit determination taken by the Passport denying or limiting an authorization of a requested service or reduces, suspends, or terminates a previously authorized service. Passport is required to follow the applicable regulations as it pertains to a member's request for a State Administrative Hearing from any adverse benefit determination.

All Passport members are informed of their right to a Cabinet Level State Administrative Hearing of an adverse benefit determination. Notification of the right to a State Administrative Hearing is sent to the member in conjunction with the Passport adverse benefit determination letter.

Members must notify the Kentucky Department for Medicaid Services (DMS) to request a State Administrative Hearing.

The member must complete all Passports internal appeal processes before requesting a State Hearing. In the event a member elects a State Administrative Hearing, DMS Administrative Hearings Branch notifies the Passport Appeals Coordinator of the appeal request. The Passport Appeals Coordinator accesses the member's electronic file containing all Passport records relating to the adverse benefit determination. The file and all internal appeal records are sent by secure email to the DMS Administrative Hearings Branch within 5calendar days of receipt of notice from the DMS a hearing has been filed.

The Appeals Coordinator notifies the Passport Legal Counsel, located within the Passport Compliance Department, of the Hearing request. The Notice of a Scheduled Hearing will be sent to the Passport Appeals Coordinator by the Hearing Officer at the DMS Administrative Hearings Branch. The notice will contain the date, time and location the Hearing is to be held. Passport's Legal Counsel files a Notice of Entry of Appearance of Counsel.

The Passport Legal Counsel and, as necessary, the Appeals Coordinator represent Passport at all State Fair Hearings and arrange for those giving testimony on behalf of Passport to appear at the hearing. Failure to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an adverse benefit determination taken by Passport or to appear and present evidence will result in an automatic ruling in favor of the member.

Upon receipt of the Findings of Fact, Conclusions of Law, and Recommended Decision from the Hearing Officer all appropriate action is taken by the Legal Counsel and the Appeals Coordinator. Upon receipt of the Final Order signed by the Secretary of the Cabinet, all appropriate action is taken as required by the Order.

The Hearing Officer at the DMS Administrative Hearings Branch is to send the final decision letter to the member within 30 days.

Passport will authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires, but not later than 72 hours from the date the Passport receives notice reversing the determination, if the services were not furnished

while the appeal was pending and the State Fair Hearing results in a decision to reverse Passports decision to deny, limit, or delay services. Passport shall pay for disputed services received by the Member while the appeal was pending and the State Fair Hearing reverses a decision to deny authorization of the services.

The member may contact Kentucky's Ombudsman or Passport Member Services for assistance at any time during the appeal process.

Provider Third Party Review

If Passport issues a final decision which denies, in whole or in part, a health care service or claim for reimbursement, we notify the provider in writing of their right to an external third-party review. A final decision is made once the provider has exhausted their internal appeal rights. A provider shall have a right to appeal a final decision by an external independent third party to the Cabinet for Health and Family Services Division of Administrative Hearings for a hearing in accordance with applicable state laws and regulations.

The notification includes:

- A statement that the provider's internal appeal rights within the Medicaid managed care organization have been exhausted;
- A statement that the provider is entitled to an external independent third-party review;
- The time period (sixty calendar days) and address to request an external independent third-party review; and
- The reason for the adverse benefit determination.

The provider must submit their request for a third-party review to Passport within sixty (60) calendar days. The request must clearly identify each specific issue and dispute directly related to Passport's final decision, clearly state the basis on which the decision is believed to be erroneous, and state the providers designated contact information (including name, phone number, mailing address, fax number, and email address).

Within five (5) business days of receiving a provider's request for third-party review, Passport will:

- Confirm in writing to the provider's designated contact Passport's receipt of the request from the provider;
- Notify DMS of the provider's request; and
- Notify the enrollee of the provider's request.

Within fifteen (15) business days of receiving the provider's request for third-party review, Passport will:

- Submit to DMS all documentation submitted by the provider in the provider's MCO internal appeal process, in addition to any other information related to Passport's final decision; and
- Designate a contact, including name, phone number, mailing address, fax number, and email address.

