UnitedHealthcare Plan of the River Valley, Inc.
UnitedHealthcare Community Plan, Tennessee

2012 Quality Improvement Program Description

Presented to NQMOC:
Presented to QMC:
UnitedHealthcare Plan of the River Valley, Inc.

United Healthcare Community Plan, Tennessee

QI Program Description
For QM/UM
2012

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# UnitedHealthcare® Community Plan

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UnitedHealthcare Plan of the River Valley, Inc.

UnitedHealthcare Community Plan, Tennessee
2012 QI Program Description
For QM/UM

Chapter 1 – Health Plan Overview

UnitedHealthcare Community Plan (UHC), Tennessee referred to herein as “the Health Plan” is a state government program business unit and a United Health Group business segment focused on public health programs. UHC Community Plan has been contracted with the Tennessee Bureau of TennCare since April 1, 2007.

The Health Plan serves approximately 572,456 non CHOICES and CHOICES TennCare members and addresses the regulatory, contractual and accreditation needs of state and federal agencies in accordance with 42 CFR §438 requirements as well as the National Committee for Quality Assurance (NCQA) standards.

The Health Plan fully integrates physical health, long term services and supports and behavioral health services to provide seamless care to our TennCare members across the continuum of care. The Health Plan is comprised of employees with specialty services in sister companies, including OptumHealth and United Behavioral Health (OHBS) DBA OptumHealth Behavioral Solutions (OHBS).

Other services are administered by the following entities:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>TennCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>TennDent</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>SXC Health Solutions</td>
</tr>
<tr>
<td>Vision</td>
<td>March Vision</td>
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</tbody>
</table>

The Health Plan uses a single system for clinical documentation of all medical, behavioral, and long term services and supports (LTSS) including utilization management, care management, care coordination, and disease management. Team members can readily task a case to a partner and create a temporary change of case ownership when a member needs more specialized assistance during a medical or behavioral health crisis. Our Health Plan committees are integrated with representation from medical, behavioral and LTSS as appropriate. To maintain consistency, a behavioral health Medical Director is involved in implementation of the behavioral health aspects of our Quality Improvement (QI) Program and reports to the Chief Medical Officer. The Health Plan has also integrated its model of care to the provider community. This initiative links the Community Health Network (CHN) and the Tennessee Primary Care Association (TNPCA) and is designed to address deficiencies of specialty providers in rural areas and to increase integrated health care for
our TennCare Members across medical and behavioral health providers.

Contracts

TennCare (Tennessee’s Medicaid population) is comprised of three contracts, one for each of the three Tennessee regions that together cover the entire state.

The Health Plan has been contracted with the Bureau of TennCare since April 1, 2007 and currently serves approximately 555,786 non CHOICES TennCare Members and approximately 16,670 CHOICES TennCare Members. Behavioral health services, which include mental health and substance abuse, are administered by OptumHealth Behavioral Solutions (OHBS), a sister company. In order to ensure that our TennCare members receive services in a holistic manner our medical and behavioral health policies and procedures are fully integrated. The Health Plans in each of the Tennessee regions include staff from both OptumHealth and OHBS who collaborate daily to meet the individual needs of our members.

A benefit for Long Term Services and Supports was added as a result of legislation passed in 2008 and is offered to qualified TennCare Members. This benefit was implemented March 1, 2010 for Middle Tennessee Members and August 1, 2010 for East and West Tennessee Members. This benefit, known as CHOICES, features a single point of entry and currently has three care options, Institutional, Home and Community Based Services, or Consumer Driven Care. A Group 3 category will be added July 1, 2012. This category is specifically for members who do not qualify for Nursing Home services according to the new criteria but who, because they are at risk for nursing home placement, the State has deemed it appropriate to offer Home and Community Based Services. There are approximately 16,670 members in CHOICES, 5,168 of those are Group 2 Members and receive Home and Community Based Services and 11,502 reside in nursing facilities.

UnitedHealthcare Community Plan, TN includes the following TennCare medical providers by service area:
1. East – approximately 5,017 practitioners, 53 hospitals and 638 facilities.
2. Middle – approximately 4,338 practitioners, 58 hospitals and 619 facilities.
3. West – approximately 2,737 practitioners, 51 hospitals and 400 facilities.

Our TennCare behavioral health providers by service area are as follows:
1. East – approximately 1,012 practitioners (Clinicians), 14 inpatient hospitals and 44 facilities.
2. Middle – approximately 868 practitioners (Clinicians), 21 inpatient hospitals and 59 facilities.
3. West – approximately 473 practitioners (Clinicians), 11 inpatient hospitals and 53 facilities.

UnitedHealthcare Community Plan, TN includes the following CHOICES providers by service area:
1. East - approximately 106 Nursing Facilities and 1 additional contract currently in process, 162 HCBS Providers, including Assisted Living Facilities with 5 additional contracts currently in process.
2. Middle - approximately 100 Nursing Facilities and 0 additional contracts currently in process, 199 HCBS Providers, including Assisted Living Facilities with 4 additional contracts currently in process.
3. West - approximately 83 Nursing Facilities and 0 additional contract currently in process, 124 HCBS Providers including Assisted Living Facilities with 5 additional contracts currently in process.

The Health Plan coordinates dental services for our TennCare members who are <21 years of age using the services administered by TennDent, an entity who has a direct contract with the State of Tennessee. Dental services are not a benefit for adults who are covered by TennCare.

Pharmacy services for our TennCare members are administered by SXC Health Solutions which has a direct contract with the State of Tennessee.

Mission/Role/Values/Guiding Principle/ Vision:

Our Mission: Our Mission is to help people live healthier lives

Our Role: Our role is to make healthcare work for everyone

Our Values:
1. Integrity
2. Compassion
3. Relationships
4. Innovation
5. Performance

Our Guiding Principle: Listen to remove barriers and empower Tennesseans to live healthier lives through trustworthy, compassionate, and responsive actions.

Our Vision: Tennessee United HealthCare Community Plan is the most respected Health Plan in the country.

Strategic Overview

The Health Plan strives to continuously improve the care and service provided by the plan and by our health care delivery system. The Health Plan’s Quality Improvement (QI) Program establishes the standards that encompass all quality improvement activities within the health plan.
UnitedHealthcare Community Plan strives to continuously improve the care and service provided by the Health Plan and by our health care delivery system. The UnitedHealthcare Community Plan’s Quality Improvement Program (QIP) establishes the standards that encompass all quality improvement activities within the health plan.

Our Corporate Culture is driven by the core values of Integrity, Compassion, Relationships, Innovation and Performance. We strive to make health care work for everyone through innovative programs such as the Personal Care Model, Healthy First Steps, and effective Disease Management. We are committed to being a good partner for states, providers, members, to the many communities in which we work and to understanding local cultures and their impact on disease and disease management.

Three pillars that support our success in this endeavor are:
A. Clinical quality and excellence
B. Access and affordability
C. Customer service and operational excellence

These pillars are achieved by:
A. Promoting and incorporating quality into the Health Plan’s organizational structure and processes.
   1. Facilitate a partnership between members, providers, state agencies and health plan staff for the continuous improvement of quality health care delivery.
   2. Clearly define roles, responsibilities and accountability for the quality program.
   3. Continuously improve communication and education in support of these efforts.
   4. Consider and facilitate achievement of public health goals in the areas of health promotion and early detection and treatment.
B. Providing effective monitoring and evaluation of patient care and services to ensure that care provided by the health plan delivery system; meets the requirements of standard medical practice, meets the cultural and linguistic needs of the membership, and is positively perceived by Health Plan Members and health care professionals.
   1. Evaluate and disseminate clinical and preventive practice guidelines.
   2. Monitor provider performance against established evidence-based medicine.
   3. Develop guidelines for quality improvement activities (e.g. access and availability, credentialing/re-credentialing, peer review, etc.).
   4. Survey health plan members’ and providers’ satisfaction with the quality of care and services provided.
   5. Conduct and analyze data such as CAHPS® and HEDIS®, develop programs to improve satisfaction and preventive services as identified. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
   6. Collect and analyze data for population specific Quality Improvement (QI) projects.
7. Develop, define and maintain data systems to support quality improvement activities and encourage data-driven decision-making.
8. Provide culturally proficient care and services.
9. Provide disease management and care coordination programs that improve the quality of life for chronically ill members.

C. Ensuring prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up.
1. Identify and monitor important aspects of care and service, quality indicators, problems and concerns about health care services provided to members.
2. Implement and conduct a comprehensive Quality Improvement Program.
3. Recognize that opportunities for improvement are unlimited.
4. Provide ongoing feedback to health plan members and providers regarding the measurement and outcome of quality improvement (clinical and non-clinical) activities.
5. Support re-measurement of effectiveness and continued development and implementation of improvement interventions.

D. Coordinating quality improvement, risk management and patient safety activities.
1. Aggregate and use data to develop quality improvement activities.
2. Provide a regular means by which risk management and patient safety are included in the development of quality improvement initiatives.
3. Identify, develop and monitor key aspects of patient safety.
4. Evaluate the consistency of the implementation of the Health Plan’s decision making system through inter-rater reliability.

E. Maintaining compliance with local, state and federal regulatory requirements and accreditation standards.
1. Monitor compliance with regulatory requirements for quality improvement and risk management opportunities and respond as needed.
2. Ensure that reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies.
3. Monitor performance and compliance separately for each contract for each TennCare Region.
4. Achieve required performance standards established by TennCare or the Health Plan for each measure. Develop an improvement action plan for each measure not meeting the required performance standards to bring performance up to at least the minimum level established.
5. Evaluate the Health Plan’s quality assessment and performance improvement programs utilizing the line of business specific performance measures (HEDIS® and CAHPS®).
6. Evaluate the consistency of the Health Plan’s decision making system through inter-rater reliability.
Chapter 2 – Quality Improvement Scope

Under the direction of the Chief Medical Officer (CMO), the Quality Management and Health Services Departments coordinate and facilitate ongoing monitoring and improvement of activities outlined in this Plan, supported by the WorkPlan. Using an integrated approach throughout the company and the provider network, quality management monitors and evaluates existing processes to identify opportunities for improvement. The Health Plan coordinates and implements action plans whenever opportunities for improvement are identified.

Quality Management Summary

In order to fulfill the goals and objectives of the QI Program, the Health Plan has integrated quality improvement activities into all health plan functional areas. These include, but are not limited to, the following functional areas and departments:

A. Medical and Behavioral Health Services, including Utilization Management, Care Management, Disease Management and Care Coordination
B. Operations, including member and provider relations
C. Network Management
D. National Credentialing Center (NCC)/Behavioral Solutions Network Services (BSNS)
E. Compliance
F. Member Service Center
G. Appeals and Complaints
H. Claims and Encounters
I. Long Term Services and Supports
J. Maternal and Child Health
K. Preventive Health Services
L. TENnerCare Services

Health promotion and health management activities are integral parts of the QI Program. Specific attention is given to high volume, high risk areas of care and services for the populations we serve.

Monitoring and improvement actions undertaken based on the Quality Improvement Program are described in detail in Chapter 4 of this program description and in the Quality Improvement Work Plan.

Utilization Management Summary

The Quality Improvement Program Description describes and guides implementation of the company's utilization management program, which integrates utilization functions—prior authorization, care management, disease management, coordination of care, behavioral health, and medical claims review, plus processes for monitoring, evaluating, and
improving them —under the direction of the Chief Medical Officer (CMO) and the Health Plan Medical Director for Behavioral Health.

The Quality Improvement Program Description and Evaluation are reviewed and approved annually by the Quality Management Committee (QMC) and the United Healthcare Plan of the River Valley Board of Directors. Utilization Management and Disease Management activities are reviewed by the Clinical Operations Subcommittee (COS) and QMC. Ultimate review and approval of the Quality Improvement Program Description, Annual Evaluation and Work Plan rests with the UnitedHealthcare of the River Valley Board of Directors.

The QI Program coordinates with Utilization Management, Care Management, Disease Management and Care Coordination activities. The Quality Improvement Program Description documents the methodology used to assess the degree of conformance to standards, practices, and activities designed to continuously improve quality service and care, with involvement of multiple organizational components and committees. The program is designed to assess complex delivery systems and customer satisfaction while optimizing health outcomes and managing costs. Incorporating the continuous quality improvement concept (CQI), the UM program is comprehensive and integrated throughout the company as well as the practitioner/provider network.

Monitoring and improvement actions undertaken based on the Quality Improvement Program Description are described in detail in the Quality Improvement Work Plan.
Chapter 3 - Program Accountability and Oversight

Quality Improvement Committees

Health Plan Committee Descriptions

A. **Board of Directors**

The Board of Directors is the governing body of the organization. The Board of Directors functions as they relate to the quality improvement program include:

1. Annual review and approval of the Quality Improvement Program Description, the annual QI Work Plan, the Annual QI Evaluation and other reports and information as required or requested.
2. Providing feedback and recommendations to the Quality Management Committee related to summary reports, documents and any issues of concern.

3. Demonstrating a senior level commitment to quality and to the Health Plan’s Quality Improvement Program, including resource allocation.

The membership of the Board of Directors is composed of Health Plan leadership and other designees as identified by the Chair. The Board of Directors meets at least annually.

The Board of Directors delegates oversight of committee functions to Health Plan and national quality improvement committees as follows:

The Health Plan Quality Management Committee oversees:
1. Annual QI Program Description, QI Work Plan and QI Annual Evaluation of the QI Program of the Health Plan
2. Development, implementation, and evaluation of Health Plan quality improvement activities,
3. Health plan performance on HEDIS® and CAHPS® surveys and other quality and satisfaction metrics,
4. Health plan performance on inpatient, outpatient (including emergency department), physician, pharmacy, and other utilization measures,
5. Appeals and complaints involving health plan members,
6. Health plan member and provider satisfaction survey processes,
7. Health plan performance on network access and availability standards,
8. Results of review of ambulatory medical records of members,
9. Identification and satisfaction of cultural and linguistic needs of health plan members,
10. Activities performed by UHG and external entities,
11. Health plan compliance with state and federal regulatory requirements,
12. Health plan accreditation by NCQA, and
13. Health plan input into national quality, utilization, and population management programs.

The Health Plan Physician Affairs Sub-Committee performs Board-delegated peer review of Health Plan practitioners and review of concerns about quality of clinical care provided to members. See below for additional committee responsibilities.

The National Quality Management Oversight Committee oversees:
1. Utilization criteria for authorization and concurrent review,
2. Actions of the National Pharmacy and Therapeutics Committee,
3. National Credentialing Program Description,
4. Establishment of clinical and preventive services guidelines for members, and evaluation of associated clinical outcomes for members,
5. Activities performed by other UHG and external entities, including:
a. Establishment of medical policies, technology assessment, and others;
b. Results of national audits.

B. Quality Management Committee

The Board of Directors has delegated responsibility for the oversight of the Health Plan’s quality improvement activities to the Quality Management Committee (QMC). The QMC is the decision-making body that is ultimately responsible for the implementation, coordination and integration of all quality improvement activities for the Health Plan.

The responsibilities of the QMC are:

1. Provide program direction and continuous oversight of quality improvement activities as related to the unique needs of the members and providers in the areas of clinical care, service, patient safety, administrative processes, compliance and network credentialing and re-credentialing.

2. Formally evaluate, at least annually, the impact and effectiveness of TennCare specific PIPs and recommend changes as necessary.

3. Review, prioritize and align the Annual QI Work Plan with strategic objectives of the organization.

4. Oversee and accept the annual QI Program Description, QI Work Plan and QI Annual Evaluation for the Health Plan.

5. Oversee and accept the annual Disease Management Program Description and associated Clinical Practice Guidelines.

6. Review and approve benchmarks, performance goals and standards for quality activities.

7. Analyze and evaluate the QI program annually and assess the overall effectiveness of the program. Recommend policy decisions based on this evaluation.

8. Submit the QI Program Description, Annual QI Work Plan and Annual QI Evaluation of the QI Program to the Board of Directors for review and approval.

9. Report annually or more frequently as needed, on Health Plan quality activities to the Board of Directors.

10. Monitor annual HEDIS®/CAHPS® survey results and develop action plan to improve results.

11. Monitor member complaints and appeals and results of member satisfaction surveys. Monitor action plan to address identified opportunities and improve performance.

12. Monitor network access and availability and review performance against standards at least annually.

13. Monitor, evaluate and implement improvement plans for access and availability of network practitioners.
14. Monitor and evaluate the cultural and linguistic needs of the Health Plan’s membership and identify opportunities to improve health outcomes.

15. Review and accept decisions of the National Quality Management Oversight Committee that have been delegated by the health plan Board of Directors, offering feedback as appropriate.

16. Review reports and recommendations from other national and Health Plan committees, act upon recommendations as appropriate and provide feedback, follow-up and direction to the committees.

17. Recommend, monitor, and oversee barrier analysis and follow up of quality activities.

18. Incorporate findings from the quality improvement activities into strategic program and resource planning. Adjust programs to address identified needs.

19. Monitor practitioner participation in clinical aspects of the QI program through the Provider Affairs Committee (PAS), including advising on clinical and practitioner issues. (Note: Peer review is performed by PAS, as detailed below).

20. Monitor compliance with regulatory requirements and accrediting organizations.

21. Provide oversight to applicable United Health Group Business Partners.

22. Provide local delegation oversight as specified by State regulatory requirements. Review and make final recommendation of approval or denial of delegation pre-assessment and annual audit results for delegates scoring <80% on audits and/or with Improvement Action Plans (IAP) to determine acceptance or denial of delegates to a given network.

23. Review and accept National Credentialing Plan, with addendum for line of business regulatory requirements as applicable.

24. Review and accept PAS peer review decisions concerning credentialing and clinical quality of care.

25. Recommend appropriate resources in support of prioritized activities.

The Quality Management Committee membership includes the following Health Plan staff, all voting members:

1. Chief Medical Officer (Chair)
2. Health Plan President or designee
3. Chief Operating Officer
4. Chief Financial Officer
5. Executive Director of Behavioral Health Services
6. Medical Directors: Medical, Behavioral, and CHOICES
7. Executive Director of CHOICES
8. VP of Network Management
9. VPs and Directors of Health Services for Medical, Behavioral, and CHOICES
10. Associate Director(s) of Medical and Clinical Operations
11. Senior Director of Quality
12. Quality Manager
13. Compliance Officer
14. Compliance Manager Behavioral Health Services
15. Director of Pharmacy
16. CHOICES Member Advocate

Non-voting Staff members:
Quality Coordinator
Quality Manager CHOICES
Support staff as appropriate

Non-staff QMC voting members:
1. Behavioral Health Practitioner(s)
2. Medical Practitioner(s)
3. CHOICES Practitioner(s)

Non-staff, non-voting QMC members:
Medical Directors, Bureau of TennCare

The Quality Management Committee is chaired by the Health Plan Chief Medical Officer or his designee. A minimum of 51% of committee membership constitutes a quorum. Voting members are designated above. Members may designate surrogate attendees with voting privileges. The Quality Management Committee meets at least every other month. It reports to the Board of Directors of the Health Plan at least annually and to the National Quality Management Oversight Committee at least two times per year.

C. Provider Affairs Subcommittee (PAS)

The Provider Affairs Subcommittee (PAS) performs peer review activities, including credentialing and review and disposition of concerns about quality of clinical care provided to members as requested by the Health Plan CMO. In addition, the committee is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, utilization, and cost of the health care rendered within the network.

The PAS functions are:
1. Review summary status reports of clinical issues referred by other health plan subcommittees.
2. Provide reports of committee activities to the QMC at least 4 times per year.
3. Monitor performance on clinical indicators (e.g. HEDIS®), Clinical Performance Improvement Projects (PIPS), Over and Under utilization related to quality, and continuity and coordination of medical and behavioral health care, conduct/review barrier analysis and recommend actions, as appropriate.
4. Review results of MRR and make recommendation regarding improvement plans as appropriate.
5. Review reports on mortality and inpatient quality of care issues and recommend actions as indicated.
6. Review and accept nationally endorsed Clinical Practice Guidelines, providing input as appropriate.
7. Review summary data regarding quality of care complaints and appeals; identify trends and make recommendations regarding actions as needed.
8. Review summary data related to Critical Incidents involving members receiving Home and Community Based Services, identify trends and make recommendations regarding actions as appropriate.
9. Review summary data related to Behavioral Health Sentinel Events and make recommendations regarding actions as appropriate.
10. Review and accept decisions of national committees (e.g., the National Quality Management Oversight Committee, National Medical Care Management Committee) and make recommendations as appropriate.
11. Annually review and recommend approval of the annual QI Program Description, QI Program Evaluation and QI Work Plan to the QMC and BOD.
12. Review summary reports related to members in Care Management and Disease Management and other health services functions and recommend actions as indicated.
13. Review and accept metrics used for practitioner pay for performance program.
14. Perform peer review on potential quality of care and service issues, including recommendations for Improvement Action Plans.
15. Review and accept the UnitedHealthcare Credentialing Plan.
16. Perform peer review and provide oversight of final decisions by the Credentialing Committee for the credentialing and re-credentialing process. Monitor process for compliance with regulatory and accreditation compliance.
17. Report to QMC all PAS actions concerning provider terminations, sanctions or board notifications.
18. Review, track, identify opportunities for improvement and make recommendations relating to medical record issues, and potential quality of care trends.
19. Review network adequacy and accessibility indicators.
20. Review provider satisfaction survey results and provide input on barrier analysis and improvement plan.
21. Review reports of Behavioral Health provider assessments.

The membership of the Provider Affairs Subcommittee is composed of:
1. Chief Medical Officer (Chair)
2. Health Plan Medical Directors: Medical, Behavioral and CHOICES
3. Network primary care and specialty practitioners.
4. Executive Director, Behavioral Health
5. Senior Director of Quality Management
6. Quality Manager
7. VPs and Directors of Health Services for Medical, Behavioral and CHOICES
8. Director of Pharmacy
9. Director of Network Services, Behavioral Health
10. Director of Provider Operations
11. CHOICES Member Advocate

Non-voting members
1. Medical Directors, Bureau of TennCare
2. Behavioral Health QI Specialists
3. Clinical Quality Analysts
4. Clinical Quality Analysts, CHOICES
5. Support staff as appropriate
6. Ad hoc specialty physicians as needed

* Voting for peer review issues is restricted to network physician and provider committee members. A strict conflict of interest and confidentiality policy is in force for this committee.

The Health Plan Medical Director chairs the Provider Affairs Subcommittee. The PAS meets a minimum of four times per year, or more frequently as needed. A minimum of 51% of committee membership constitutes a quorum. Members may attend by teleconference if necessary. Provider members may not designate surrogate attendees. Health Plan voting members may declare a surrogate to attend the PAS meeting and vote in their absence, only physicians may substitute for physicians. Members may not participate in peer review activities in which they have a direct or indirect interest in the outcome. Non-credentialing peer review must include at least one member of the involved party’s specialty and must meet state regulatory requirements. The Chair may vote in the case of a tie vote. The PAS reports to the Quality Management Committee at least four times per year.

D. Clinical Operations Subcommittee (COS)

The Clinical Operations Subcommittee (COS) monitors all clinical quality improvement and utilization management activities within the health plan. In addition, the committee is responsible for evaluating and monitoring the continuity, accessibility, availability, utilization, and cost of the medical care rendered within the network.

Responsibilities of the Clinical Operations Subcommittee include:
1. Review and approve Disease Management Program Description, including Healthy First Steps.
2. Review and approve appropriate UM and QI Policies and Procedures at least annually to assure they reflect current standards of medical practices.
3. Review summary reports related to members in Care Management and Disease Management and other health services functions and recommend actions as indicated.
4. Review TENNderCare reports as well as reports related to prevention and wellness outreach activities.
5. Oversee implementation of the QI Program and Work Plan.
6. Review and approve performance metrics from all clinical areas, medical, behavioral and long term services and supports health services. Monitor progress on clinical performance improvement programs.
7. Review summary reports of quality of care investigation tracking and trending, including quality of care and service provided within facilities as well as, by home health, DME and ancillary service providers, identify trends and recommend corrective actions as needed.
8. Review reports on mortality and other clinical quality issues and advise improvement actions as indicated.
9. Establish and evaluate data driven interventions to improve performance in identified areas, such as member missed appointments (no-shows).
10. Conduct and monitor identified special studies for quality improvement, including targeted Performance Improvement Projects (PIPs).
11. Monitor performance indicators related to over and under utilization, and continuity and coordination of medical and behavioral health. Recommend improvement actions, as identified.
12. Review and accept summary reports regarding activities delegated by the Health Plan Board of Directors from the National Quality Management Oversight Committee.
13. Evaluate the consistency of the UM decision making process through inter-rater reliability reports. Recommend improvement actions as indicated.
14. Monitor metrics related to psychiatric readmissions and improvement plan.
15. Oversee consistent clinical criteria used in UM decisions.
16. Provide a summary report of subcommittee activities to the QMC at least 4 times per year.

Voting membership on the COS is appointed by the Chairpersons, in collaboration with the Chief Medical Officer, but will include, at a minimum:
1. Vice President Health Services (Chair)
2. Chief Medical Officer
3. VPs and Directors for Medical, Behavioral and CHOICES
4. Medical Directors from Medical, Behavioral, and CHOICES
5. Behavioral Health Services CM and UM Managers and Directors
6. Compliance Officer  
7. Senior Director Quality Management  
8. Director of Special Projects  
9. Quality Manager  
10. Manager Prevention, Wellness and Education  
11. Disease Management Manager  
12. Regional Manager Healthy First Steps  
13. Supervisor Appeals Unit  
14. Prior Auth Nurse Manager  
15. Intake Prior Auth Manager

The COS meets at least 4 times per year and is chaired by the Vice President Health Services or designee. Members may designate surrogate attendees. A minimum of 51% of committee membership constitutes a quorum. The COS reports at least 4 times per year to the Quality Management Committee. Cross reporting to the PAS is made as appropriate for peer review and other matters.

Ad hoc Health Plan support staff will be in attendance as needed and are non-voting members. Ad hoc members may include Supervisor Appeals Unit, Staff members from Quality Management, Utilization Management, Care Management, Disease Management, Healthy First Steps, CHOICES and Pharmacy as needed to lend subject matter expertise.

E. **Service Quality Improvement Subcommittee (SQIS)**

The Service Quality Improvement Subcommittee monitors the quality of service delivered to the Health Plan’s membership. The SQIS oversees non-clinical services and delegated functions to monitor and to support improved service to members.

Responsibilities of the SQIS include:

1. Oversight of member and practitioner satisfaction activities.
2. Recommending interventions based on member or practitioner satisfaction surveys; including submitting suggestions to QMC regarding goals for the Health Plan.
3. Monitoring of metrics and trends of member complaint and appeal activities and recommending and monitoring interventions when opportunities for improvement are identified.
4. Monitoring of metrics and trends of member and provider call center activities, recommending and monitoring interventions when opportunities for improvement are identified.
5. Monitoring of access and availability metrics and trends, recommending and monitoring interventions when opportunities for improvement are identified.
6. Review report of Annual Network Adequacy and provide input on improvement activities as appropriate.

7. Review, approval, and monitoring of member and provider service quality improvement activities (QIAs).

8. Monitoring of provider service metrics (e.g. claims lag, frequency of office visits, complaint resolution timeframes), and recommending and monitoring actions as indicated.

9. Review summary data related to appeals and complaints; identify trends, conduct barrier analysis and recommend corrective actions as needed.


11. Provide a summary report of subcommittee activities to the QMC.

The SQIS receives reports from:
1. Customer Services – Member and Provider Service Center metrics
2. Network Management – Access and Availability data, Provider Satisfaction results and related data
3. Hospitality, Assessment and Reminder Center (HARC): HARC metrics
4. Appeal and Complaints – Member Appeals and Complaint Reports and metrics

The membership of the SQIS is composed of:
1. Chief Operating Officer (COO) or designee - Chair
2. Chief Medical Officer
3. Executive Director(s)
4. Manager of Operations
5. Director Provider Relationship Management
6. Senior Director of Quality
7. Customer Services representative
8. Claims and Pharmacy representative (if applicable), and Enrollment representatives as needed
9. Compliance Officer
10. Compliance Analyst
11. Supervisor Appeals Unit
12. Quality Manager
13. Behavioral Health QI Specialist
14. Quality Coordinator
15. Quality Manager, CHOICES
16. CHOICES Member Advocate
17. Director, Provider Operations
18. Director of Network Services, Behavioral Health
The SQIS meets at least 4 times per year and is chaired by the Health Plan COO or designee. Members may designate surrogate attendees. A minimum of 51% of committee membership constitutes a quorum. The SQIS reports at least 4 times per year to the QMC; cross reporting to the COS or the PAS is made as appropriate for clinical issues and medical/peer review advice.

F. Compliance Committee (CC)

The Health Plan is committed to providing its members with access to high quality medical care while complying with all state, federal and local laws, regulations and other requirements applicable to the products it services. UnitedHealthcare Community Plan, TN has instituted the Principles of Ethics & Integrity (“Principles”) adopted by its parent company, UnitedHealth Group (“UHG”) and amended from time to time as part of its Compliance Program (“Program”), to reflect these commitments.

The Compliance Committee will oversee the comprehensive health plan compliance program, including compliance with all contractual, legal, and regulatory requirements related to its Products, as well as the implementation of the Principles, monitoring compliance with the Principles, and responding to violations of the Principles.

The Health Plan and all employees, independent contractors and agents shall comply with all state, federal and local laws, regulations and other requirements applicable to the Products. Each employee is responsible for being aware of the requirements applicable to his or her duties.

The Health Plan entrusts its supervisory personnel with the responsibility for achieving compliance with the Program and the Principles. Supervisors are responsible for ensuring that the individuals they supervise understand their obligation to:
1. Comply with all contractual, legal, and regulatory requirements related to its Products
2. Comply with the standards contained in the Program and the Principles
3. Immediately report any potential violation to their supervisor or to any member of the compliance or legal staff
4. Assist as necessary in investigating any allegations of violations.

The Compliance Committee responsibilities include, but are not limited to:
1. Overseeing compliance with all state, federal and local laws, regulations and other requirements applicable to the Products.
2. Overseeing and coordinating implementation of the Principles and any amendment thereto, in addition to this Program.
3. Ensuring that a process exists to identify, review, communicate and implement all new standards and requirements that are applicable to the Products.
4. Oversee the training of employees in compliance and regulatory subjects.
5. Answering questions by employees regarding any aspect of the state, federal and local laws, regulations and other requirements applicable to the Products.
6. Ensuring that independent contractors, agents, and vendors are aware of the requirements applicable to the Products.
7. Coordinating reviews or other internal audits of certain departments, vendors or functions to monitor compliance with applicable requirements.
8. Coordinating with legal counsel and others as needed to conduct investigations, compile reports and submitting such as needed to government enforcement agencies.

The Health Plan Compliance Officer may also directly report to, and consult with the oversight committees or Board of Directors as applicable, regarding compliance or regulatory issues without prior consultation with the CEO or any member of UnitedHealthcare Community Plan, TN or Plan management.

Voting membership on the Compliance Committee will include, at a minimum, senior staff representing:
1. Health Plan Chief Executive Officer
2. Health Services – Behavioral, Medical and Long Term Services and Supports
3. Quality Management
4. Operations
5. Product Compliance
6. Finance
7. Legal

Ad hoc support staff will be in attendance as needed and are non-voting members.

G. Cultural Competency Subcommittee (CCS)

The purpose of the Cultural Competency Subcommittee is to foster a robust cultural competency program. The purpose of the program is to identify and eliminate cultural barriers to accessing health care services, including language, lack of appropriate information, distrust of delivery system, and/or lower education levels.

The program integrates with the overall organization, using incremental strategic approaches for its achievement to provide a culturally competent work environment and an external service approach within manageable, but concrete timelines.
The Cultural Competency Subcommittee responsibilities include, but are not limited to:

1. Promote, facilitate, and monitor cultural competency practices both internally and externally to support the provision of program-wide culturally competent care and services;
2. Conduct on-going cultural sensitivity and competency education and training for internal Program staff and external stakeholders and providers who will be interacting with clients;
3. Determine cultural needs of our clients based on information from community demographics, surveys, forums, and community leaders;
4. Identify potential barriers and solutions to ensure cultural competency while managing and coordinating care;
5. Identify potential barriers and solutions to ensure cultural competency in client communications and client materials;
6. Identify and partner with local community resources to support culturally competent care and service delivery;
7. Identify potential barriers and approaches to address health care disparities experienced in the various cultural groups; and
8. Ensure compliance with Federal and State requirements including Title VI of the Civil Rights Act, and State-specific requirements.

Voting membership on the CCS will be appointed by the CCS Chairperson, in collaboration with the Chief Executive Officer and the Chief Medical Officer, but will include, at a minimum:

1. Health Services Staff – two physical health and two behavioral health
2. Community Outreach
3. Network Management
4. Government Affairs/Compliance
5. Quality Staff
6. Long Term Services and Supports
7. Marketing and Communications

Ad hoc health plan and behavioral health support staff will be in attendance as needed and are non-voting members.

The Cultural Competency Subcommittee is chaired by the Senior Director of Quality Management and meets at least quarterly or as often as necessary. The Chairperson has reporting responsibilities to and is a voting member of the Quality Management Committee. A minimum of 51% of committee membership constitutes a quorum. CCS voting members may declare a proxy to attend the CCS meeting and vote in their absence. The CCS reports at least 4 times per year to the QMC; cross reporting to the COS or the PAS is made as appropriate for clinical issues and medical/peer review advice.
A CCS voting member must declare that a conflict of interest exists if he/she has been professionally involved with the issue in question and/or feels his/her judgment may be otherwise compromised.

H. Behavioral Health Advisory Committee

At a minimum, Behavioral Health Advisory Committee members consider and provide input into policy development, planning for services, service evaluation, as well as the training curriculum/education for providers, members and family members.

The Health Plans Behavioral Health Advisory Committee is comprised of at least fifty one percent (51%) consumer and family representatives. Family representatives are family members of adults with serious and/or persistent mental illness (SPMI) and family members of children with serious emotional disturbance (SED).

Membership of the Behavioral Health Advisory Committee includes providers of substance abuse services and consumers (or family members of consumers). Membership of the Behavioral Health Advisory Committee is diverse with respect to geographic location, culture, race and ethnicity. Provider representation on the Behavioral Health Advisory Committee also includes major subspecialty areas - such as co-occurring disorders, children and youth, aging, crisis, psychiatric rehabilitation, recovery, etc.

1. The Health Plan’s Behavioral Health Advisory Committee members serve three (3) year terms. There is no limit to the number of consecutive terms a member may serve.
2. Terms are staggered so that no more than approximately one-third of the Behavioral Health Advisory Committee membership rolls off in any given year.
3. Terms start and end according to the calendar year.
4. As new members join the Behavioral Health Advisory Committee and/or members discontinue membership, a revised Committee membership list is submitted to the State.

Meeting Frequency & Methods

1. The Health Plans Behavioral Health Advisory Committee meets face-to-face quarterly, at a minimum.
2. The Committee, in conjunction with the Health Plan Behavioral Health staff, may also employ additional methods of deliberation (e.g., conference calls, etc.) in an effort to allow Committee members to provide as much timely, flexible and user-friendly input as warranted.
3. The Health Plans Behavioral Health staff provides administrative support to the Behavioral Health Advisory Committee (e.g., arrange meeting space, arrange for and provide teleconference capabilities, develop and/or
distribute meeting notices, develop and/or distribute meeting minutes, facilitation, etc.).

**Member Reimbursement and Stipend**

1. Consumer and family members who serve on the committee in non-professional capacity are paid a stipend for their participation.
2. The Health Plan reimburses Behavioral Health Advisory Committee members, who are eligible for stipend for his/her travel costs to and from face-to-face Committee meetings using the standard federal mileage reimbursement rate.
3. When possible, participation in the Health Plan sponsored Behavioral Health Advisory Committee conference calls is free to Committee members. Such conference calls are funded by the Health Plan.

**TennCare Reporting Requirements**

The Health Plan submits a semi-annual Report on the Activities of the Health Plan Behavioral Health Advisory Committee to the State on March 1 and September 1 each year, according to the format specified by the State. The Behavioral Health Advisory Committee has a direct reporting line to the Board of Directors and a dotted line to the Quality Management Committee.

**J. CHOICES (Long Term Services and Supports) Advisory Group**

At a minimum, CHOICES Advisory Group members consider and provide input into CHOICES planning and delivery of long term services and supports, CHOICES QM/QI activities, CHOICES program monitoring and member, family and providers education..

The Health Plan’s CHOICES Advisory Group is comprised of CHOICES members, member’s representatives, advocates, and providers. At least fifty one percent (51%) of the Group membership is CHOICES members or their representatives (e.g., family members or caregivers)

Membership of the CHOICES Advisory Group is diverse with respect to geographic location, culture, race and ethnicity of the Grand Region in which it serves. The Group representation includes representatives from nursing facility and Home and Community Based Services (HCBS) providers, including community-based residential alternative providers.

1. The Health Plan’s CHOICES Advisory Group members serve two (2) year terms. There is no limit to the number of consecutive terms a member may serve.
2. Terms are staggered so that no more than approximately one-third of the CHOICES Advisory Group membership rolls off in any given year.
3. Terms start and end according to the calendar year.
4. As new members join the *CHOICES Advisory Group* and/or members discontinue membership, a revised *Group* membership list is submitted to the State.

**CHOICES Advisory Group - Meeting Frequency & Methods**

1. The Health Plan’s *CHOICES Advisory Group* meets face-to-face quarterly, at a minimum. The Health Plan keeps a written record of meetings.
2. The Health Plan provides an orientation and ongoing training for *Group* members so they have sufficient information and understanding of the *CHOICES* program to fulfill their responsibilities.
3. The *Group*, in conjunction with the Health Plan *CHOICES* staff, may also use additional methods of meeting other than face to face (e.g., conference calls, etc.) in an effort to allow *Group* members to provide as much timely, flexible and user-friendly input as warranted.
4. The Health Plan *CHOICES* staff provides administrative support to the *CHOICES Advisory Group* (e.g., arrange meeting space, arrange for and provide teleconference capabilities, develop and/or distribute meeting notices, develop and/or distribute meeting minutes, meeting facilitation, etc.).

**CHOICES Advisory Group - Travel Reimbursement**

2. Members, family members or their personal representatives receive a $50 stipend for each face-to-face meeting attended.
3. The Health Plan reimburses *CHOICES Advisory Group* stipend eligible *CHOICES* members or their representatives for travel costs to and from face-to-face *Group* meetings using the standard federal mileage reimbursement rate.
4. Participation in the Health Plan-sponsored *CHOICES Advisory Group* conference calls is at no cost to all *Group* members. Such conference calls are funded by the Health Plan.

**CHOICES Advisory Group – Reporting Requirements**

The Health Plan submits a semi-annual Report on the Activities of the Health Plan *CHOICES Advisory Group* to the State on March 1 and September 1 each year, according to the format specified by the State. The *CHOICES Advisory Group* has a direct reporting line to the Board of Directors and a dotted line to the Quality Management Committee.

**National and Regional Committees:**

A. **National Quality Management Oversight Committee (NQMOC)**
The NQMOC serves as the responsible clinical quality governing body monitoring and regulating at a national level the affairs of the Quality Improvement, Utilization Management, and Outreach Programs in all applicable health plans and OptumHealth Care Solutions (OHCS) functions. It receives appropriate reports and minutes from national United Healthcare Community and State Committees and UHG Committees, national leaders of QM, DM, UM, Care Management, Government Compliance, Outreach and the OptumHealth Care Solutions (OHCS), as well as summary reports and feedback from Health Plan Quality Management Committees.

The NQMOC responsibilities are:

1. In general, to provide direction to the programs by review and approval or by monitoring to completion any necessary course correction.
2. To review and approve national Quality Improvement, Performance Improvement and Outreach initiatives.
3. To accept national utilization management criteria annually.
4. To serve as the responsible governing body monitoring and regulating the affairs of the Disease (Condition) Management Programs in all health plans and OptumHealth Care Solutions (OHCS) functions.
5. To annually review and approve/accept all quality, utilization, and population management program documents, materials and/or reports integral to national program operations and accreditation requirements annually, including but not limited to:
   a. National Credentialing Program Description
   b. Reports on clinical guideline performance
   c. Ambulatory Medical Record Review audit results
   d. Appeals, complaints and grievance reports
   e. Annual reports of Health Plan HEDIS and CAHPS results, analysis and development of action plans to improve performance
   f. Quality contract compliance or regulatory issues
6. To review and approve national policies, documents and document templates used in the programs, as applicable.
7. To perform oversight of clinical and service activities of other business partners and committees, e.g., UnitedHealthcare Network (UHN), OptumHealth Behavioral Solutions (OHBS), National Medical Care Management Committee (NMC). 
8. To review and approve appropriate National Delegation Services and Corporate Compliance annual audits, national delegation oversight and semi-annual reports, as appropriate.
9. To review, approve and monitor National Improvement Action Plans (IAPs) for national delegates and inter-segment partners. (Health Plan specific IAP issues with inter-segment partners are the responsibility of the Health Plan.)
10. To provide oversight of the annual health plans’ HEDIS and CAHPS project management and reports including analysis and development of action plans to improve performance

11. To provide clinical oversight for review, analysis, and revision of corporate processes for areas of clinical improvement including but not limited to:
   a. HEDIS data and reports
   b. CAHPS and other member satisfaction data
   c. Member and Provider Outreach data and improvement activities
   d. Provider Satisfaction data
   e. Patient Safety data

The membership of the NQMOC includes:
1. National Vice President Quality Management (Chair)*
2. National Chief Medical Officer*
3. Regional Chief Medical Officers*
4. Corporate Compliance representative
5. National UnitedHealthcare Medical Director(s)*
6. Senior Vice President Operations*
7. Vice President Authorizations and Appeals
8. National Medical Director – Women’s Health*
9. National Sr. Director Quality Operations*
10. National Director HEDIS Reporting*
11. National Director HEDIS Improvement
12. Associate Director National Long Term Care Quality
13. National Medical Director Long Term Care*
14. National Senior Director Long Term Care Operations*
15. Long Term Care Medical Director*
16. National Vice President Pharmacy Management or designee*
17. National legal representative
18. Behavioral Health Medical Director(s)*
19. Health Plan CMOs/Medical Directors or designees*
20. Vice President Clinical Program Development
21. National Director-Healthy First Steps Program
22. National Director Clinical Program Development
23. Executive Director, OptumHealth Care Solutions (OHCS)
24. Vice President Clinical Operations, Medical Management
25. Director Integrated Case Management
26. Internal and external subject matter experts – ad hoc

* Designates voting members. For the purpose of conducting business, a quorum will consist of 51% of the voting membership. Voting members may designate surrogate attendees with voting privileges. Committee meetings are held at least quarterly or more often at the discretion of the Chair. The Committee proceedings are documented, contemporaneously. Minutes and/or Executive Summaries from the NQMOC are reported to the health plan’s QMC.
B. National Credentialing Committee

The National Credentialing Committee’s purpose is to conduct initial credentialing and re-credentialing of practitioners who may provide care and services to a UnitedHealthcare Community and State member as indicated in the UnitedHealthcare Credentialing Plan.

The National Credentialing Committees’ responsibilities are to:
1. Review credentials of practitioners and decide if practitioners are credentialed, not credentialed or decredentialed.
2. Review and provide input on UnitedHealthcare Credentialing Plan and Policies.
3. Review committee membership annually to determine adequate spread of specialty representation.

The National Credentialing Committee’s membership includes but is not limited to:
1. A Medical Director from a UnitedHealthcare health plan serving as Committee Chairperson
2. Health Plan Chief Medicaid Officers/Medical Directors
3. Maximum of seven licensed independent practitioners representing different specialties
4. Other representatives as requested by the Committee chairperson

The National Credentialing Committee meets a minimum of one time per month and reports on health plan specific activity at least quarterly to the health plan Provider Affairs Subcommittee and to the NQMOC at least annually.

C. Executive Medical Policy Committee (EMPC)

The Executive Medical Policy Committee (EMPC) is responsible for overseeing the development, implementation and evaluation of the medical policies across UnitedHealth Group.

Functions of the EMPC include, but are not limited to, the following:
1. To develop a company-wide strategy for medical policy development.
2. To promote the consistency of company-wide medical policy decisions.
3. To review, evaluate and recommend guidelines for enterprise-wide implementation.
4. Develop enterprise-wide clinical policies and procedures for quality of care issues, credentialing and other processes in which clinical input is required.

The Executive Medical Policy Committee membership may include but is not limited to:
1. Individuals functioning in roles designated as Chief Medical Officers for individual UnitedHealth Group businesses, including but not limited to
Government Programs, UnitedHealthcare, Ovations, and Specialized Care Services.

2. National Medical directors and other clinical leaders in various areas of medical management.

3. Representation from UnitedHealth Pharmaceutical Solutions and Prescription Solutions.

4. Representatives from legal departments of UnitedHealth Group businesses,

5. Representatives from compliance departments of UnitedHealth Group businesses,

6. Other representatives as requested by the Committee Chair.

The EMPC meets on a quarterly basis and is chaired by the Executive Vice President, Chief of Medical Affairs, UHG or designee. Minutes from the EMPC are reviewed and accepted by the NQMOC.

D. National Medical Technology Assessment Committee (MTAC)

The National Medical Technology Assessment Committee (MTAC) is responsible for:

1. The development and review of evidence-based position statements on selected medical technologies.

2. Assessments of the evidence supporting new and emerging technologies as well as new indications for existing technologies.

3. Review and approval of externally licensed criteria and references.

4. Review, evaluation and recommendation for approval of Clinical Practice Guidelines (CPGs) for company-wide implementation

5. The consideration and incorporation of nationally accepted consensus statements and expert opinions into the establishment of national standards for UnitedHealth Group.

6. Ensuring that clinical decisions about the safety and efficacy of medical care are consistent across all products and businesses.

The membership of the MTAC may include:

1. National Medical Director, UnitedHealth Health Services (Chair)

2. Health Plan and Health Services Medical Management, Medical Directors with diverse specialty backgrounds

3. Medical Policy staff

4. UnitedHealthcare Community and State Regional Chief Medical Officer

5. Guest Physician Specialists designated by the Chair

The Committee meets at least 10 times per year and reports at least quarterly to the National Medical Care Management Committee. The health plan’s Provider Affairs Subcommittee and the NQMOC review minutes and reports from the MTAC.
E. National Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics (P&T) Committee is responsible for providing the clinical oversight for the development and maintenance of the Preferred Drug List (PDL) and Clinical Pharmacotherapy policies. The mission of the National P&T Committee is to promote the use of appropriate drug therapy based upon clinical evidence.

The P&T Committee membership includes:
1. Medical Directors representing health plans
2. National Chief Medical Officer
3. UnitedHealthcare Community and State Vice President of Pharmacy Services
4. UnitedHealthcare Community and State Clinical Pharmacist(s)
5. External providers from various clinical specialties

The UHC Community and State National P&T Committee meets at least four times per year. A minimum of 51% of committee membership constitutes a quorum. All members are voting members. Members may not designate surrogate attendees. Minutes and actions of this committee are reviewed and accepted by the NQMOC. Determinations of the National P&T committee are sent to the Provider Affairs Committees as educational updates.

F. National Joint Operating Committee (NJOCs)

The NJOCs’ primary focus is to perform oversight of all nationally delegated entities of UnitedHealthcare Community & State.

The responsibilities of the NJOCs include:
1. Review all proposed national delegations and make recommendations on the appropriate action.
2. Receive and evaluate reports and audit results on a regular basis, as required by the various regulatory and accreditation agencies with which health plans contract or report.
3. Evaluate the need for additional reports or corrective action plans if opportunities for improvement are identified.
4. Determine the need for, and assure the communications to, the delegated entities.
5. Review and approve policies and procedures related to national delegation as well as the policies and procedures of the delegated entities as necessary.

The NJOCs are chaired by the Community & State (C&S) management business owners who report to C&S Executive Management. Each NJOC includes but is not limited to the national director and/or representatives from:
1. Public and Senior Marketing Group (PSMG)
2. Claims
3. Credentialing
4. Legal
5. Compliance
6. Provider Relations
7. Contracting
8. Medical Management
9. Quality Operations
10. Other departments as appropriate from time to time as determined by the Chairperson.

The NJOCs meet at minimum on a quarterly basis and more often as needed. The NJOCs report up to the Medicaid Delegate Oversight Committee (MDOC) which acts as a senior level body that monitors the integrity of the procurement processes of UnitedHealthcare Community & State. The MDOC has specific focus on the qualifications and performance of delegates, the performance of internal contracting procedures, and compliance with legal and regulatory requirements in the contracting process.

The NJOCs activities and meeting minutes are presented to the National Quality Management Oversight Committee. A minimum of 51% of committee membership constitutes a quorum. All members are voting members. Members may not designate surrogate attendees. Minutes are created contemporaneously and are forwarded to the National Quality Management Oversight Committee at least on a quarterly basis.

G. National Healthcare Disparities Committee

The purpose of the committee is:
1. to identify disparities in delivery of health services and in health outcomes that are related to remediable cultural barriers,
2. to develop strategies to improve delivery of health services and health outcomes in identified, underserved populations, and
3. to evaluate effects of interventions,
4. to develop a consistent approach to education and management of healthcare disparities across the organization.

The National Healthcare Disparities Committee responsibilities include:
1. Support of the implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards across the organization;
2. Identification of the leading innovative market initiatives that address cultural competency and health care disparities
3. Survey of all clinical sites to determine current best practice
4. Review and dissemination of disparity initiatives among health plans;
5. Promotion of the collection of racial and ethnic data through eligibility and enrollment processes, vital statistics data, birth records, and member-supplied information;
6. Discussion of the utilization of racial and ethnic data to identify healthcare disparities among specific minority or unique populations;
7. Promotion of analysis of data to identify geographic pockets of healthcare disparities;
8. Collaboration on targeted interventions to improve services to identified populations;
9. Support of the establishment of relationships with community and national resources;
10. Establishment of a consistent source of education for staff to learn about cultural diversity;
11. Establish a consistent education source for network providers to learn about cultural diversity, including provider newsletters;
12. Review and analysis of outcomes of interventions;
13. Facilitation of ad hoc groups, as needed, to work on specific projects; and
14. Other activities as deemed appropriate to accomplish objectives.

The National Healthcare Disparities Committee membership may include but is not limited to:
1. Associate Director Long Term Care Quality - Chairperson
2. Health Plan Quality Management Leadership
3. Health Plan Medical Directors
4. Regional Chief Medical Officers
5. National VP Quality Management
6. National Senior Director Quality Operations
7. Director HEDIS Improvement
8. Director HEDIS Reporting
9. Associate Director Quality Programs
10. National Quality Program Managers
11. Associate Director Quality Improvement
12. LTC Clinical Quality Analyst

All members are voting members. For the purpose of conducting business, a quorum will consist of 50% of the voting membership. Voting members may designate surrogate attendees with voting privileges. Committee meetings are held at least semiannually or more often at the discretion of the Chair. Minutes are created contemporaneously and are presented to the National Quality Management Oversight Committee at least two times per year.

H. National Medical Care Management Committee (NMCMC)

The National Medical Care Management Committee (NMCMC) is responsible for overseeing the development, implementation and evaluation of the
UnitedHealthcare Medical Management (MM)/Utilization Management Program (UM) for all entities within the program’s scope as outlined in the National UM Program Description. In so doing, the NMCMC is guided by the medical policies of UnitedHealth Group.

Functions of the NMCMC include, but are not limited to:
1. Review and approve the UnitedHealthcare (UHC) Utilization Management Program Description (UMPD)
2. Oversee implementation and evaluation of the Utilization Management Program
3. Evaluate the UM Program Description no less than annually.
4. Review and approve medical criteria and guidelines recommended by the Medical Technology Assessment Committee.
5. Oversee activities of the Document Oversight Committee, which, in accordance with UnitedHealthcare Health Service Document Management policy, approves Medical Management/Utilization Management (MM/UM) policies and procedures that impact multiple departments and delegates authority for the approval of the department procedural documents to a MM Director or above.
6. Oversee activities of the Training/Audit Steering Committee which is responsible for the development, implementation and evaluation of the UnitedHealthcare Utilization Management program training and process improvement activities.
7. Monitor and evaluate, at least annually, the efficiency and effectiveness of processes through analysis and review of under and over utilization and satisfaction with MM/UM processes.
8. Maintain approved records of all committee meetings
10. Promote compliance with regulatory and accreditation requirements, including oversight of market conduct corrective actions, as applicable.

Membership of the NMCMC may include:
1. Senior Vice President, Medical Management, Health Services (Chair)
2. National Vice President, Health Services (CCR) (Vice Chair)
3. Regional Chief Medical Officer and/or designated alternate
4. National Vice President, Health Services (Appeals & Grievances/Quality of Care)
5. National Vice President, Health Services (Operations)
6. National Medical Director, Health Services (Medical Policy)
7. Representatives from Ovations
8. Representatives from UnitedHealthcare Community and State
9. Representatives from OptumHealth Solutions

The NMCMC meets at least quarterly. A quorum exists when at least 50% of the voting members are present. The NMCMC reports to the UnitedHealthcare Health
Services National Quality Oversight Committee (NQOC), the Ovations National Quality Oversight Committee (NQOC) and the UnitedHealthcare Community and State National Quality Management Oversight Committee no less than annually.

**OHBS Corporate Committees:**

**A. Policy and Procedure Committee (PPC)**

The purpose of the Policy and Procedure Committee is to ensure all policies and procedures and related documents, as well as clinical document templates clearly, accurately and completely reflect operational standards and, where applicable, superseding contract, regulatory and/or accreditation requirements.

Key responsibilities of the PPC include:

1. Maintains a standardized set of organizational policies and procedures for clinical operations, network operations, standalone teams such as LifeSolutions and Clinical Claims Review, and affiliated areas such as Behavioral Health Sciences and Fraud Waste and Abuse.
2. Ensures that policies and procedures and related documents clearly, accurately and completely reflect operational standards and, where applicable, superseding contract, regulatory and/or accreditation requirements.
3. Maintains a standardized set of organizational policies and procedures which guide the development of materials under the purview of the Policy & Procedure Committee.
4. Ensures that there are adequate document control systems for policies and procedures and related documents, clinical document templates, and other materials under the purview of the Policy & Procedure Committee.

This PPC meets monthly and is chaired by the Vice President of Care Advocacy.

**B. Quality Committee (QC)**

**Role/Purpose:**

The QC reviews and analyzes results achieved by the organization’s quality management programs and makes improvement recommendations to the National Quality Committee (NQC).

Key responsibilities of the QC include:

2. Ensure responsible parties apply continuous quality improvement principles to correct adverse performance trends on core quality metrics.
3. Summarize and present a quarterly report to the NQC addressing organizational performance on core metrics, action plans, and recommendations.

4. Assure clinical risk issues identified and reviewed by the Sentinel Event Committee and Peer Review Committee are appropriately and promptly addressed.

5. Review all formal quality management program descriptions, Work Plans and annual evaluations produced by in-scope functional areas and make recommendations to the NQC for approval and actions.

6. Develop and recommend the annual Corporate Quality Improvement/Utilization Management (QI/UM) Work Plan to the NQC for approval.

7. Prepare the annual review of the QI/UM Work Plan, results achieved, lessons learned and recommendations for the coming year.

The QC meets monthly and is chaired by the Vice President of Quality Improvement with the Senior Director of Quality Improvement serving as vice chair.

C. Credentialing Committee (CC)

The purpose of this committee is to ensure that network practitioners and providers meet minimum standards of training, licensure and performance. The CC oversees and conducts the credentialing and recredentialing of network practitioners and facilities in accordance with the organization’s credentialing standards.

Key Responsibilities of the CC include:

1. Administers the Credentialing Plan, and provides a fair and consistent review of clinician credentials and facility information as per the policy, Credentialing Committee.

2. Reviews credentials and other relevant qualifications of practitioners and facilities applying to the organization’s network.

3. Credentials and recredentials practitioners and facilities who meet the organization’s credentialing standards.

4. Approves or denies delegation of credentialing and recredentialing to qualified organizations, ensures conduct of appropriate delegation oversight, and oversees completion of corrective actions needed for opportunities for improvement identified during delegation oversight.

5. Conducts peer review of every applicant who does not meet criteria and may require the applicant to comply with a site visit and/or treatment record audit.

6. Implementation of other responsibilities identified in the policy Credentialing Committee.
The CC meets a minimum of monthly and is chaired by the National Medical Director for Outpatient Services.

**Committee Governance**

**A. Committee Quorum**

A quorum, as outlined by the individual Committee charters, is required for all meetings. If not stated, a majority of members present constitutes a quorum.

**B. Committee Minutes**

Minutes are recorded at all quality committee meetings using a standardized format including topic, discussion, recommendations, and follow-up. The meeting scribe will be assigned by the chairperson. Follow-up items will become topics for the next committee meeting. All minutes are maintained in a confidential manner. The appropriate chairperson reviews the minutes for accuracy and completeness. The chairperson signs and dates the minutes. The minutes of all national and regional committees may be summarized for review at the health plan level.

**C. Robert’s Rules of Order**

All Committees are conducted according to Robert’s Rules of Order as modified by UnitedHealthcare Community Plan.

**Chapter 4 Quality Improvement Program**

**Organizational Structure**

The Board of Directors has ultimate responsibility for the QI Program and related processes and activities. The Board of Directors has delegated to the NQMOC and the QMC responsibility for ensuring the quality improvement processes outlined in this plan are implemented and monitored.

Below is an organizational chart depicting key staff of the health plan related to the QM Program, followed by brief descriptions of senior level positions and Quality Management positions.
A. **Health Plan President**

The Health Plan President is responsible for oversight of the implementation of the Quality Improvement (QI) Program. The President is responsible for monitoring the quality of care and service the Health Plan provides, and ensuring the appropriate level of resources is available for the QI Program. The President also ensures that fiscal and administrative management decisions do not compromise the quality of care and service the Health Plan provides to members.

B. **Chief Medical Officer**

The Chief Medical Officer (CMO) is a Tennessee licensed physician who is responsible for implementation of the QI Program. The CMO reports to the President and provides the medical direction for Health Plan staff. The CMO or designee chairs the Quality Management Committee (QMC) and Provider Affairs Subcommittee (PAS). The CMO participates in the credentialing and recredentialing process for the Health Plan and coordinates review with the PAS. The CMO oversees and implements activities to measure health services efficacy. The CMO, in collaboration with legal and network management, is responsible for the immediate decision and resolution of all situations involving the potential of Imminent Harm.
C. **Senior Director of Quality Management**

The Senior Director of Quality Management (QM), under the direction of the Chief Medical Officer, is responsible for oversight of the implementation of the QI Program, including monitoring the quality of care and service complaints and provides the evaluation of quality improvement initiatives involving member and provider outreach. The Senior Director of Quality Management is also responsible for oversight of activities designed to increase performance on HEDIS® measures, preparation of the annual QI program documents, oversight of submission of quality regulatory reports, oversight responsibility for implementation of quality improvement studies and patient safety initiatives, oversight of delegated vendors and managing the Health Plan Quality Improvement infrastructure. The Senior Director of Quality Management is responsible for the CAHPS Surveys, Provider Satisfaction Surveys and the Disease Management Surveys. The Director is responsible for coordinating the National Committee for Quality Assurance (NCQA) Health Plan Survey, the three regional Annual Network Adequacy Surveys, three Annual Quality Surveys, Performance Improvement Projects, Quality Improvement Activities and Disease Management for the Health Plan. The Senior Director of Quality Management is a point of contact for regulatory inquiries and works with the Compliance Officer to assure compliance with regulatory and accreditation standards. The Senior Director of Quality Management reports to the Chief Medical Officer and the Regional Quality Director.

D. **Quality Manager**

The Quality Manager is responsible for leading and coordinating clinical quality improvement activities, assisting in the development of the Annual QI Program Description and Work Plan, analysis and reporting on continuous monitors of clinical quality. The Quality Manager is also responsible for regulatory reporting, as well as supporting the Health Plan’s NCQA survey and annual regulatory surveys. The Quality Manager reports to the Senior Director of Quality Management regarding all quality management functions.

E. **Clinical Quality Analysts**

The Clinical Quality Analysts are Tennessee licensed registered nurses who support QI activities at the Health Plan level. The Clinical Quality Analysts report to the Senior Director of Quality Management and also communicate routinely with the Chief Medical Officer regarding quality of care issues. The Clinical Quality Analysts manage the Health Plan Quality of Care and Credentialing related functions, prepare quarterly regulatory reports, manage investigation of peer review and quality of care issues and interface with the CMO, Health Services, Medicaid Operations, and Administrative management to ensure appropriate resolution of quality of care issues throughout the Health Plan. The QMC and PAS provide oversight of these activities.
F. Behavioral Health Quality Improvement Specialists

The Behavioral Health Quality Improvement Specialists support QI activities at the Health Plan level. The QI Specialists report to the Quality Manager and also communicate routinely with the Chief Medical Officer for Behavioral Health regarding quality of care issues. The Quality Improvement Specialists manage the Health Plan Quality of Care, prepare quarterly regulatory reports, manage investigation of peer review and quality of care issues and interface with the CMO, Behavioral Health Services, and Administrative management to ensure appropriate resolution of behavioral health quality of care issues throughout the Health Plan. Oversight of these activities is reviewed at the PAS meeting and by the QMC. Additionally, the Quality Improvement Specialists conduct employee training relative to QI functions, and participate in QI initiatives, including action plan development and committee/work group participation.

G. Manager of Early and Periodic Screening, Diagnosis and Treatment and Preventive Health Education

Within the Quality Management unit, the Manager of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Preventive Health Education and the EPSDT/Preventive Health Clinical Quality Analysts are responsible for developing and implementing initiatives designed to improve EPSDT and other Preventive Health Screening rates through member and provider education. Initiatives are aligned with the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Healthcare and the United States Preventive Services Task Force Guide to Clinical Preventive Services. The Manager of EPSDT and Preventive Health Education reports to the Senior Director of Quality Management and works with other Quality Management, Community Outreach staff, Provider Relationship Management staff and Operations staff to coordinate activities which impact member screening rates and provider documentation of screening components. The Manager of EPSDT and Preventive Health has lead responsibility for sections in the Annual Quality Survey related to the John B. Federal Consent Decree, assists with HEDIS®, the internal medical records review process, the Access and Availability survey and monitoring and reporting on the Centers for Medicaid and Medicare (CMS) - 416 screening rates.

H. Quality Management EPSDT/TENNderCare Prevention and Wellness Education Quality Analysts

Within the Quality Improvement unit, the Quality Management TENNderCare Prevention and Wellness Education Quality Analysts are responsible for developing and implementing CQI initiatives designed to ensure members receive timely preventive health services. The Quality Analysts report to the Manager of TENNderCare Prevention Health Education. The Manager and Senior Director of Quality Management work with National and Health Plan HEDIS® staff, CQI teams
in Health Services, Operations, and others throughout the Health Plan to effectively coordinate performance improvement initiatives. The TENNderCare Prevention and Wellness Education Quality Analysts are responsible for leading the TENNderCare program, and all other prevention and wellness population based activities and coordinating collaborative initiatives with the Health Plan Community Outreach staff and community organizations. Oversight of these activities is reviewed at the COS meetings and by the QMC.

I. **Manager of HEDIS® and Clinical Practice Consultants**

Within the Quality Management unit, the Manager of HEDIS® along with the Clinical Practice Consultants are responsible for developing and implementing CQI initiatives designed to assist providers in delivering timely and effective health services. The Clinical Practice Consultants report to the Manager of HEDIS® who reports directly to the Senior Director of Quality Management. They work with other Quality Management, Provider Relationship Management staff and Operations staff to resolve provider issues which impact quality. They perform provider audits related to pain management issues and are assisting with the implementation of the primary care medical home project. The Manager of HEDIS® is responsible for management of the internal medical records review process, the provider satisfaction and CAPHS surveys, analysis and review of quality outcomes at the provider level, provider education on quality programs, monitoring and reporting on key measures to ensure providers meet quality standards and implementation of pay for performance initiatives. Oversight of these activities is reviewed at the COS meetings and by the QMC.

J. **Clinical Quality Analysts for CHOICES Long Term Services and Supports (LTSS)**

The Clinical Quality Analysts for CHOICES are Tennessee licensed registered nurses who support QI activities for CHOICES at the Health Plan level. There is a Clinical Quality Analyst for CHOICES located in each Grand Region and they report to the Director of Special Projects who reports directly to the Senior Director of Quality Management. They communicate routinely with the Medical Director for Long Term Services and Supports regarding issues related to Quality of Care/Service or Critical Incidents. The Clinical Quality Analysts for CHOICES compile and maintain report data in a standard format to support the LTSS Choices program. They prepare quarterly regulatory reports, manage investigations of peer review, critical incident, quality of care and quality of service issues and interface with the CMO, Health Services, Provider Advocates, Health Plan Operations, and Administrative management to ensure appropriate resolution of these issues. Oversight of these activities is reviewed by the PAS and by the QMC. The Clinical Quality Analysts are responsible for educating providers and internal staff about reporting and investigation of Critical Incidents and Care and Service complaints as
needed. In addition, the Clinical Quality Analysts assist with preparation of CHOICES Performance Improvement Projects.

**Quality Improvement Program Activities**

Integration is a key component of successful quality management. Departments involved in quality management activities are integrated with one another through coordinated referral systems (for quality/risk/utilization issues, care management, care coordination, member/practitioner complaints), an integrated computer information system that is accessible to all areas, and cooperative problem-solving practices. As the central area for receiving potential quality/risk management issues and coordination of quality improvement activity, the Quality Management Department acts as a critical interface between members, members' representatives, practitioners, providers, The Bureau of TennCare, other regulators, and various Health Plan departments. Information received by Quality Management is reviewed, investigated and coordinated as necessary with Care Management, Care Coordination, Prior Authorization, and other departments (such as Network Management, Customer Service, Appeals and Claims Disputes, Claims, or Finance).

The QI Program uses a variety of mechanisms to continuously measure, evaluate and improve the services provided to Health Plan members. All are founded on CQI principles which focus on implementing the PDSA (plan, do, study and act) cycle as a means to meet or exceed the minimum performance standards established by the Health Plan and the Bureau of TennCare. The following activities are included in reviews that reflect important aspects of care and service:

A. **Clinical and Preventive Care Guidelines**

Evidenced-based guidelines are used to monitor and improve the quality of care provided by participating practitioners. The Health Plan adopts pediatric, adolescent, adult and maternal preventive health and clinical practice guidelines that are reviewed at least annually and whenever the guidelines change. The guidelines are approved by the National Medical Care Management Committee (NMCMC). The Health Plan QMC also reviews and approves these guidelines as well as the behavioral health clinical practice guidelines. The NMCMC evaluates guidelines from the most current and reasonable medical evidence available, including but not limited to, the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention and specialty organizations. The Health Plan measures population-based performance against preventive health and clinical guidelines annually, primarily through HEDIS® measurement.

Preventive health and clinical practice guidelines are available to both members and providers on the Health Plan website. To encourage the use of appropriate preventive care, the Health Plan promotes member focused educational and
outreach programs. These programs identify at-risk members and involve members and providers in the decision-making process.

B. Complaints

Member complaints are expressions of dissatisfaction with any aspect of care or service provided by the Health Plan and/or subcontracted provider, excluding appeals and other actions such as service denials, claims and billing issues. Allegations of a violation of member’s rights are included in complaint investigations. Member complaints are tracked and trended through the QI program to:
1. Monitor effective and timely resolution of member concerns
2. Identify opportunities for improvement in the quality of care and service provided to members

Complaints can be made on behalf of the member by their representative, as well as identified by any Health Plan department, member, provider or regulatory agency. Member complaints are also identified through escalation by the Customer Services Department. The Clinical Quality Analysts and the CHOICES Clinical Quality Analysts review member complaints and identifies potential quality of care/service issues. They facilitate the investigation and resolution process. Data for quality of care/service issues are collected, reviewed, tracked and trended to identify opportunities for improvement. Analysis of quality of care and service issues is presented to the PAS, for review of aggregate trends and identification of actions for improvement.

C. Credentialing and Re-credentialing

All participating practitioners and providers undergo a careful review of their qualifications, such as education and training, board certification status, license status, hospital privileges and malpractice and sanction history. Provider review includes but is not limited to licensure, accreditation, and certification. The National Credentialing Center (NCC) for physical health providers and the OHBS Credentialing Committee (OHBS CC) for behavioral health providers facilitates credentialing and re-credentialing primary source verification activities. All practitioners and providers undergoing initial credentialing and re-credentialing every three years. These providers are reviewed and approved by the NCC and the OHBS CC and the Health Plan Provider Affairs Subcommittee. Re-credentialing decisions incorporate findings from quality of care or member satisfaction issues identified at the provider level. Final decisions are made by the Health Plan PAS and QMC. Detailed policies, procedures and process flow diagrams exist to describe the credentialing, re-credentialing and provisional credentialing process. The QI program monitors the timeliness of credentialing activities and interventions to meet standards.
D. Disease Management (DM)

Members are either referred into DM or they are systematically identified using IPRO, our proprietary predictive modeling software. Once identified systematically, Members are stratified into one of five groups and forwarded to the appropriate queue:

1. Level 3 - Top 1% regardless of diagnoses to Care Management

   or

   Top 1% of CHOICES members with one or more of the targeted diagnoses to Level 3 Disease Management

2. Level 2 - Disease management (must have one of the nine targeted diseases)

3. Level 1 - Disease management (must have one of the nine targeted diseases)

4. Low Risk - Disease management (must have one of the nine targeted diseases)

The Health Plan uses a hierarchy for Members with multiple diseases to assign ownership. The care/disease manager with the highest priority disease is responsible for managing the member holistically, including all disease states. For CHOICES Members, the assigned Care Coordinator always has primary responsibility; however, other members of the disease management team may assist with disease specific interventions as appropriate based on the Member’s stratification level. The disease hierarchy is as follows:

1. Healthy First Steps for pregnant women
2. Schizophrenia
3. Bipolar Disorder
4. Heart Failure
5. Diabetes Mellitus
6. Major Depressive Disorder
7. Coronary Artery Disease
8. Asthma/Chronic Obstructive Lung Disease
9. Obesity

The Program includes, but is not limited to:

1. Members at risk or already experiencing poor health outcomes due to their disease burden
2. Interventions with specific programs that are founded on evidence based guidelines.
3. Methodologies to evaluate the effectiveness of programs including education specifically related to the identified member’s ability to self-manage their disease.
4. Methods for supporting both the member and the provider in establishing and maintaining relationships that foster consistent and timely interventions and ongoing understanding and adherence to the plan of care.
5. Components for providers include, but are not limited to:
a. Education regarding the specific evidence based guidelines and desired outcomes driving the program.
b. Involvement in the implementation of the program.
c. Methodology for monitoring provider compliance with the guidelines.
d. Implementation of actions designed to bring the providers into compliance with the practice guidelines.

E. Medical Record Review (MRR)

The objectives of Medical Record Review activities are to:

1. Evaluate compliance with medical record documentation requirements.
2. Document the presence of information that conforms to accepted standards of medical practice, which includes evidence of continuity and coordination of care.
3. Evaluate compliance with medical record confidentiality policies.

The Health Plan MRR for primary care providers (PCPs) and high volume specialists are conducted by an approved UHG vendor. Audits occur in accordance with State, or quality related requirements. Reviewers trained in the use of the MRR tools collect the data.

A separate TennCare Medical Record Review is conducted on a sample of records of members age birth to 21 to evaluate compliance with the documentation of the components of a TENNderCare screening. The TENNderCare Prevention and Wellness Education Coordinators developed a training manual, an TENNderCare Medical Record Review audit tool and an TENNderCare MRR Exit Summary provider handout to review for additional provider education during the MRR exit interview. The TENNderCare Prevention and Wellness Education Coordinators also participate in the vendor training to ensure a thorough vendor understanding of the requirements of documentation of the components of a TENNderCare screening.

As a part of the Health Plan MRR process, high volume behavioral health providers are evaluated according to the Health Plan’s Provider Evaluation of Performance (PEP) plan. Within the PEP plan, high volume behavioral health care providers are evaluated in a number of areas including but not limited to, clinical record documentation, treatment planning, specialized training, adherence to level of care guidelines (as applicable), and adherence to member rights and responsibilities.

The Health Plan QI program monitors implementation of MRR process. Feedback on MRR results, including areas for improvement if applicable, is disseminated to each provider. Overall results and opportunities for improvement are reported to the Provider Affairs Subcommittee (PAS). Improvement action plans as recommended from the PAS are implemented and monitored by the Quality Management
department. The Senior Director of Quality Management is responsible for the day-to-day operations of this program.

F. Member Satisfaction

Member satisfaction is assessed through annual member satisfaction surveys such as the CAHPS® as well as member complaint data.

The CAHPS® survey tools utilized include:
1. Adult
2. Child
3. Child with chronic care supplemental questions

Member survey results are used to:
1. Measure Health Plan performance and identify opportunities for improvement
2. Establish benchmarks and monitor Health Plan performance against national CAHPS® performance data
3. Assess overall levels of satisfaction to determine if the Health Plan is meeting member expectations
4. Assess service performance compared to competitors and other UnitedHealthcare Community Plan Health Plans

The Health Plan conducts CAHPS® surveys by region for our TennCare members, both adult and children.

In 2012, the Health Plan will conduct the Member satisfaction surveys for CHOICES Members in each region.

Complaint data are trended to identify potential opportunities for improvement. Action plans to address opportunities for improvement based on member satisfaction results are reviewed and approved by the Health Plan Service Quality Improvement Subcommittee (SQIS).

G. Monitoring of Performance Indicators

Ongoing monitoring of performance indicators is designed to reveal trends and improvement opportunities in targeted populations. National standard indicators, i.e. HEDIS® and CAHPS® are used to measure Health Plan performance. Results are used to identify current gaps in care or service and are integrated in quality improvement projects for the Health Plan.
H. Peer Review

Peer review is the mechanism to review suspected substandard or inappropriate care or inappropriate professional behavior by a practitioner while providing care to a Health Plan member. If the findings of an investigation indicate that a practitioner has potentially provided substandard or inappropriate care, has exhibited inappropriate professional conduct or has been sanctioned, the Health Plan will refer such cases to the PAS for peer review. The scope of actions that may be recommended by the PAS include, but are not limited to, development of an improvement action plan with time frames for improvement, education, counseling, monitoring and trending of data, de-credentialing and referral to the appropriate state, federal or regulatory agencies. Follow-up processes are defined by policies addressing quality of care referrals as well as the Health Care Quality Improvement Act of 1986, including the applicable appeal process. All peer review information is confidential and protected by state and federal statute.

I. Practitioner Accessibility and Availability Monitoring

Practitioner accessibility and availability monitoring is conducted on an ongoing basis to ensure that established standards for reasonable geographic location of practitioners, number of practitioners, appointment availability, provision for emergency care, and after hours service are measured. The cultural, ethnic, racial, linguistic needs of its members are assessed on an ongoing basis and formally evaluated at least annually. Monitoring activities include practitioner surveys, on-site visits (including verification of appropriate license, employee background checks, employee training, liability insurance coverage, TennCare provider ID and disclosure of ownership annually for all HCBS providers unless credentialed as a Home Health Agency or Nursing Facility), evaluation of member satisfaction, and evaluation of complaints, geo-access surveys and when applicable, monitoring of closed primary physician panels. Specific deficiencies are addressed with an improvement action plan, and follow-up activity is conducted to reassess compliance. Practitioner accessibility and availability activities are reported to the Health Plan SQIS.

J. Practitioner Satisfaction

Practitioner satisfaction surveys are designed to:
1. Assess which services are important to health plan providers
2. Determine provider satisfaction with Health Plan processes, including the utilization management process.
3. Assess satisfaction with continuity and coordination of care

Practitioner satisfaction surveys are conducted annually. The survey results are summarized and reviewed by the Health Plan Service Quality Improvement
Subcommittee, Provider Affairs Committee and Quality Management Committee to identify areas for improvement and develop action plans.

K. Pay for Performance Program

The Health Plan has two pay for performance program for contracted physicians.

1. The Quality Appreciation Program is focused on primary care. The eleven selected measures emphasize both the quality of care and the support of the medical home and access to primary care services. The sole “efficiency” measure, Emergency Room visits, actually reflects true medical home access and care management.

This initiative offers significant financial incentives to primary care physicians who exceed certain levels of access, preventive and chronic proactive care services for our TennCare members. To qualify for this program network primary care providers in internal medicine, family medicine, and pediatrics must have assigned panels of 100 or more members. Program measures selected include six HEDIS® measures:

a. Adolescent Preventive Care
b. ADHD Medication Follow-up Care (Pediatric)
c. Antidepressant Medication Management (Adult)
d. Diabetes Care: Hemoglobin A1C Management (Adult)
e. Diabetes Care: Lipid Measurement (Adult)
f. Breast Cancer: Mammography (Adult)

There are five measures which makeup the Care Management component-

a. Open Panel to new Members and After Hours Care
b. Panel Size
c. Health Information Technology: Use of EDI
d. Reduction in ER Visits
e. Participation in the Vaccine for Children Program

Quality Appreciation Payments are above the contracted physician fee schedule. There is no penalty to the physician if the targets are not reached.

Participating providers have access to the Health Plan’s online provider portal to view their total member panel and individual patient compliance with each of the quality indicators. The selected indicators are evaluated annually for effectiveness in improving patient quality, access to care, and effectiveness. They will be amended as necessary to reflect results, new programs, and newly identified areas with an opportunity for improvement.

2. The goal of the Behavioral Health Provider pay for performance program is fourfold:
a. To promote the Personal Care Model in the provider community; use of the right services, at the right time, and for the right amount
b. To reduce involuntary psychiatric and substance abuse inpatient admissions and emergency room services
c. To promote community tenure for members who are severely and/or persistently mentally ill and seriously emotionally disturbed
d. To reduce expenditures paid for services that are not medically necessary

The Health Plan will focus on the following key areas:

a. Reduction of hospital/residential treatment readmission rates for adults and children/youth
b. Improved access to initial appointments for psychiatry, outpatient therapy, and outpatient substance abuse services
c. Increased rates of comprehensive and timely inpatient discharge plans for members

The pay for performance program constitutes reimbursement beyond contracted rates and is limited to the TennCare line of business only. The Health Plan anticipates that this program will not only produce better outcomes for members but also improved relationships with providers.

L. **Performance Improvement Projects (PIPs)**

Performance Improvement Projects (also known as Quality Improvement Projects) may be designed for the entire plan population or a targeted population or subgroup. PIPs are studies designed to include measurement of performance, interventions, improving performance and systematic and periodic follow-up on the effect of the interventions. Performance Improvement indicators are objective, clearly defined, based on current clinical knowledge or health services research, and capable of measuring outcomes such as changes in health status, functional status and enrollee satisfaction, or valid proxies of those outcomes. Interventions are evaluated and refined to achieve demonstrable improvement. Results of evaluations and recommendations are reviewed and approved by the COS and QMC. Current PIPs are defined in detail as part of UnitedHealthcare Community Plan annual QI Work Plan.

G. **Patient Safety and Risk Management**

The Health Plan supports the prevention and elimination of healthcare errors by our commitment to the practice of Evidence-Based Medicine. This is accomplished through a variety of mechanisms, including but not limited to measurement tools and reporting metrics focusing on patient safety, evidence-based claims and prescription reports to identify adverse events, quality of care referrals and databases to identify, track, and address patient safety concerns. Our comprehensive
policies and procedures address the management of sentinel events and clinical quality of care complaints to reduce clinical risk. Annually, patient safety indicators are developed and integrated into the overall Quality Improvement Work Plan.

The Health Plan patient safety program is also supported through several UnitedHealthcare (UHC) initiated activities. UHC supports the Leapfrog Group’s four pillars of: transparency, standardized measures and practices, incentives and rewards, opportunity rate and external collaboration. The Health Plan medical record review program, Epocrates™ and ePrescribing, adverse event monitoring provide evidence of the networks’ adherence and commitment to evidence-based medicine.

The Health Plan is committed to providing quality care and service while preserving the financial integrity to continue our mission. Risk management is a coordinated, interdisciplinary process designed to identify, evaluate, and resolve actual and potential liability exposures. The risk management program includes coordination between the Health Plan staff and corporate Legal counsel.

H. TENNderCare and Preventive Health Program

The Health Plan provides comprehensive preventive health benefits to its members from birth to age 21. The Early & Periodic Screening, Diagnosis, and Treatment program which in Tennessee is referred to as TENNderCare includes administrative and direct services. The administrative services include a variety of member/provider outreach and follow-up activities. Direct services offer comprehensive preventive health care screenings through contracted providers.

The primary goal of a TENNderCare screening is to prevent disease and detect treatable conditions early to avoid further serious health problems. In addition, anticipatory guidance and health education are integral components of a comprehensive TENNderCare exam. The Health Plan makes every effort to inform its members under the age of 21 years that TENNderCare services are available. Claims/encounter data are monitored on an ongoing basis to identify members in need of services and to provide feedback to providers on individual performance as well as Health Plan performance.

Outreach activities include both written and verbal methods for the purpose of providing education about the benefits of TENNderCare exams for its members. Routine mailings and automated calls are generated to inform members of the benefits of TENNderCare exams and to encourage members to schedule screening visits. In addition to providing education, outreach staff members are available to provide assistance with gaining access to services when needed. When a TENNderCare screening indicates the need for follow-up and/or further evaluation, outreach staff is available to assist in that care coordination. Preventive health
educational information is included in member newsletters and is available to members on the UnitedHealthcare Community Plan in Tennessee websites. Additionally, a separate TENNderCare adolescent newsletter targets 15 – 20 year old members with teen focused health articles and encourages preventive health screenings in this group of members with traditionally lower screening rates. Furthermore, the Health Plan maintains a website called Just4Teens. This TENNderCare website is aimed at educating the Health Plan members under 21 years and those who work with teens. The site includes preventive health education for teens, providers, parents, and teachers. The website content is developed collaboratively by various United Healthcare Community Plan departments to make teens aware of programs and services available for them while also educating them on the importance of preventive health. The goal of the site is to more fully educate teens in the health plan community and those working with them by offering resources and opportunities regarding preventive health that they might otherwise be unaware of. Ultimately the site is a medium for interaction with teens in a teen friendly format. The teen newsletters and a link to the Just4Teens website link are available on the Health Plan website.

Communication with internal departments including care management, customer services, and provider services is ongoing to promote the Preventive Care program and to work collaboratively on individual cases when indicated. A database, the Health Education Registry of Interventions (HENRI), was developed for documentation of all population based education for TNNderCare Members.

The Health Plan conducts outreach to providers as part of its TNNderCare program. This outreach is provided through multiple avenues including written education such as provider newsletters that include information such as the components of a comprehensive screening exam, importance of member screenings, immunizations and the American Academy of Pediatrics periodicity schedule. Additional provider education includes billing and coding information and the availability of reports on assigned members in need of services. The Health Plan, through a secure on-line portal, has up-to-date reports available to the provider on his assigned members in need of TNNderCare services. On-site visits with providers may also be conducted to provide focused outreach. In addition, collaboration between the Health Plan and the provider is fostered to help ensure the availability and timely receipt of services by its members. The Health Plan includes the TNNderCare program in its provider orientation and provider Town Hall meetings. In 2012 a new TNNderCare Provider University course was initiated and is conducted monthly online.

The Health Plan TNNderCare program also includes collaboration with community and state organizations. The Health Plan partners with Sesame Street for an education outreach program to help low-income families make food choices that are both affordable and nutritional for young children. The materials provide a valuable resource for Health Plan members and other low-income families who
participate in community outreach events. Through these partnerships, multiple resources are linked to enhance member and provider educational efforts. The TENVnderCare Prevention and Wellness Education Quality Analysts are responsible for collaborating with the Community Outreach Department staff by providing data to direct community based activities used to target areas with low CMS-416 screening rates.

Using state and/or national guidelines, quality indicators for preventive care services are monitored and evaluated on a continual basis and interventions are implemented as indicated for continued quality improvement.

**Prevention and Wellness Education Program**

The Prevention and Wellness Education Program is an outreach program serving Health Plan members. The Health Plan provides preventive health and screening services for its members within its program benefits. Because of the demographics of the enrolled population, targeting these groups for preventive services has the potential to yield improvements for a large number of members.

The Health Plan chooses preventive service indicators that reflect important aspects of care for our members -- indicators that are relevant to the enrolled population, are reflective of high volume services, encompass preventive and chronic care, and span a variety of delivery settings. Categories of indicators may include the following:

1. Preventive (e.g. TENVnderCare, lead screening, immunizations, cervical cancer screening, breast cancer screening, prostate cancer screening, and flu vaccine).
2. Chronic care (e.g. diabetes, cholesterol management, treatment of asthma)

Preventive services are both population and condition based. Using multiple data sources, including but not limited to HEDIS® data, members are identified for outreach. Claims/encounter data are monitored on an ongoing basis to identify members in need of services and to provide feedback to providers on individual performance as well as Health Plan performance. A database, the Health Education Registry of Interventions (HENRI), was developed for documentation of Tennessee Members’ population based education.

Outreach is provided in both written and verbal form. On a routine basis, mailings are sent to members to provide education related to preventive care and/or screenings due. Verbal outreach is provided through both automated telephone calls and direct-member outreach. In addition, on an annual basis, written information is mailed to members to encourage the utilization of physical exams and recommended screenings. Educational information related to preventive care is also made available to members on the UnitedHealthcare Community Plan in
Tennessee website. Communication with internal departments including care management, customer services, and provider services is ongoing to promote the Prevention and Wellness Education Program and to work collaboratively on individual cases when indicated.

The TENNderCare Prevention and Wellness Education Quality Analysts are responsible for collaborating with the Community Outreach Department staff by providing data to direct community based activities used to target areas with low HEDIS® rates.

Educational and member-specific information is submitted to providers on a routine basis to provide up-to-date screening guidelines and notification of screenings due among the assigned member panel. The Health Plan in Tennessee, through a secure on-line portal, has up-to-date reports available to the TennCare providers on his assigned members in need of preventive health services. This portal includes an option for providers to contact the TENNderCare and Preventive Health Education staff directly by secure email if they have questions regarding member specific data included in the online reports. On-site visits to providers may also be conducted for focused education and/or medical record review.

Health Plan staff develops partnerships with community and state agencies for health promotion on a community-wide scale. Through these partnerships, multiple resources are linked to enhance member and provider educational efforts. These resources may also be used to coordinate services and/or to identify additional means of contact for hard-to-reach members.

Using state and/or national guidelines, as well as HEDIS® data, quality indicators for preventive care services are monitored and evaluated on a continual basis and interventions are implemented as indicated for continued quality improvement.

I. Provider Profiling

Annual Primary Care Provider (PCP) utilization and quality profiles are designed by the national quality management department. Profiles summarize utilization history on five utilization and nine quality indicators for PCPs with sufficient data to generate statistically significant profiles. Individual provider scores are compared to network peer scores.

The utilization indicators are:
1. Encounters,
2. Specialist visits,
3. ER visits,
4. Hospital days, and
5. Hospital discharges.

The quality indicators are:
1. Completed well child visits for adolescents,
2. Children 3 – 6 years of age,
3. Children age 7 – 11 years of age and
4. Children 15 months old,
5. Childhood immunizations,
6. Adolescent immunizations,
7. Cervical cancer screening,
8. Mammograms.

To identify potential over-utilization or under-utilization, profile data is further analyzed to identify scores greater than one standard deviation from the mean. Providers in the lowest quartile are targeted for quality improvement initiatives.

Chapter 5 - Health Services Program

Introduction

The Health Services Program is designed to employ a comprehensive approach to health care. The program integrates medical, behavioral and pharmacy benefits according to state contract requirements and reimbursement structure. Other key components of the program include member and practitioner education and quality management to monitor cost and quality of services to members. Health Services staff work collaboratively with members, practitioners, and other health care providers to promote a seamless delivery of health care services.

The goal of the UM Program is to manage the health care of members by effectively utilizing existing resources while assuring that quality care is delivered. The HealthPlan uses Milliman Care Guidelines for review of inpatient confinements directed by contracted and non-contracted providers. Emphasis is placed on coordinating the member’s transition through the full continuum of care. Further complimenting the UM Program is UnitedHealthcare Community Plan’s hallmark care management program called the “Personal Care Model”.

The Personal Care Model (PCM) is a holistic approach to care for members with complex needs and especially for members with chronic conditions.

The PCM provides the following:
1. Personal contact with the member and the development of ongoing relationships between care managers/care coordinators and members.
2. Interventions comprised of telephonic care management/care coordination and home visits/on site care management/care coordination.
3. Enrollment as appropriate in disease/care management programs.
4. Education with mailings of educational materials, and outreach component.
5. Member stratification according to diagnosis and severity of medical and psychosocial condition.
6. Practical, everyday solutions, not just medical remedies, to maintain or improve health status.

7. Involving not only family members, but also community-based organizational resources and government social service programs as elements of a comprehensive support structure for the member.

The goal of the PCM is to keep the member in his or her community – with the resources necessary to maintain the highest functional status possible. Because early identification and intervention are keys to the program, all employees are encouraged to identify and refer high-risk members to the Care Management/Care Coordination.

Once enrolled, members become the focus of a concerted, hands-on outreach effort. The staff designs and implements a comprehensive treatment plan based on the evaluation of at-risk members’ health and living conditions. Members are identified for the program by Impact Pro, Health Risk Assessments, inpatient census, a review of claims and pharmacy data, or by referral from a PCP, or other provider or community groups and social services agencies. A registered nurse and/or a behavioral health specialist conduct a comprehensive needs assessment and develop a plan to address all relevant health and environmental issues. The assessment takes into account medical, emotional and socio-economic factors. Additional information may be gathered from a member’s family and physicians.

The care plan is implemented as a partnership between a member’s PCP and the PCM Care Manager/Care Coordinator that has been assigned to the member. Members are contacted regularly via telephone, home visits, or written/letter as deemed appropriate. The staff addresses health-related issues as well as social, economic and other concerns related to overall quality of life. The care manager/care coordinator monitors the care management and coordinates care through the PCP as needed.

A. Accountability and Organizational Structure

The Chief Medical Officer along with the Quality Management Committee (QMC) and the Health Plan Clinical Operations Subcommittee (COS) are responsible for implementation and oversight of the Health Services Program.

Included in this oversight are the following activities:
1. Review the Utilization Management Program and criteria used to review decisions annually.
2. Review and assess utilization management practices for selected cases and diagnoses.
3. Review and analyze data on outcomes and trend studies, utilization appeals.
4. Recommend actions based on utilization management findings.
5. Review reports related to members in care/disease management and CHOICES.
6. Review findings of the Provider Affairs Subcommittee (PAS) related to quality of care issues arising primarily from inpatient providers.
7. Review and approve UM/CM/DM Policies and Procedures annually as well as the QI Program Evaluation, Program Description and Work Plan.

B. Staffing Model and Structure

The Health Plan has a multidisciplinary approach to providing personalized care to its members. The goal of the program is to provide continued support to members with complex medical conditions and comorbidities, or those who may be at risk for a medical condition as identified by Health Risk Assessments or predictive modeling. The Health Plan model emphasizes the importance of a team approach by working with members, practitioners, and other health care team members to promote a seamless delivery of health care services. The multidisciplinary team consists of an Inpatient Care Manager, a telephonic or field-based Care Management team member and several other key team members who could include a Social Worker, a Discharge Planner, a Health Coach, a Care Coordinator, a Data Analyst, a Behavioral Health Utilization Manager, and a Discharge Specialist. A member may receive services and support from all or just a few of the team members, depending on that member’s individual needs, all of which are coordinated by the member’s primary care manager/care coordinator. The Chief Medical Officer is responsible for the implementation and oversight of the Health Services program.

Members of the team include the following medical and behavioral staff:
1. Chief Medical Officer
2. Regional Vice President, Inpatient Management Southeast
3. Medical Directors for Health Services, Behavioral Health and CHOICES
4. Associate Directors Medical and Clinical Operations
5. Managers Medical and Clinical Operations
6. Vice President Behavioral Health Services
7. Vice President Medical Health Services
8. Director of Behavioral Health Field Care Management
9. Director of Behavioral Health Utilization
10. Managers of Utilization Management
11. Managers of Field Care Management
12. RN’s (Utilization Management and Care Management)
13. Social Workers
14. Behavioral Health Practitioner CHOICES Care Coordinator
15. Support Staff
C. Staff Qualifications and Responsibilities

Chief Medical Officer Qualifications and Responsibilities
1. Maintain a current non-restricted license to practice medicine in Tennessee
2. Demonstrate adequate education, training and clinical experience in a medical or clinical practice setting to utilize medical appropriateness criteria and other applicable review standards or medical policy
3. Develop and implement clinical (medical and behavioral health) components of UM/CM/DM Program.
4. Develop clinical strategies to improve UM/CM/DM policies, procedures, processes and outcomes.
5. Oversee clinical decision making activities of UM/CM/DM staff.
6. Develop clinical policies, procedures and programs.
7. Oversee clinical appeals process/decision making.
8. Facilitate multi-disciplinary rounds and case conferences.
9. Become and maintain credentialed status with UnitedHealthcare Community Plan

Physician Reviewer Qualifications and Responsibilities:
1. Maintain a current non-restricted license to practice medicine in the State
2. Demonstrate adequate education, training and clinical experience in a medical or clinical practice setting to utilize medical appropriateness criteria and other applicable review standards or medical policy
3. Ability and credentials (e.g., Board Certification) to review cases for which a clinical decision cannot be made by the first level reviewer
4. Ensure reasonable availability, within one business day, to discuss clinical determinations with the attending or ordering physician
5. Obtain consultations from specialist physicians if indicated

Medical Director Qualifications and Responsibilities
1. Maintain a current non-restricted license to practice medicine in Tennessee
2. Demonstrate adequate education, training and clinical experience in a medical or clinical practice setting to utilize medical appropriateness criteria and other applicable review standards or medical policy
3. Develop and implement clinical (medical and/or behavioral health) components of UM Program.
4. Develop clinical strategies to improve UM policies, procedures, processes and outcomes.
5. Oversee clinical decision making activities of UM staff.
6. Develop clinical policies, procedures and programs.
7. Oversee clinical appeals process/decision making.
8. Facilitate grand rounds and case conferences.

V.P. of Medical Health Services
1. Demonstrate and maintain appropriate education, training and clinical experience.
2. Develop and oversee integrated medical management model.
3. Develop and implement UM/CM/DM Program.
5. Monitor key performance and outcomes indicators indicative of program success.
6. Collaborate with other department heads and external customers (e.g. physician hospital organization, hospitals, home health agencies, community agencies) to facilitate coordination of activities to achieve goals.

V.P. of Behavioral Health Services
1. Demonstrate and maintain appropriate education, training and clinical experience.
2. Develop and oversee integrated clinical medical management model.
3. Develop and implement UM/CM/DM Program.
5. Monitor key performance and outcomes indicators indicative of program success.
6. Develop and implement Health Care Quality and Affordability Initiatives focused on behavioral health outcomes.
7. Collaborate with other department heads and external customers (e.g. physician hospital organization, hospitals, home health agencies, community mental health agencies) to facilitate coordination of activities to achieve goals.

Regional V.P. Inpatient Care Management
1. Accountable for the profitability of the regional Inpatient Care Management (ICM) as impacted by medical expenses and trend.
2. The Regional ICM Director is accountable for the team achieving the previously established ICM program goals.
3. Promotes a positive public image, facilitates the establishment of effective and efficient internal and external customer interfaces and ensures development of staff through the implementation of logically developed goals, objectives and strategic plans.
4. Achieve and maintain profitability as impacted by medical expenses and trends in each of the regional sites.
5. Set direction and strategic planning to develop, implement and monitor action plans to modify care delivery patterns and reduce expenses.
6. Reduce medical expenses that correlate with continuous performance improvement efforts.
7. Develop strategic initiatives as ongoing improvement.
8. Produces analysis documents to guide strategic planning.

**Director/Manager of Inpatient Care Management and Behavioral Health Utilization Management**

1. Oversee the operations of the health care professionals that conduct Utilization Management activities.
2. Oversee the management of staff clinical decision-making regarding intensity of service, appropriateness of setting and coverage.
3. Review and monitor staff performance as dictated by corporate policy; educate and direct staff to facilitate compliance or improvement.
4. Develop, maintain, and enhance the processes that lead to quality authorization generation

**Inpatient Care Managers/ Behavioral Health Utilization Managers Responsibilities**

1. Maintains current license in Tennessee (registered nurse, or licensed behavioral health clinicians such as clinical social workers, professional counselors, or senior psychological examiners).
2. Apply criteria to clinical information presented for intensity of service, appropriateness of setting and coverage.
3. Evaluate the medical necessity of outpatient, inpatient admissions and concurrent stay services; certify cases meeting criteria.
4. Refer cases not meeting criteria to a Medical Director or Physician Reviewer for review and adverse determination.
5. Proactively coordinate discharge planning with hospital/provider staff
7. Involve Field Care Management staff when needed to ensure member receives appropriate care.

**Clinical Pre-certification Reviewers Responsibilities**

1. Maintains current license in Tennessee (registered nurse, or licensed behavioral health clinicians such as clinical social workers, professional counselors, or senior psychological examiners).
2. Apply criteria to clinical information presented for intensity of service, appropriateness of setting and coverage.
3. Evaluate the medical necessity of proposed services; certify cases meeting criteria.
4. Approve cases meeting criteria.
5. Refer cases not meeting criteria to a Medical Director or Physician Reviewer for review and adverse determination.
Care Managers Responsibilities

1. Facilitate coordination and continuity and appropriateness of care and services in ambulatory setting as well as collaborate with member’s health care delivery team.
2. Assess members’ clinical and psychosocial needs.
3. Develop plan of care in conjunction with the member and member’s health care delivery team.
4. Advocate for members.
5. Provide health education to members
6. Facilitate open communication and service coordination between the member, the Health Plan, and the member’s practitioner and appropriate community agencies.
7. Provide practitioners with disease specific clinical information regarding members.
8. Identify barriers to optimal care and outcomes or clinical concerns and communicate with members and providers to formulate action plan to address.
9. For Healthy First Steps members, monitor pregnancies and assess for development of complications or concerns that warrant follow up with the member and practitioner.

Behavioral Health Field Care Manager Responsibilities

1. Coordination of delivery of comprehensive services for members.
2. Work with Network Services to enhance the network and foster relationships with providers.
3. Coordinate and attend on-site treatment teams at hospitals, personal care homes, or other community sites.
4. Ongoing disease-specific education, coaching on lifestyle changes, and referrals to community based social supports.
5. Ongoing evaluation and assessment of services, needs and coordination of systems for problem resolution.
6. Independently manage Public Sector (Medicaid/TennCare) inpatient and outpatient psychiatric treatment, chemical dependency, and co-occurring diseases of members through comprehensive care management consisting of telephonic and/or face to face assessment.
7. Assist with the coordination of member’s care with the goal of optimizing the quality of care and efficiency with which care is provided.
8. Recommend level of service interventions based on risk factors.
9. Complete appropriate clinical assessments and individualized Plans of Care.
10. Work with the member, family, and service providers ensuring barriers are removed to promote recovery and wellness and promote low risk service use.
11. Utilize regular contact, empowerment strategies, and cultural competency to develop rapport with the member and encourage member’s active participation, personal growth, and control over her/his health and wellness.

**Behavioral Health Discharge Specialists**
1. Telephone contact with members and providers to ensure that appropriate plans are in place for discharge follow-up treatment.
2. Assist members in overcoming any potential barriers to keeping aftercare appointments.
3. Contact providers to verify initial aftercare appointment attendance by members.
4. Identification of signs of risk or symptoms that may require intervention by a Care Manager.
5. Provision of member and provider education related to discharge follow-up issues and resources.

**Transition Coach Responsibilities**
1. Conduct initial patient visit in hospital to introduce Transition Program
2. Perform assessment of general needs and complete the Personal Health Record
3. Conduct home visits 24 and 72 hours post discharge
4. Identify medication discrepancies
5. Conduct patient education on s/s of change in condition, “red flags” and development of response plan
6. Ensure follow-up appointments are scheduled
7. Conduct follow-up on issues discussed during hospital/home visit
8. Conduct telephonic outreach at day 7 and 14

**Intake/Notification Coordinators:**
1. Non-clinical staff and is responsible for the intake, eligibility verification, documentation and communication of information received by telephone and/or fax that assists the requesting party with the notification process for service requests and guides them to the appropriate utilization management resources and staff.
2. Responsible for documenting accurate information related to the enrollee, provider and requested health care services in the clinical system database-CareOne.
3. Non-clinical staff is monitored by licensed health professional staff.

**Social Worker/Discharge Planners:**
1. Provide direction for routine aspects of non-medical problems of patients and their families.
2. Acts as a resource for information about and referral to other community based services.
3. Assesses and interprets customer needs and requirements.
4. Identifies solutions to non-standard requests and problems.
5. Solves moderately complex problems and/or conducts moderately complex analyses.
6. Assist with transfer to lower levels of care.

**Behavioral Health Discharge Specialists:**
1. Monitors timely discharge plans for psychiatric inpatient and residential discharges.
2. Conducts Welcome Home calls to members discharged from psychiatric and residential facilities to insure member understanding of aftercare discharge appointments, as well as discuss community resources and promotion of recovery.
3. Confirm member attendance to post discharge appointments with the outpatient provider.
4. Participate in clinical group rounds specific to members with frequent hospital recidivism.

**Clinical Administrative Coordinator:**
1. Responsible for administrative intake of members or managing the admission/discharge information post-notification, working with hospitals and the clinical team.
2. Manage incoming calls and requests for services from providers/members, providing information on available network services and transferring members as appropriate to clinical staff.
3. Manage the referral process by processes incoming and outgoing referrals, and prior authorizations. This function includes intake, notification and census roles.

**Health Coach:**
1. Assist members by answering questions, providing program information and education about the program services, guidelines and policies in an accurate and courteous manner.
2. Encourage members to appropriately utilize services in an effort to improve the health and well being of all members. This might include educational materials for specific disease management.
3. Provide ongoing education for all members based on individual needs identified through questions or conversations, while paying attention to special cognitive issues with members.

**Clinical Program Consultant**
1. Works directly with Health Plan Vice President to support and lead clinical projects.
2. Assist in the development of the Patient Centered Medical Home (PCMH) and monitor the PCMH model to include providing support for the Provider
practice to improve access to care, reduce ER utilization, reduce avoidable admissions and improve the care of high risk patients.

3. Lead and assist with current projects (CHF, COPD, Telemedicine) to expand the projects across the State of Tennessee and monitor the program to ensure optimal success of the programs.

Associate Director of Utilization Management for Health Services
1. Oversight of Private Duty Nurse, Home Health and Transition Coach teams and cases
2. Coordination with other teams including Choices, Behavioral Health, and ICM for discharge planning and appropriate treatment
3. Collaboration with state on appeals, hearings, and other legal issues
4. Reports including ORR's, Quarterly reports, etc
5. Collaboration with Providers
6. Documentation to monitor teams, review results, and ensure appropriate processes

Private Duty Nurse Care Managers and Social Workers
1. Process requests for home health and private duty nursing
2. Field assessments
3. Case conferences
4. Entering notifications for services; securing agency; and ensuring member is receiving services
5. Case management of members in our department including regular and PRN contacts; education; medication assistance; transportation assistance; DME issues, etc.
6. Integration with other teams including Behavioral Health and Choices to ensure appropriate treatment for members

CHOICES Medical Director Qualifications and Responsibilities
1. Maintain a current non-restricted license to practice medicine in the State
2. Demonstrate adequate education, training and clinical experience in geriatric or long term care setting
3. Develop clinical strategies for CHOICES Program to improve policies, procedures, processes and outcomes.
4. Oversee clinical decision making activities of Care Coordination staff.
5. Facilitate grand rounds and case conferences
6. Liaison to network management for network development related to nursing facility/ HCBS services
7. Support all Clinical Quality initiatives and peer review processes including
8. Become and maintain credentialed status with UnitedHealthcare Community Plan
Director Health Services CHOICES Long Term Services and Supports Responsibilities
1. Provide strategic clinical direction to the clinical team in partnership with the CHOICES Medical Director
2. Supervise Care Coordinator staff, including Managers and Regional Directors.
3. Represent the CHOICES clinical program to the executive team to assist in business decisions

Care Coordinator Qualifications and Responsibilities
1. Facilitate coordination and continuity and appropriateness of care and services in the long term care setting.
2. Collaborate with member’s health care delivery team
3. Assess members’ clinical and psychosocial needs
4. Develop plan of care in conjunction with the member and member’s health care delivery team
5. Advocate for members
6. Provide health education to members
7. Facilitate open communication and service coordination between the member the Health Plan, and the member’s practitioner and appropriate community agencies
8. Provide practitioners with disease specific clinical information regarding CHOICES HCBS members
9. Identify barriers to optimal care and outcomes or clinical concerns and communicate with members and providers to formulate action plan to address
10. Monitor pregnancies and assess for development of complications or concerns that warrant follow up with the member and practitioner

E. Staff Training

A formal program of orientation and ongoing training is provided for clinical staff at all levels. Staff is trained in the appropriate concepts, components and processes of Utilization Management, Care Management, Disease Management and Care Coordination, use of medical necessity criteria, clinical information systems and tools such as CareOne, our integrated clinical information system, Impact PRO, our predictive modeling system, and Universal Tracking Database (UTD), our tracking system for member compliance with wellness and prevention recommendations. Medical and behavioral health staff train together to reinforce integration.

F. Pharmacy and Therapeutics (P&T)

Pharmacy services for our TennCare members are administered by SXC Health Solutions which has a direct contract with the State of Tennessee.
G. Health Services Functional Areas

1. Utilization Management

The Medical Inpatient Care Managers (ICMs) and Behavioral Health Utilization Managers (BHUMs) are registered nurses or licensed behavioral health clinicians such as clinical social workers, professional counselors, or senior psychological examiners, who provide the link between the Health Plan, the member and the practitioner as the Health Plan strives for a seamless delivery of health care services. To this end, the utilization management process focuses on early discharge planning. The ICMs are assigned specific hospitals where they work closely with the hospital discharge planners to determine the most appropriate discharge setting for the member. The ICMs also review for medical necessity and appropriateness for home health, skilled nursing facility, infusion therapy, rehabilitative services, and various behavioral health levels of care and services. The BHUMs also are assigned to different facilities/providers and work in close cooperation with provider utilization review staff to determine the most appropriate discharge setting in cooperation with the member. The BHUMs review for medical necessity and strive to identify a discharge setting that will meet the expectations of the member and ensure the least restrictive, most clinically appropriate living environment that will continue to serve the member on his/her journey of recovery. The utilization management process is designed to ensure the highest quality care in the most cost-effective manner without compromising the quality of care. All Utilization Management decisions are objective and use evidence-based criteria taking into consideration individual circumstances and the local delivery system. They are based on appropriateness of care and service and the existence of coverage. Utilization Management decision makers are not rewarded for issuing denials of coverage or care nor do they receive financial incentives that encourage decisions that result in underutilization.

The UM Program is reviewed, evaluated and updated as necessary annually under the direction of the Chief Medical Officer. It is reviewed by the Clinical Operations Subcommittee and approved by the Quality Management Committee and the Board of Directors. Annual surveys are conducted to measure provider satisfaction and member satisfaction and includes satisfaction with the UM processes. Activities to improve member and provider satisfaction are incorporated into the QI/UM Workplan in collaboration with Sales, Marketing and UHN staff.

Purpose

The Inpatient Care Management (ICM) activities focus on promoting delivery of care for facility based patients at the appropriate time while
developing a member-centric holistic discharge plan. The ICM nurses perform onsite or telephonic review using Milliman Care Guidelines, a nationally recognized set of evidence-based guidelines. The ICM consults with the hospital utilization management team or attending physician to discuss the clinical documentation relevant to the Milliman Care Guidelines. They consult with the program medical director to review cases and discuss treatment plans. If a case requires escalation, a nurse to physician or peer-to-peer dialogue between the medical director and treating physician occurs as needed to collaboratively discuss treatment options and plans, and to facilitate access to care or alternate care settings.

Hospitalized members, who are considered high risk for readmission or who have complex discharge planning needs, are referred by ICM staff for post-discharge case management or disease management. Paid claims data are utilized to measure utilization rates.

Utilization Management is defined as: Effectively influencing the processes required for controlling and managing the utilization of health care services across a broad variety of settings. The purpose of Utilization Management is to coordinate, direct and monitor the quality and cost effectiveness of health care resources. Utilization Management ensures that services are rendered in a timely manner, provided in appropriate settings and that services are planned and individualized – and evaluated for quality and effectiveness. The Utilization Management process establishes continuum of care principles that integrate a range of services appropriate to meet members’ needs, while maintaining flexibility in modifying services, as needs change.

Scope

The Utilization Management Program, utilizing the principles of medical necessity and continuous quality improvement, monitors the delivery of the health care services provided to all members.

The scope of the Utilization Management Program is to:

a. Ensure that health care services provided are medically necessary.

b. Ensure that health care services are provided in the most appropriate setting.

c. Ensure the integration of physical and behavioral health care occurs to bring about the best overall outcomes for our members. Integrated rounds and reaching out to physical or behavioral counterparts for information based on their published areas of expertise are two examples.

d. Manage medical benefits resources effectively and efficiently while ensuring quality care is provided.
e. Manage members through a continuum of care including through an acute illness and transitioning to the home setting as well as providing intensive care management as to reduce readmission.

f. Support the establishment of a medical home and coordination of care with the PCP among various health care settings for members.

g. Provide a Multi-disciplinary team approach to address the member’s needs from the acute care phase through the post-acute care phase.

h. Identify effects of underutilization as well as over-utilization.

i. Identify and coordinate with QI Department in the management of quality of care issues or trends.

Availability of Utilization Management Staff

The Utilization Management staff is available for practitioners and members to discuss Utilization Management issues. Staff members are accessible for inbound calls (including collect calls) during normal business hours and can send outbound Utilization Management communications during a normal business day. Utilization Management staff are required to identify themselves by name, title and organization with all communication. Each staff member also has the capability of receiving and sending voicemail, email and fax messages. Behavioral Health Staff is available through the call center to take crisis calls directly from members as well as to give providers pre-authorization for inpatient hospitalization. In addition, Behavioral Health staff is available at the prior authorization call center after normal business hours to receive and respond to any inquires regarding utilization management that are deemed urgent; that is, not able to wait until the next business day for action.

Utilization Management Objectives

The objectives of Utilization Management are to:

a. Ensure consistent application of UM functions across all health plans through standard policies, procedures and practices. The program is supported by a combination of local and centralized programs to enhance the member’s experience and quality of care.

b. Monitor and evaluate the quality of hospital care, outpatient procedures and selected high volume, high cost services for appropriateness, necessity, efficiency and quality.

c. Establish utilization goals and monitor variance from goals through Utilization Management data collection and reports.

d. Promote cost containment without compromising quality of care by monitoring the timeliness of care rendered, quality of care indicators and appropriateness of acuity levels and care settings.
e. Identify, assess and refer members who could benefit from care management/disease management and assist member in post-acute phases of illness.

f. Ensure confidentiality of member and practitioner information.

g. Identify patterns of care in which outcomes may be improved through efficient utilization management and implement actions to improve performance.

h. Ensure timely responses and resolution to appeals and complaints.

i. Maintain ongoing integration through systematic communication between medical care management and behavioral health utilization managers to ensure the most holistic approach to member care.

j. Integrate Utilization Management activities with the Quality Improvement activities through the committee process and joint representation in performance improvement teams.

k. Establish and disseminate evidence-based guidelines that promote quality/cost effective care.

l. Ensure the Utilization Management decisions, including adverse decisions, meet established turn-around time standards that meet or exceed regulatory and accreditation requirements.

m. Develop, maintain and communicate medical and behavioral health policies including new technology review and the new application of existing technologies in collaboration with accreditation and State requirements.

n. Identify potential over and under utilization of health plan services.

o. Collaborate with local health delivery systems to align initiatives and facilitate program success.

p. Annually, measure and improve member and provider satisfaction with the UM/DM process.

**Inter-Rater Reliability (IRR)**

The Health Plan recognizes the importance of consistent and appropriate clinical determinations among ICM/BHUM and medical director/physician reviewer staff. No less than annual IRR audits are conducted for medical ICM nurses, BHUM clinicians and medical directors/physician reviewers, both medical and behavioral. Opportunities for improvement in the medical/behavioral determination process are identified and feedback is provided at the individual level and the individual’s direct supervisor coordinates action plans for improvement.

Grand Rounds are conducted on a weekly basis. The UM staff along with the Medical Directors/physician reviewers discuss determinations and problem cases. Recommendations for alternative management of a case occur as needed.
Criteria

Licensed Clinical staff conducts medical necessity reviews for admissions and continued stay requests using the following guidelines:

a. TennCare Medical Necessity Criteria (Grier)
b. Milliman USA Healthcare Management (to estimate length of stay)
c. Level of Care Guidelines (LOC)
d. American Society of Addiction Medicine Guidelines (ASAM)
e. TennCare Applied Behavior Analysis criteria (for applied behavior analysis)

These guidelines are integrated into the CareOne clinical information system.

The Health Plan uses Milliman USA’s interpretation of their guidelines, which states: "The guidelines are, quite simply, guidelines for providing the right care at the right time in the right setting. They show what can be accomplished under the best circumstances and are not meant as a substitute for a physician's judgment about an individual patient." This interpretation is applied to the use of all guidelines used by the Health Plan.

Updates to guidelines are licensed and distributed as they become available. Medical guidelines are reviewed annually by the national Executive Medical Policy Committee and the National Quality Management Oversight Committee (NQMOC) and the behavioral health guidelines are reviewed by the OHBS Clinical Policy and Oversight Committee. All guidelines are then reviewed and approved by the Health Plan PAS. The Health Plan also uses Milliman USA Guidelines for the following areas where applicable criteria or guidelines exist:

a. Hospice
b. Home health care
c. Skilled nursing facility
d. Inpatient rehabilitation
e. Inpatient psychiatric hospitalization
f. Psychiatric residential treatment for adults
g. Partial Hospitalization
h. Intensive Outpatient
i. ECT

In instances where national criteria do not exist, the medical director makes the medical decision based on TennCare guidelines (1200-13-13), Knowledge Library, Evidence Based Medicine and on clinical judgment specific to that case. Alternate level care criteria are utilized during discharge planning and care management processes.
Medical Policies and Guidelines

The Chief Medical Officer oversees the adoption/approval of medical and behavioral health policies and evidence-based guidelines. Nationally recognized evidence-based medical guidelines are reviewed, updated and approved at least every two years by the national Executive Medical Policy Committee (EMPC) and the NQMOC. The behavioral health guidelines are reviewed by the OHBS Clinical Technology Assessment Committee and the Clinical Policy and Oversight Committee. The Health Plan COS, PAS and QMC evaluate and accept these guidelines. Policies and guidelines may be developed for medical, surgical and diagnostic criteria. Medical guidelines are also derived from:

a. Current medical literature and peer reviewed publications.
b. Medical Technology Assessment Reviews

Medical and behavioral health guidelines are shared with practitioners upon request. Some guidelines are made available on the provider website, http://www.uhcommunityplan.com/health-professionals/TN/provider-information. In all cases the phone number to request the specific guideline used to make a UM decision is available on the provider website. Policies and guideline updates are communicated through provider notices prior to implementation.

Integration and Linkage with Other Departments

The Utilization Management staff and the Medical Directors plan, coordinate and direct the operation of the UM Program. The UM staff interface daily with other Health Plan functional areas to promote an interdisciplinary approach. The Utilization Management staff can readily coordinate covered services with their medical or behavioral health services counterparts as appropriate since they are collocated in each Health Plan.

Management with Quality Management Programs

UM staff interface with and support clinical quality improvement in a variety of ways. Through the Quality of Care (QOC) referral process and in accordance with the QOC policy and procedure, screening indicators are used by staff to identify potential quality of care concerns. All potential quality of care concerns are forwarded to the Quality Management Department for review, tracking, trending and follow-up.

Quality issues and trends identified by UM are measured and reported to the Clinical Operations Subcommittee and/or the Provider Affairs Subcommittee. Areas that are measured and may be reported include but are not limited to:
a. Appeals Metrics
b. Utilization Management Prior Authorization abandonment rates and average speed of answer
c. High volume diagnoses and associated metrics (inpatient days/1000, visits/1000).

**Review Types**

a. Precertification Review

The UM staff conduct pre certification reviews for benefit determinations consistent with State/CMS contracts and to determine the medical necessity and appropriateness of inpatient hospital stays (medical and behavioral), short procedure units and special treatment rooms for elective procedures, psychiatric residential treatment and several behavioral health and substance abuse outpatient services. Evaluation is made by utilizing accepted clinical criteria. If the requested services do not meet criteria for medical necessity, the case is referred by the pre certification reviewer to a Medical Director for determination. Decisions will be made within 14 calendar days of receipt of the request. Requests for pre certification may be in writing, by telephone or submitted by facsimile.

b. Concurrent Review

The ICM nurse and/or behavioral health clinician reviews the inpatient (or outpatient) plan of care of the member with the facility’s/provider’s utilization designee for appropriateness and to monitor the quality of care being rendered to the member. In December 2011, the Health Plan implemented non-payment policies for Provider Preventable Conditions (PPCs) including Health Care-Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPCs) for all admissions. During the concurrent review, the UM nurse evaluates each case for possible conditions that were not part of the original admission diagnoses. Any potential PPC and HCAC are reviewed by the Medical Director. If the Medical Director determines the condition to be a PPC or HCAC, documentation is entered into CareOne and payment is down adjusted based upon the concurrent review findings.

The goal of the concurrent review clinician is to establish a collaborative process to monitor the member’s response to the treatment plan and proactively plan to support the member’s needs after hospitalization or completion of the service. UM staff conducting concurrent review collaborate with internal and external
staff practitioners and their representatives. They insure that discharge needs are met in a timely manner and that continuity of care is provided. Assessments are conducted concurrently by onsite visits, telephone, or fax. Procedures for completing reviews in a timely fashion and notifying providers of all decisions have been established.

In DRG reimbursed facilities, admission appropriateness is reviewed; concurrent review is conducted during low and high trim point periods and at the midpoint of the DRG to evaluate discharge planning needs.

Denial notice letters are sent to providers and/or members and included is information to inform them of appeal rights including expedited appeals.

For cases admitted to the hospital through the emergency room, concurrent review is performed to determine medical necessity and appropriateness of the admission and the need for continued inpatient stay.

On a concurrent basis, UM staff work collaboratively with hospital staff to consider the member’s health care needs post discharge. Providers are encouraged to begin the discharge planning process as early in the hospitalization/service as feasible. The goal is to affect a timely discharge at the same time ensuring that the member will not return to an acute phase secondary to lack of access to appropriate health and support services.

c. Discharge Planning
Discharge planning ensures that members treated in the inpatient setting have a planned program for continued care. The discharge plan reviewed or developed with the provider should be based on knowledge of the member’s resources, covered benefits, and post discharge environment.

The UM’s role in discharge planning include:

i. Coordination and facilitation of continued care after hospital discharge. Short-term discharge planning follows the member for up to 30 days

ii. Initiation of discharge planning upon admission and monitoring through concurrent reviews.

iii. Serving as a resource for the provider and the member to help ensure efficient and effective care and appropriate utilization consistent with benefits and network services.
iv. Referral of members to the multidisciplinary team if it is determined that the member needs more complex services past the 30 days. The team member begins to manage the care and makes all necessary referrals for continued care as well as new referrals for more complex issues.

The ICM/BHUM team utilizes the support of the social workers to assist with post acute services. These services include home health, DME, outpatient therapies and skilled nursing placement – as cost effective alternatives as appropriate. The purpose is to provide a clinical focus for members treated in the inpatient setting with a planned program for continued care based on knowledge of medical necessity, the member’s resources, covered benefits, post discharge environment.

Interventions:

i. Define expectations for discharge planning by hospital staff

ii. Officially change discharge planning accountability for members in care management to CMs and CHOICES members to their care coordinator.

d. Out of Network Referral Determinations

Out of network referrals require prior authorization. These requests are considered on an individual basis. Requests are considered through interaction and clinical discussion with the member’s PCP or behavioral health practitioner. Out of network referrals are generally approved in the following instances but are not limited to:

i. Continuity of care issues exist

ii. Necessary services are not available in network

Out of network referrals are monitored on an individual basis and trends related to individual physicians or geographical locations are reported to Network Provider Services to assess root causes for action planning.

e. Prior Authorization

Prior authorization presents an opportunity to determine medical necessity and appropriateness of services, procedures, and equipment prospectively. It also affords the opportunity to determine whether the services, procedures or equipment are a covered benefit for the member and whether the member can be directed toward in-network services where applicable and appropriate. As noted previously, requests for prior authorization are reviewed against
established criteria. Appropriate clinical reviewers complete prior authorization after obtaining all relevant information and, when required, Medical Director or appropriate behavioral health practitioner review. The member, practitioner, and facility (if indicated) are notified of any adverse determinations in writing and, as needed, by telephone of the decision if an urgent decision is necessary.

Procedures and services requiring prior authorization are posted on the Health Plan’s provider website and are included in the appropriate Health Services Policies and Procedures. The list of services requiring authorization is minimal to facilitate the provision of services to members and providers.

g Variation in Authorization Process

At times, it may be necessary for the Health Plan to use “business rules” that allow for authorizations to be created without all the necessary clinical data present in the system. Situations may arise in which this is the only way a provider can be paid for services they have delivered to our members. When these rare occasions arise, Health Plan conjunction with the claims division institute this type of business rule to be used in order to allow for claims payment to occur.

Decision Timeframes

Utilization management decisions and notice requirements are developed consistent with applicable state and federal laws and regulations and accreditation standards.

<table>
<thead>
<tr>
<th></th>
<th>Decision TAT</th>
<th>Practitioner notification of approval</th>
<th>Written practitioner/member notification of denial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent</td>
<td>14 calendar days of receipt of request</td>
<td>Within 14 calendar days of the request</td>
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<tr>
<td>Pre-service</td>
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<td>24 hours of receipt of request</td>
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<tr>
<td>Post-service</td>
<td>30 calendar days of receipt</td>
<td>Within 30 calendar days of the request</td>
<td>Within 30 calendar days of the request</td>
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<tr>
<td>Decision</td>
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</table>
Adverse Determinations

The adverse determination letter includes the following information:

a. The specific reason(s) for the denial, in easy to understand language
b. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial was based
c. Notification that the member or practitioner can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based.
d. Explanation of the appeal process, including the right to member representation, the right to submit written comments, documents or other information relevant to the appeal and time frames for deciding appeals.
e. If the denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeals process.
f. That a Health Plan Medical Director is available to discuss the denial determination with the practitioner.

Denial Process

The process of review, utilizing established criteria, involves the first level review by appropriate clinical reviewers. The Chief Medical Officer or medical director reviews services not meeting criteria. All denial and alternate level of care decisions are made at the physician level. The denial process consists of the following:

a. The first level review assesses medical necessity against established medical necessity criteria and the member’s benefit package and limitation
b. If criteria are met, the services are approved
c. If the service(s) does not meet criteria or if the criteria specifically require physician authorization, the reviewer submits the case for review
d. All denial decisions are followed with written notification to the requesting practitioner and member.
e. Denial decisions include the rationale for the denial and information on the appeals process in writing

Whenever there is an adverse action affecting TennCare services, required timely notices are sent to the member.

A list of Health Plan Board Certified physicians can be utilized as Physician Advisors, as needed. The list contains physicians certified in a variety of specialties, allowing for access to pertinent specialties as necessary.
The Medical Review Unit reviews claims for incorrect provider numbers, mismatched dates of service and ER claims

**Appeals Process**

The Bureau of TennCare processes all member appeals for the TennCare population in accordance with the Grier Consent Decree. The Grier Consent Decree is a Federal Court Consent Decree governing the processing and resolution of member appeals for individuals enrolled in TennCare, the Tennessee State Medicaid Program. The role of the Health Plan is limited to responding to requests from the Bureau of TennCare regarding the appeal.

The purpose of an appeal is to provide a formal reconsideration or second look at a denial. The Health Plan abides by the written appeal process outlined by the Bureau of TennCare and utilizes approved letter formatting.

An appeal may be a standard appeal with a 14 day response time or maybe requested expedited with a 5 day response time. Requests may be initiated by telephone, fax or in writing by the member, member's practitioner or authorized representative. The complete member grievance and appeal process, including expedited appeals, is outlined in written Policies and Procedures.

Any medical necessity appeal will be processed according to applicable state regulations (Grier). This may include a binding decision by an external review entity; or a Board Certified physician from a same or similar specialty not associated with the original determination.

A member or provider may file for a Fair Hearing at anytime during the appeals process.

**Emergency Services**

The Health Plan does not require prior authorization for use of emergency services. The Health Plan covers emergency services necessary to screen and stabilize members where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed. In addition, the Health Plan covers all emergency services if an authorized representative, acting for the Health Plan, authorized or facilitated the provision of emergency services.
New Technology

The National Medical Technology and Assessment Committee (MTAC) evaluates emerging and new uses of existing technologies and medical interventions to determine safety and effectiveness. This committee is comprised of physicians/Medical Directors from various geographical areas from United Health Group including UnitedHealthcare Community Plan, and practicing physician specialists as required. In researching decisions regarding the investigational status or medical necessity of new and existing technologies, the MTAC makes use of technology evaluation criteria. Extensive computerized literature searches through the National Library of Medicine aid the committee members. The committee may also use the technology evaluation programs of Hayes, Inc. the American Medical Association, the FDS, other regulatory bodies, the United States Agency for Health Research Quality, the American College of Physicians, various medical societies and other technology assessment entities. MTAC decisions are reviewed by the EMPC, the NQMOC, and Health Plan PAS committee.

2. Care Management

The Health Plan has a care management program that is comprehensive, evidence-based and focuses on high cost/complex, and catastrophic conditions. Personal contact is made via telephone or by home visit. Assessment and care planning are conducted collaboratively with the member and his/her physician. Care managers (CMs) are available for in-bound and out-bound calls during business hours.

The process of care management begins with identification of high-cost/complex individuals who meet the criteria for and can benefit from care management services.

Health risk assessments are conducted. The CM develops a care plan that will facilitate communication and coordination between the member, family and the health care team. The member and the family are involved in the decision making process to minimize disruption in the health care plan. The Health Plan educates the member and other members of the health care team about care management services, treatment options and community resources so informed decisions are made. Care management interventions include the following: education, referral to appropriate community agencies, coordination of care, psychological support, and arrangement of transportation and monitoring of health care status until optimal health status is achieved.
Emergency Room Diversion (ERD) Program

The objective of the Health Plan ERD Program is to encourage the establishment of a medical home, proactive use of PCPs for most appropriate continuity of care and to decrease inappropriate use of the emergency room while maintaining the prudent layperson standards. Utilization Management initiatives include:

a. Work with high volume ERs to collaborate on reduction in inappropriate utilization
b. Transition more PCPs to new PCP reimbursement model to increase physician incentive to improve member access
c. Develop PCP specific provider profiling reports relative to members ER utilization and review reports with PCP quarterly
d. Develop ER specific reporting and relationships to impact frequent utilizers of regional ERs
e. Initiate non-essential drug coordination program to reduce polypharmacy and non-emergent ER rate by locking non-essential drugs for members who meet criteria.
f. 24/7 NurseLine to answer questions and assist members needing advise or assistance

The Health Plan also has a member outreach component of the ERD. Members are enrolled in Care Management when they meet a predetermined threshold for Emergency Department visits.

Goal: Reduce inappropriate utilization of emergency room services.

a. Reduce ER visits per 1000 per year
b. Reduce ER costs PMPM.

ERD Outreach Interventions:

a. Send written notification of the member’s enrollment into the program to the PCP.
b. Contact the member to ensure the member knows who his/her PCP is, understands the role of his/her PCP in providing primary care, and redirect the member to the PCP for primary care.
c. Send the member a notification letter from the outreach specialist.
d. Offer ancillary services such as education, transportation and community support services.
e. Assess whether the over-utilization is due to an access issue, quality issue, or coordination of care issue with the PCP.
f. Refer any member who has ongoing needs or chronic health conditions that require health management services to care/disease management.
g. Send each member identified as high ER utilizing a packet of information that includes:
3. **High Risk Obstetrical/Healthy First Steps**

The Healthy First Steps Program ensures a proactive integrated delivery of a member’s care throughout her pregnancy. The obstetrical (OB) team is responsible for coordinating a member’s care from the onset of pregnancy, through delivery, and their postpartum checkup. This integrated system is efficient and comprehensive for both members and providers. From the onset of pregnancy, providers contact one individual who can assist with all their needs. This approach enables the team to capture high-risk pregnancies early and immediately refer to the OB care manager. Further, members who are hospitalized during their pregnancy will work with their OB care manager, therefore, ensuring a continuity of care after discharge. The OB Inpatient care manager is involved with concurrent review and provides handoff to the member’s care manager upon the member’s discharge. Additionally, the care manager follows the mother of NICU babies after delivery through the 8 week postpartum period. An NICU care manager begins following that NICU baby while still in NICU and contacts the mother to make her aware of the care management that will follow the baby. The OB care manager is involved with concurrent review as well as care management activities. Additionally, the care manager follows NICU cases after delivery, ensuring continuity of care, discharge planning, and referrals as needed to the pediatric care manager.

The ultimate goal is to ensure the highest quality of care for our pregnant members and to facilitate a proactive approach to promoting health pregnancies:

The Health Plan implemented a high risk prenatal program to identify all pregnant members with risk factors proactively and provide care management in order to achieve optimal birth outcomes. Several mechanisms are used to identify those members at risk such as, Health Risk Assessments (HRA), Emergency room report, utilization management and the daily census.

A dedicated OB care manager with extensive experience in obstetrics will contact all identified high risk pregnant members to confirm the level of risk and target contact frequency. A pregnancy is considered high risk when a risk factor is identified for a preterm delivery or a poor pregnancy outcome due to medical, nutritional, psychosocial or compliance issues. Members are contacted as often as necessary, but minimally care managers make monthly telephone contacts with these members. Member education and outreach is an important part of the prenatal program. Members are educated regarding
the importance of timely prenatal care during the initial assessment and when follow-up contact is made. Members are educated on the avoidance of drugs, alcohol, smoking, and also preterm labor signs and symptoms. The prenatal care manager makes referrals to educational or community resources for those members identified with needs. Members receive a welcome to care management letter which includes the prenatal care manager’s name and phone number, a brochure describing the Healthy First Steps program and a TENNderCare brochure. Members receive free transportation to all medical appointments and to the pharmacy. The Health Plan partners with OB-specialized vendors to provide services for members in the home setting when appropriate.

The OB care manager makes every effort to work closely with the member’s obstetrician to support the treatment plan and coordinate any necessary care. The prenatal care manager educates providers about the services offered to their patients.

Providers are encouraged to refer high risk pregnant members to the program as well as those members who exhibit non-compliant behavior.

Postpartum contacts are attempted on all members who were in care management and for those members who had a complicated pregnancy. Members receive a postpartum letter encouraging follow-up visits for mom and for the newborn. The letter also encourages immediate contact with the OB provider for any physical or emotional concerns. The phone assessment attempts to educate the member on the importance of the 6 weeks postpartum visit, the newborn visit with the pediatrician, and possible referral to Member Service if pediatrician assignment wasn’t done prior to delivery. Members receive a postpartum packet that includes an immunization schedule, information about lead level testing and a TENNderCare brochure. A referral to the pediatric care manager is made if the infant needs additional services or coordination of care.

4. **Long Term Services and Supports (LTSS)**

The TennCare CHOICES Program was implemented in Middle Tennessee on March 1, 2010 and East and West Tennessee on August 1, 2010.

The program goals of the program include the following:

a. Improving access to LTSS services
b. Expediting the process for enrollment to LTSS services
c. Enhancing and increasing the Home and Community Based Services available to members
d. Integrating the primary, acute, LTSS and behavioral services for Medicaid members
e. Developing community based alternatives that allow members to age at home, including adult care homes, HCBS in rural communities, adult day care facilities, and,
f. Modifying nursing home admission criteria to encourage members to stay at home longer with community support services

The State makes the enrollment determinations for LTSS CHOICES members. Members can be assigned to Group 1 – receiving nursing facility services; Group 2 receiving home and community based services but qualify for nursing facility level of Care or Group 3 – receiving home and community based services as an “at risk” category. Each member is assigned to a Care Coordinator to assess and develop a plan of care through face to face assessments.

The Quality improvement program includes, but is not limited to, investigation, tracking, and trending of quality of care, quality of service, and critical incidents as well as performance improvement projects.

H. Confidentiality

The Health Plan is committed to preserving the confidentiality of its members and practitioners and strictly adheres to the United Health Group Integrity and Compliance standards. Written corporate and departmental policies and procedures are in place to ensure the confidentiality of patient information, protected health information (PHI) and medical records. Patient information (PHI) gathered to facilitate utilization reviews and claims administration is available only for the purposes of review and is maintained in a confidential manner. Records requested from practitioner and providers are those, which will provide relevant information to complete reviews or facilitate adjudication of claims. Education includes appropriate storage and disposal of confidential information. Documents of a sensitive or confidential nature are shredded prior to disposal.

Chapter 6 – Annual Oversight

Communication

Various mechanisms communicate QI Program activities and communicate the availability of the QI Program Description and reports on the health plan’s progress in meeting its goals. These mechanisms include but are not limited to:

1. Board of Director reports
2. Committee reporting; specific, summary and feedback
3. Member, provider newsletters and internet portals
4. Member and Provider Handbooks
5. Regulatory body reports and surveys
6. Staff meetings, employee communication materials and intranet portals

The Health Plan informs practitioners and providers about the QI Program and its progress toward meeting goals; improvement activities, and utilization and care management policies, activities, and results of surveys and studies at least annually through the Provider Manual, the Provider Newsletters, provider training, on-site training, mailings, and one-on-one discussions with Medical Directors. Feedback to practitioners and providers about individual performance (such as record reviews, complaints, profile information, or peer review decisions) is given by face-to-face discussions and direct mailings to the practitioner or provider. Members are informed of the QI Program and progress towards meeting goals; improvement activities; and results of surveys and studies at least annually through the Member Manual and Member Newsletters. Information is communicated to staff members during new employee orientation, at departmental staff meetings, and designated committee meetings.

Delegation

Currently, the Health Plan delegates the quality functions of credentialing and prior authorization of radiology services. When Quality Improvement delegates any Health Plan activity to another organization the Health Plan evaluates the organization’s capacity to perform the proposed delegated activities prior to entering into a delegation agreement. Document(s) to be reviewed may include, but are not limited to:

1. The formal, written contract or description of delegated activities
2. The delegated organization’s Program Description and Work Plan
3. The delegated organization’s Annual Evaluation
4. The delegated organization’s pertinent policies and procedures
5. Appropriate activity reports, files, or committee minutes regarding the delegated activity for the past 12-24 months.

If the assessment results in a mutually agreed upon delegation agreement, the Health Plan will obtain regulatory approval from the State and CMS as appropriate prior to implementation. The organization will provide periodic reports no less than annually to the Health Plan. At least annually, the Health Plan will assess the organization performance of delegated activities against expectations. The Health Plan may request corrective action plans at any time to address deficiencies in the delegated organization’s performance, and retains authority to rescind the delegation agreement at any time.

Annual Evaluation

An annual evaluation of the QI Program is conducted to assess the overall effectiveness of the Health Plan’s quality improvement processes. The evaluation reviews all aspects of the Program Work Plan, focusing on whether the Program has
demonstrated improvements in the quality of care and service provided to members.

The annual evaluation includes:
1. An assessment of goals and objectives for each activity were met
2. A review of human and technological resources
3. A summary of all quality improvement activities performed during the year
4. Reports for each Quality/Performance Improvement Project.
5. The impact and effectiveness the QI process had on improving the care and service provided to members
6. Trends and related improvement activities
7. Potential and actual barriers to achieving our goals
8. Recommendations for QI Program and QI Work Plan revisions, rationale and timelines

The annual evaluation is reviewed and approved by the QMC and the Board of Directors. The results of the annual evaluation are used to develop and prioritize the next year’s annual QI Work Plan. Annual Health Plan evaluation reports are submitted to the State or Federal agencies as required.

**Annual Work Plan**

The Annual Work Plan focuses on QI Program goals, objectives, and planned projects for the upcoming year. The QI Work Plan includes specific tasks, responsible owners of activities and anticipated time frames for completion. It serves as the road map to reflect a coordinated strategy to implement the QI Program including planning, decision-making, interventions, assessment of results and achievement of the desired improvements. The Board of Directors and the QMC approve the QI Evaluation as well as the QI Work Plan based on the QI Program Description. The QI Work Plan is a living document with periodic updates expected as a result of interim project findings and reports. Updates to the QI Work Plan are reviewed and approved by the COS, QMC, and are submitted to the State or Federal agencies as required and/or when substantial changes are made.

The annual QI Work Plan specifically addresses the following:
1. Quality of clinical care
2. Quality of service
3. Safety of clinical care
4. Program scope
5. Yearly objectives
6. Yearly planned activities
7. Time frame within which each activity is to be achieved
8. The staff member responsible for each activity
9. Monitoring previously identified issues
10. Evaluation of the QI program

**Policies and Procedures**
National and Health Plan policies are reviewed annually and are available to all Health Plan employees through a shared online source.

**Data Sources**

Data to support the Quality Improvement Program is obtained through many sources including but not limited to:

1. **Facets Claims System**: Houses eligibility, claims and encounter data and feeds into the data warehouse.
2. **Macess**: Supports customer service interactions and the electronic routing of information throughout the Health Plan.
3. **Data Warehouse**: Houses data from Facets, pharmacy data, etc. in a format which allows utilization of proprietary systems to assist with disease management programs, physician profiling tools, prevention and wellness as well as utilization trending.
4. **SMART**: Is a data mining tool which allows staff to easily and accurately configure reports regarding Health Plan data and utilization.
5. **ImpactPro**: Incorporates the utilization experience of all UHG plans to provide more accurate predictive modeling and risk stratification of at-risk members for care and disease management programs.
6. **Adjusted Clinical Groups® (ACG)** - is a statistically valid, diagnosis-based, case-mix methodology that allows healthcare providers, health plans, and public-sector agencies to describe or predict a population’s past or future healthcare utilization and costs.
7. **Business Objects**: Is a data mining tool used by staff to create accurate member level reporting and mailing lists for outreach activities.
8. **Utilization Tracking Database (UTD)**: Is used to accurately track physician performance against prevention and wellness requirements and the best practices for the management of diseases such as diabetes, heart failure and asthma. Specific listings of overdue screenings and tests may be generated for practitioners. The UTD allows an entire family to be viewed by Health Plan staff conducting outreach calls.
9. **CareOne**: Is our clinical information system housing medical and behavioral health data. This is an excellent tool for managing member care holistically. A complete history of inpatient and outpatient history and clinical notes are available to care managers to better assist members. The tool allows clinical staff to establish tasks for themselves or others and keeps care and disease management staff working in concert.
10. **VIPS/Med Measures**: Is used for profile data and HEDIS®
11. **National Committee for Quality Assurance – Quality Compass®** comparative data is utilized when setting benchmarks and performance goals.
12. **State Agencies** – Data from the State of Tennessee are utilized to supplement Health Plan data.
Confidentiality

The Health Plan maintains confidentiality policies, and no voluntary disclosure of peer review information is made except to persons authorized to receive such information to conduct QI activities. Information is strictly confidential and is not considered discoverable under state and federal peer review laws.

The Health Plan adheres to HIPAA and the American Recovery and Reinvestment Act of 2009 (ARRA) Regulations. No voluntary disclosure of identifiable member information or Personal Health Information (PHI) is made without obtaining prior consent from the member except as required by law. Member information is used only as necessary to meet the administrative and legal obligations of the Health Plan.

The data used in the QI Program are maintained in a confidential manner using codes and summary information. Only those persons who require information to perform corrective action(s) are given access to identifiers. Committee records are available only to authorized personnel in accordance with local, state, federal, and other regulatory agencies. Each external committee participant must agree to comply with these confidentiality policies and sign a Committee Member Confidentiality Statement.
Appendices

Quality Management Work Plan
HEDIS®, Clinical Performance Work Plan

Glossary

The following abbreviations are used in this document:

- CAHPS: Consumer Assessment of Healthcare Providers and Systems
- CC: Credentialing Committee (OHBS)
- CCC: Compliance Committee
- CCC: Cultural Competency Subcommittee
- CCIP: Chronic Care Improvement Program
- CMO: Chief Medical Officer
- CMS: Centers for Medicaid and Medicare Services
- CNS: Clinical Network Services (Behavioral Health)
- COS: Clinical Operations Subcommittee
- CPC: Clinical Practice Consultant
- CQI: Continuous Quality Improvement
- DIDD: Department of Intellectual and Developmental Disabilities
- EMPC: Executive Medical Policy Committee
- EPSDT: Early and Periodic Screening Diagnosis and Treatment program (TENNderCare)
- ICM: Inpatient Care Managers
- IRR: Inter-Rater Reliability
- JOC: Joint Operating Committee
- MDT: Multi-Disciplinary Teams
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<thead>
<tr>
<th>Abbreviation</th>
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<td>MM</td>
<td>Medical Management</td>
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<td>Medical Record Review</td>
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<td>Medical Technology Assessment Committee (United)</td>
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<td>National Credentialing Center (Medical)</td>
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<td>Optum Health Behavioral Services</td>
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<td>Provider Affairs Subcommittee</td>
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<td>Plan, Do, Study, Act quality improvement cycle</td>
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APPROVALS

__________________________________________________________  Date:__________________
Scott Bowers  
President  
UnitedHealthcare Community Plan, TN

__________________________________________________________  Date:__________________
David O. Hollis, M.D.  
Chief Medical Officer  
UnitedHealthcare Community Plan, TN

__________________________________________________________  Date:__________________
David O. Hollis, M.D.  
Chair, Quality Management Committee  
UnitedHealthcare Community Plan,TN

__________________________________________________________  Date:__________________
{Insert Name}  
Chair, Board of Directors  
UnitedHealthcare Plan of the River Valley, Inc.