There are three types of independent third-party reviews:

- Medical Necessity – a claim involving a medical necessity determination;

- Service Coverage Requirements – a claim involving whether a given service is covered by the Medicaid program; and
- Service Coverage Requirements – whether the provider followed Passport's requirements for the covered service.

After a third-party review is completed, either the provider or Passport can request an administrative hearing.

There is no fee associated with the external third-party review. The adverse party in the administrative hearing will be required to pay DMS a $600 fee within 30 days of the final order. The hearing officer will determine the adverse party.

XV. Clinical Initiatives

Reduction in Emergency Room Utilization

The department will continue to administer various Emergency Room (E.R.) programs to decrease the use of the Emergency Room for non- urgent diagnosis; to outreach, follow-up and provide education to our members and will utilize varied methods to reduce the rate at which our members seek treatment for non-urgent symptoms in an Emergency Department (ED) such that it does not exceed 2% of the total ED services sought within each Medicaid Region per the Department of Medicaid Services (DMS).

Project Rationale

- Passport's Emergency Room costs are in excess of 3 million dollars per month
- Kentucky has been chosen to collaborate on a project to design better ways to provide responsible medical care to so-called "super- utilizers" – people who frequently use emergency rooms for regular health care instead of lower-cost alternatives

Project Objectives

- Identify and educate members who utilize the E.R. for non-urgent diagnosis
- Coordinate with Passport alternative programs (Case Management; Disease Management; Behavioral Health)

Project Strategies
Continue E.R. Lock-in program in accordance with Regulation 907KAR 1:67
Goal:

- Identify members eligible for E.R. lock-in
- Assign member to a designated facility

Continue E.R. Navigator Program
Goal:

- Work in collaboration with facilities to identify Passport members utilizing the E.R.
- Meet face to face with members for direct education and identification to barriers to care
- Outreach and educate members and providers

Continue E.R. Coordinator program
Goal:

- Identify members who utilize the emergency room for non-urgent medical conditions through hospital E.R. data
- Identify needs for health education based on obtained data
- Outreach to members to educate on proper utilization of the E.R.
- Enable individuals to use knowledge in ways transforming unhealthy habits into healthy habits

Definitions:
Non-Urgent medical condition: The member's life or health or ability to attain, maintain, or regain maximum function is not at risk .

Urgent / Emergent medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

Tiny Tots

The department will continue to administer the Tiny Tots Program which assists members with the transition of newborns from the hospital to home after the newborn's medical condition has been stabilized.

Project Rationale

- One in nine babies born in the United States are premature
- Almost two-thirds of all childhood hospital stays are for newborns (babies up to 30 days old)
- Three of the top 10 diagnoses with the longest length of stay are conditions originating in the newborn period: prematurity, respiratory distress, and cardiac and circulatory birth defects

Project Objectives

- Identify and educate members on the importance of follow up care
- Ensure a secure and healthy transition of the detained newborn from hospital to home
- Ensure compliance with follow-up visits for detained newborns

Project Strategies
Identify detained newborns and primary caregiver at point of initial hospitalization
Goal:

- Provide early education regarding care of medically fragile infant
- Coordinate a safe transition to home
- Assist in arranging discharge needs when medically stable

Identify gaps in care
Goal:

- Ensure adherence to after care instructions
- Ensure adherence to scheduled physician appointments
- Ensure appropriate interventions are followed

Definitions:
Detained Newborn: Infant in the first 28 days of life that remained hospitalized after birth mother has been discharged

XVI. Provider Experience

The Utilization Management Department monitors the level to which the network serves the needs of our members and providers by analyzing the following data at least annually:

- Provider Experience with the UM Process Annual Survey

Data collection and evaluation provider satisfaction are conducted primarily through the Quality Improvement Department (QMMC) with input from the Utilization Management Department.

Analysis of provider experience / satisfaction are tracked and analyzed to promote effective organizational changes, and to develop quality improvement plans and interventions. These activities are reported to the Quality Medical Management Committee with input requested from that committee.

Acknowledgement and Approval

This PHP 2019 Utilization Management Program Description is submitted by:

Anna Page, RN
Senior Director, Utilization Management
Approvals: