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

2013 Quality Improvement Program Description

Presented to Board of Directors: 3-25-2013
Presented to QMC: 3-27-2013

Confidential

UnitedHealthcare Plan of the River Valley, Inc.

United Healthcare Community Plan, Tennessee

QI Program Description
For QM/UM
2013

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UnitedHealthcare Plan of the River Valley, Inc.

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2013 QI Program Description
For QM/UM

I. INTRODUCTION AND BACKGROUND

UnitedHealthcare Plan of the River Valley, Inc., dba UnitedHealthcare Community and State is a state government program business unit and a UnitedHealth Group business segment focused on public health programs. UnitedHealthcare Plan of the River Valley, Inc. has been contracted with the State of Tennessee, Bureau of TennCare since April 1, 2007 to serve Tennessee's Medicaid population and to address 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. Our DBA in the State is UnitedHealthcare Community Plan and will be referred to in this document going forward as "UHCCP" or "The Health Plan".

The Health Plan manages three separate contracts with the Bureau of TennCare, one for each of the three Tennessee regions. Each contract includes both non CHOICES and CHOICES Membership. The Long Term Services and Supports (LTSS) benefit 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 new category, Group 3, was added July 1, 2012 when the criterion for nursing home placement was changed. Group 3 includes members who do not qualify for Nursing Home placement according to the new criteria but whom, 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 17,128 members in CHOICES. 6,110 of CHOICES members receive Home and Community Based Services (HCBS). 5,166 CHOICES members are in Group 2 and 944 are in Group 3. 11,018 CHOICES members reside in nursing facilities.

The Health Plan currently serves approximately 553,432 non CHOICES TennCare Members. 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. Behavioral health services, which include mental health and substance abuse, are administered by OptumHealth Behavioral Solutions (OHBS), a sister company. 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. Our Health Plan committees are integrated with representation

from medical, behavioral and LTSS as appropriate. To maintain consistency, the Chief Medical Officer for Behavioral Health is involved in implementation of the behavioral health aspects of our Quality Improvement (QI) Program and reports to the Chief Medical Officer for Medical Health. 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.

The Health Plan uses a single system, CareOne, for clinical documentation of all one-on-one interactions with members whether for medical, behavioral or long term services and supports services. All clinical documentation related to utilization management, case management, chronic care management, high level health risk management and care coordination is included. 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.

Other services coordinated by UHCCP include the following:

Service Type	Administered by:	Contracted with:
Dental	DentaQuest	Direct contract with TennCare
Pharmacy	Magellan Health Services	Direct contract with TennCare
Vision	March Vision	Contracted with UHCCP, TN

UHCCP coordinates dental services for TennCare members who are <21 years of age using the services administered by DentaQuest, 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 are coordinated through Magellan Health Services, a Pharmacy Benefit Management (PBM) company which has a direct contract with the State of Tennessee

The Quality Improvement (QI) Program, hereafter referred to as the Program, is designed to objectively monitor, systematically evaluate, and effectively improve the quality and safety of clinical care and quality of services provided to its TennCare members. This Program describes activities of the UnitedHealthcare Community Plan (UHCCP), in Tennessee, and includes medical and behavioral health activities for all three regions, West, Middle and East plus CHOICES.

This Program describes the coordinated and collaborative activities and initiatives of UHCCP to provide the services necessary to meet the needs of its members and to continuously improve physical and behavioral health care outcomes**.** The Program's monitoring extends to both delegated and non-delegated activities/functions.

UnitedHealthcare Community Plan includes a medical network of providers under contract to deliver quality services, including access and availability, as follows by service area:

	East	Middle	West
Practitioners	5330	4548	2919
Hospitals	53	52	51
Facilities	629	615	390

Our TennCare behavioral health providers by service area are as follows:

	East	Middle	West
Practitioners (Clinicians)	852	844	413
Inpatient Hospitals	15	14	11
Facilities	41	71	49

UnitedHealthcare Community Plan includes the following CHOICES providers by service area:

1. East - approximately 107 Nursing Facilities and 1 (change in ownership) additional contract currently in process, 177 HCBS Providers, including Assisted Living Facilities with 5 additional contracts currently in process (some of the contracts are amendments to add additional services).
2. Middle - approximately 101 Nursing Facilities and 1 additional new contract currently in process, 213 HCBS Providers, including Assisted Living Facilities with 6 additional contracts currently in process (some of the contracts are amendments to add additional services).
3. West - approximately 82 Nursing Facilities and 1(change in ownership) additional contract currently in process, 134 HCBS Providers including Assisted Living Facilities with 7 (6 new plus 1 change in ownership) additional contracts currently in process (some of the contracts are amendments to add additional services.

Quality Improvement Program Documents

The QI Program Description and QI Work Plan promote effective coordination of quality improvement activities with all appropriate functional areas, including, but not limited to: Clinical Operations, United Clinical Services (UCS), Customer Service, Appeals and Grievance, Population Health Management, Network Management, Quality Management

and Performance, Pharmacy, Clinical Analytics, Legal, Regulatory, Claims, and Credentialing.

The QI Work Plan identifies planned activities related to program priorities that address the quality and safety of clinical care and service. Action steps include target dates for completion and identification of responsible oversight committees. Monitoring activities include tracking and trending of identified issues and planned interventions. The Work Plan is reviewed at least bi-annually by the Quality Management Committee, (QMC).

Evaluation of the overall effectiveness of the QI Program is conducted annually to determine how well resources have been deployed to improve the quality and safety of clinical care and service provided to members. The QI Evaluation addresses all aspects of the quality improvement process as outlined in the Program and is presented to the Quality Management Committee and to the Boards of Directors (BOD) for approval.

II. UNITEDHEALTHCARE'S MISSION AND VALUES

Mission: UnitedHealthcare's (UHC) mission is to help people live healthier lives. Our role is to make health care work for everyone. Our collective leadership will guide the way forward.

Values: Collectively we can move forward to realizing our role by living our values with:

1. **Integrity –** Honor commitments. Never compromise ethics.
2. **Compassion** – Walk in the shoes of the people we serve and those with whom we work
3. **Relationships –** Build trust through collaboration
4. **Innovation** – Invent the future, learn from the past
5. **Performance –** Demonstrate excellence in everything we do

Community and State Vision: To be the premier state & public health care delivery organization in the eyes of our customers. To be the plan of choice for governments seeking innovative partners to manage their underserved populations; for Members seeking a Health Plan that is attentive and sensitive to their needs; and among providers seeking an effective partner in serving their patients.

III. GOALS AND OBJECTIVES

UnitedHealthcare, UHC, strives to continuously improve the quality of care and service provided by our health care delivery system both from the clinical and non-clinical perspective. The Quality Improvement (QI) Program establishes goals and objectives that encompass the quality improvement activities across the markets we serve. The 2013 goals and objectives include:

A. Promote and incorporate quality into the Health Plan's organizational structure and processes.

1. Facilitate a partnership between customers, practitioners, providers and Health Plan staff for the continuous improvement of quality health care delivery.
2. Continuously improve communication and education in support of these efforts.
3. Consider and facilitate achievement of public health goals in the areas of health promotion, early detection, treatment and end of life care.

B. Provide effective monitoring and evaluation of patient care and services provided by contracted practitioners/providers as compared to the requirements of evidence based medicine.

1. Evaluate and disseminate clinical and preventive practice guidelines.
2. Monitor performance of practitioners and providers against evidence-based medicine.
3. Develop guidelines for quality improvement activities (e.g. access and availability, credentialing/recredentialing and peer review).
4. Conduct and analyze data such as CAHPS®[1] and HEDIS®[2], develop programs to improve satisfaction and preventive services as identified.
5. Provide complex case management, chronic care management and health risk management programs that improve the quality of life for chronically ill members.

C. Ensure prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up.

1. Implement and conduct continuous quality and performance improvement as opportunities are identified through analysis.
2. Identify and monitor important aspects of, problems with, and concerns about health care services provided to members.
3. Identify and analyze existence of significant health care disparities in clinical areas.
4. Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language specific risks.
5. Provide ongoing feedback to Health Plan customers and practitioners regarding the measurement and outcome of quality improvement activities.

D. Coordinate quality improvement, risk management, patient safety and operational activities.

[1] CAHPS ®is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

1. Aggregate and use data to identify potential gaps, opportunities for improvement and for the development of quality improvement activities.
2. Develop and implement a consistent process, by which risk management and patient safety are included in the development of quality improvement initiatives.
3. Monitor key aspects of patient safety, identify opportunities and develop programs to promote safe patient care.

E. Maintain compliance with local, state and federal regulatory requirements and accreditation standards.

1. Monitor compliance with regulatory requirements for quality improvement opportunities and respond as needed.
2. Ensure that reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies.

F. Serve culturally and linguistically diverse populations

UnitedHealth Group has made a commitment to enterprise wide improvements based on the needs of our changing member population. These improvements are expected to reduce health disparities by establishing the foundation for multicultural population stratification, understanding of health care needs across multicultural populations, driving/enforcing a patient centered approach and reducing health disparities across multicultural populations. Goals include:

1. Enhance the spectrum of clinical programs to meet the diverse needs of our members
2. Accelerate growth in multicultural markets as well as to understand the needs of the multicultural markets and modify programs and materials as needed.
3. Provide culturally competent member services and materials and ensure parity in access to quality care for all populations

G. Serve members with complex health needs

The core of high risk case management (HRCM) focuses on identifying high-cost, complex, at risk individuals who meet criteria for and can benefit from Case Management (CM) services. The emphasis is placed on improved outcomes through development of partnerships with individuals to facilitate health care access and decisions that can have dramatic impact on the quality and affordability of their health care. Goals of the HRCM program are to achieve the following objectives for consumers, clients and providers:

1. Improve the health outcomes and satisfaction of consumers.
2. Ensure appropriate, quality and cost effective healthcare services to all consumes participating in CM.
3. Ensure quality of care issues are identified, acted upon and resolved.

4. Ensure professional and competent CM staff resources.
5. Ensure compliance with state/federal regulations and accreditation agency standards.

In addition to HRCM programs, UHC offers additional programs for members with complex medical needs such as the Transplant Solutions Program and Private Duty Nursing.

IV. SCOPE OF QUALITY IMPROVEMENT PROGRAM

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

In order to fulfill the goals and objectives of the QI Program and effectively use resources, the Program is integrated into all the activities of UHCCP including our Population Health Program. This includes, but is not limited to, interactions with OptumHealth for High Risk Case Management, Chronic Care Management, Care Coordination (medical) and Maternal and Child Health, OptumHealth Behavioral Services for Behavioral Health High Risk Case Management and Care Coordination, OptumHealth Specialized Solutions for High Level Health Risk Management, Long Term Services and Supports, Preventive Health Services and TENNderCare Services for Wellness, Network Management, National Credentialing Center (NCC), Behavioral Solutions Network Services (BSNS), Compliance, UCS, and Operations (Claims, Customer Care and Clinical Services Appeals (CSA)). Special attention is given to high volume, high risk areas of care and service for each population. Health promotion, health management and patient safety activities are also an integral part of the QI Program and are specialized according to regulatory requirement, population needs and delivery models within each of the service models.

Program activities include but are not limited to the following:

1. Measure performance against key monitors for quality improvement as identified by the Program and activities identified in the QI Work Plan.
2. Review of the quality and utilization of clinical care and service, including inpatient and outpatient care provided by hospitals, practitioners and ancillary providers.
3. Analyze, identify and address continuity and coordination of care.
4. Analyze, identify and address areas that will improve patient safety.
5. Analyze, identify and address member and practitioner satisfaction information.
6. Analyze, identify and address access to and availability of care.
7. Analyze, identify and address the effectiveness of complex case management.

8. Develop programs to address culturally and linguistically diverse membership needs.
9. Monitor activities related to home and community-based services for long term care.

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.

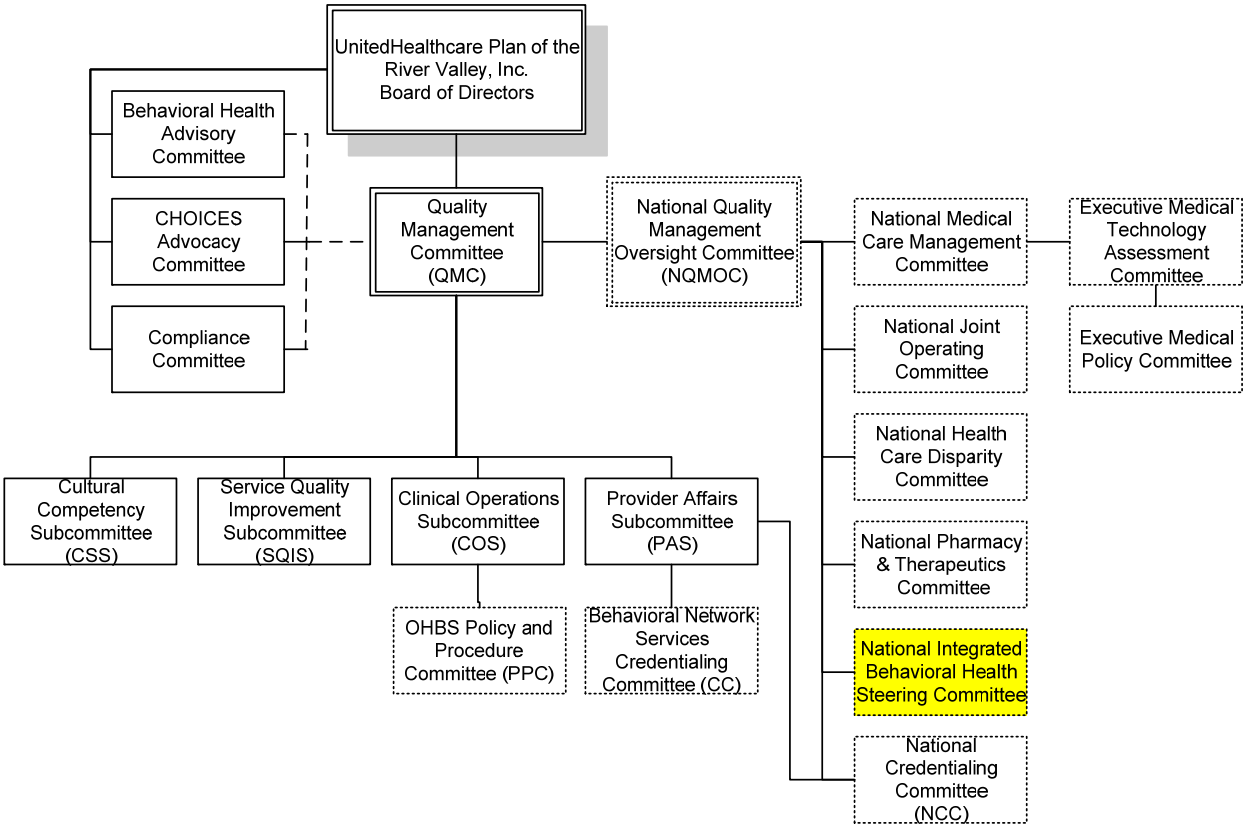
Utilization Management Summary

The Quality Improvement Program Description describes and guides implementation of the company's utilization management program, which integrates utilization functions—prior authorization, Population Health, 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 for Physical health , the Chief Medical Officer for Behavioral Health and the Medical Director for Long Term Services and Supports.

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, Inc. Board of Directors. Utilization Management and Population Health 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 Plan of the River Valley, Inc. Board of Directors.

The QI Program coordinates with Utilization Management, High Risk Case Management, Chronic Care Management, Maternity Management, Health Risk Management, Care Coordination and Wellness 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 (CQI) concept, 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.

V. PROGRAM ACCOUNTABILITY AND OVERSIGHT
Quality Improvement Committees



Health Plan Committee Descriptions

The Board of Directors has ultimate responsibility for the Quality Improvement Program and related processes and activities. The Board of Directors has designated to the NQMOC and the local QMC responsibility for oversight of the quality activities related to the medical, behavioral health and long term care of UHCCP members.

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. Responsible for medical, behavioral health, and long-term care management governance: Review and approve the QI/UM Program Descriptions and Work Plan and the Population Health Program Description annually.
2. Annually review and approve the Final QI Evaluation

3. Provide feedback and recommendations to the Quality Management Committee (QMC);
4. Oversee recommendations made to the QMC;
5. Demonstrate senior level commitment to the quality of medical, behavioral health, and long-term care delivered to UHCCP members;
6. Provide feedback and recommendations to QMC.

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 UHCCP 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 Provider 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 designated the Quality Management Committee (QMC) to oversee quality activities related to the medical, behavioral health, and long-term care of UHCCP members. This includes but is not limited to the continuous improvement of the quality of medical, behavioral health, and long-term care and service delivered to members, ongoing monitoring, evaluation, and education of health care delivery processes.

The QMC is also accountable to the UHCCP Executive Management Team. The Executive Management Team provides feedback and recommendations to the QM Committee and demonstrates a senior level commitment to the quality of medical, behavioral health, and long-term care delivered to the UHC RV/UHCCP members.

The QMC communicates initiatives to its subcommittees and receives regular reports from the subcommittees, as well as Committees that have an indirect reporting relationship to the QMC. The QMC monitors activities from entities conducting medical, behavioral health, and long-term care activities including all the components identified in the scope of the QM/UM, CM, and Population Health Program descriptions and Work Plan.

Subcommittees that report to the QMC include:
1. Provider Affairs Subcommittee (PAS)
2. Service Quality Improvement Subcommittee (COS)
3. Cultural Competency Subcommittee (CCS)
4. Clinical Operations Subcommittee (COS)

Committees that indirectly report to the QMC, but have a direct reporting relationship to the Board of Directors:
1. Compliance Committee (CC)
2. Behavioral Health Advisory Committee (BHAC)
3. CHOICES Advisory Committee (CAC)

The responsibilities of the QMC are:
1. Review, give direction, and approve the QM/UM, CM, and Population Health Program and Policies and Procedures annually;
2. Recommend policy decisions;

3. Analyze and evaluate the results of QI activities;
4. Ensure practitioner participation in the QM/UM, CM, and Population Health Program through planning, design, implementation or review;
5. Oversee and approve the Program, Work Plan, Quarterly Work Plan Reports and Final Evaluation, the Committee will submit documents to the Board of Directors.
6. Communicate the annual Program, Work Plan, and Final Evaluation to its subcommittees and the Board of Directors and participating network physicians as requested;
7. Review regular standing reports/minutes from subcommittees to ensure coordination, linkage, and integration of medical, behavioral health and long-term care activities;
8. Review and recommend actions based on aggregated and trended information regarding members' complaints/grievances, member satisfaction surveys, clinical care and service initiatives, medical/behavioral health care management initiatives, member access and availability, and provider satisfaction;
9. Review delegated entity activities related to quality management, utilization management, credentialing, and member services to ensure that NCQA, state, federal, and contractual requirements are met. Make recommendations of approval or denial for delegate agencies.
10. Monitor all subcommittee work (PAS, SQIS, COS) via quarterly summary reports;
11. Monitor the cultural/ ethnicity needs of the membership;
12. Ensure compliance with regulatory requirements and accrediting agencies;
13. Provide oversight to applicable United Health Group Business Partners
14. Provide program direction and continuous oversight of QI 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 recredentialing.
15. Evaluate, at least annually, the impact and effectiveness of Medicaid specific Performance Improvement Projects (PIPs) and recommend changes as necessary.
16. Report annually or more frequently as needed, on Health Plan quality activities to the Board of Directors.
17. 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.
18. Review reports and recommendations from other national and Health Plan QI subcommittees, act upon recommendations as appropriate and provide feedback, follow-up and direction to the committees.
19. Ensure compliance with regulatory requirements and accrediting organizations.
20. Provide local delegation oversight as specified by State regulatory requirements.

21. Recommend appropriate resources in support of prioritized activities.

Voting membership is appointed by the Committee Chairperson, and will include but not be limited to the following:

1. Committee Chairperson, Chief Medical Officer Medical Health
2. Chief Medical Officer for Behavioral Health
3. Health Plan Chief Financial Officer
4. Health Services Associate Medical Director
5. Vice Presidents; Health Services
6. Behavioral Health Vice President
7. Behavioral Health Clinical Director
8. Health Plan Vice President; Operations
9. Health Plan Compliance Officer
10. Long-term Care Services, Director
11. Long-term Care Services, Medical Director
12. Pharmacy Services Representation
13. Senior Director Quality Management
14. A minimum of three community-based actively practicing network practitioners who represent medical, behavioral health, and long-term care.

Non-voting members who assist with committee discussion include, but are not limited to:

1. Quality Management Director
2. Quality Manager

Ad hoc support staff may from time to time attend meetings as needed, but will not have voting privileges.

In order for a practitioner to be appointed as a voting member on the QM C, he/she must meet the following requirements:

1. Signed UHC RV/UHCCP provider contract
2. Board certification or board eligible in his/her specialty
3. Approved through National Credentialing Center or United Behavioral Health credentialing process

A QMC member must abstain from voting on an issue if he/she feels there is a conflict of interest, has been professionally involved with the issue and/or individual in question, or feels his/her judgment may be otherwise compromised The community-based practitioner voting membership will serve a term of not more than four years. Extended terms may occur at the discretion of the Chief Medical Officer. Termination of members is at the discretion of the Chief Medical Officer.

The Quality Management Committee reports to the Board of Directors and is chaired by the Chief Medical Officer or designee unless otherwise directed by the Board of Directors. A minimum of 51% of the voting membership constitutes a quorum. Members may designate surrogate attendees with voting privileges. The Quality Management Committee meets at least quarterly or as otherwise deemed necessary by the QMC or the Board of Directors. 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 purpose of the Provider Affairs Subcommittee (PAS) is to promote the appropriateness of medical, behavioral health, and long term care services delivered to members. PAS is responsible for evaluating the quality, continuity, integration of care, accessibility, availability and cost-effectiveness of the medical and behavioral health care rendered within the network, as well as peer review activities. PAS is a mechanism by which network practitioners can interact on a regular basis and discuss issues relevant to medical, behavioral health and long term care management, utilization management, case management, quality management, Population Health, and pharmacy issues. PAS offers medical, behavioral health, and long term care input into the development of clinical programs, adoption of clinical guidelines, and utilization criteria.
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 Chief Medical Officer. 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 responsibilities of the PAS include but are not limited to:

1. Offer medical, behavioral, and long term care health input into the development of Population Health programs, approval of clinical guidelines, and utilization criteria;
2. Serve as a reference and medical/behavioral health/long term care consultant for quality improvement studies, preventive medicine guidelines, and medical/behavioral health/long term care utilization and pharmacy management issues;
3. Offer input into design of programs to assure integration and continuity of medical, behavioral health, and long term care services;
4. Participate in the development of quality targets and measures relevant to the membership;
5. Provide a mechanism to educate and obtain input from network practitioners to ensure consistent decision-making;
6. Coordinate, monitor, integrate, recommend actions, and provide feedback to the local practitioner community on medical, behavioral health, and

long term care management processes for utilization management, case management, pharmacy, quality activities, HEDIS results, over/under utilization, and continuity/coordination of health care;
7. Conduct and/or review barrier analysis for medical/behavioral health/long term care clinical issues and develop appropriate interventions;
8. Review data regarding quality of care complaints, identify trends and recommend corrective actions, as needed;
9. Review corporate Medical Technology Assessment Committee and UnitedHealthcare Technology Assessment Group Committee decisions and make recommendations, as needed;
10. Conduct peer review evaluations, to include quality of care and provider appeals, as needed;
11. Review and make recommendations relating to Credentialing/Recredentialing Plan;
12. Maintain ultimate decision authority for the credentialing and recredentialing of practitioners and facilities;
13. Make decisions related to quality of care issues, complaints and grievances, sanctions, etc. and monitor for potential quality of care trends;
14. Review reports on mortality and inpatient quality issues; and
15. Reviews reports on provider satisfaction and offers input into action plans to address opportunities for improvement.

The voting membership of the Provider Affairs Subcommittee is composed of:
1. Chief Medical Officer for Physical Health or designee (Chair)
2. Chief Medical Officer for Behavioral Health
3. Medical Director for CHOICES
4. A minimum of seven (7) network primary care and specialty practitioners including behavioral health practitioners.

A PAS 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. For peer review evaluations the PAS must include at least one member of the involved party's specialty; thus, the Chairperson of the PAS may, from time to time, seek consultation from network physicians outside the Provider Affairs Subcommittee.

In order for a practitioner to be appointed as a voting member on the PAS, he/she must meet the following requirements:
1. Signed UHC RV/UnitedHealthcare Community Plan provider contract
2. Board certification or board eligible in his/her specialty
3. Approved through National Credentialing Center or United Behavioral Health credentialing process

Non-voting members
1. Medical Directors, Bureau of TennCare

2. Vice President; Health Services or designee
3. Vice President of Behavioral Health Services or designee
4. Health Services Directors of CM and UM, medical and behavioral health
5. Senior Director Quality Management
6. Behavioral Health Clinical Director or designee
7. Behavioral Health Quality Management Director
8. Health Services Quality Improvement Coordinator
9. Behavioral Health QI Specialist (QC/QS/Audits)
10. Long Term Care Executive Director
11. Long Term Care Clinical Director
12. Pharmacy Director, Southeast Region, or designee
13. Health Plan Compliance Officer
14. Ad hoc Medical and Behavioral Health support staff 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 PAS meets a minimum of eight times per year, or more frequently as needed. A minimum of 51% of committee membership constitutes a quorum. Non-credentialing peer review must include at least one member of the involved party's specialty; thus the Chairperson of the PAS may, from time to time, seek consultation from network physicians outside the Provider Affairs Subcommittee. The Chairperson of PAS presents summary reports of committee activities to the Quality Management Committee quarterly.

D. Clinical Operations Subcommittee (COS)

The Clinical Operations Subcommittee (COS) is a standing subcommittee established by the QMC. The COS oversees medical, behavioral health, and long term care services operational activities and reports – including UM, Population Health, EPSDT/TENNderCARE and HCAI activities and process/outcome improvement opportunity.

The COS shares responsibility with the Service Quality Improvement Subcommittee for monitoring of member and provider satisfaction with clinical operations programs. The Clinical Operations Committee is chaired by the Vice President of Health Services who has reporting responsibilities to and must be a voting member of the Quality Management Committee.

Responsibilities of the Clinical Operations Subcommittee include but are not limited to the following:
1. Oversee implementation of the Health Plan UM Program;

2. Review and approve UM performance metrics from all clinical areas, including behavioral health services. Monitor progress on clinical performance improvement programs;
3. Monitors integration/continuity/coordination between medical, behavioral health, and long term care and external agencies. Recommend improvement actions as indicated;
4. Monitors trends related to appeal activities;
5. Reviews and approves Health Services policies and procedures at least bi-annually;
6. Reviews and provides input into the QM/UM Program Description and Work Plan and the CM/ Population Health Program Description;
7. Reviews the Program Final Evaluation;
8. Reviews reports and provides input into related CM, UM, ICM, and Population Health and other medical, behavioral health, and long term care services functions;
9. Letter Compliance;
10. Reviews Clinical Quality Improvement Activities (QIAs) and Performance Improvement Projects (PIPs);
11. Review SOX Results and Trends;
12. Reviews staff Inter-rater Reliability;
13. Evaluate the consistency of the UM decision making process through inter-rater reliability reports;
14. Identify over- and under-utilization issues and recommend corrective actions as indicated;

Voting membership on the COS is appointed by the COS Chairperson, in collaboration with the Chief Medical Officer, but will include, at a minimum:

1. Health Services Associate Medical Director
2. Chief Medical Officers
3. Long Term Care Medical Director
4. Vice President of Health Services
5. Vice President of Behavioral Health (Co-Chairperson)
6. Health Services CM and UM Directors, medical and behavioral
7. Long Term Care Director
8. Senior Director QM
9. QM Director, Behavioral Health
10. Prevention, Wellness and Education Manager
11. Population Health Manager
12. Appeals Manager
13. Prior Authorization Nurse Manager

COS voting members 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. The COS Chairman may, from time to time, seek consultation from network physicians

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 Chairperson of COS presents a summary of committee activities to the Quality Management Committee quarterly.

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

E. Service Quality Improvement Subcommittee (SQIS)

The Service Quality Improvement Subcommittee is a standing committee established by the Quality Management Committee to oversee the quality of service delivered to members and providers. The SQIS functions to track, trend, and recommend improvement opportunities to monitor member and provider call center activities, access/availability, member and provider satisfaction, provider complaints and dispute activities, and marketing issues.

The Service Quality Improvement Subcommittee responsibilities include, but are not limited to:

1. Oversight of member and practitioner satisfaction activities and recommending interventions to improve member/practitioner satisfaction, including submitting improvement goals to the Quality Management Committee;
2. Monitoring of metrics and trends of provider complaints and dispute activities and recommend interventions;
3. Monitor trends related to member and provider call center activities and recommendation of improvement opportunities for services
4. Review access and availability reports and follow up actions from contracting review
5. Recommending of interventions to improve member access and availability to medical, behavioral health, and long term care practitioners and providers, as needed;
6. Development, evaluation, and completion of member and provider service quality improvement activities
7. Review and approval of Member Service and Network Management policies and procedures.

The membership of the SQIS is composed of:

1. Vice President of Operations (Chairperson)
2. Vice President of Account Management
3. Member Services Representative
4. Network Management Representatives (Medical, BH, and Long-term Care)

5. Quality Management Representatives
6. Community Outreach Representatives

Ad hoc Health Plan staff may from time to time attend and support committee discussion but will not have voting privileges.

A SQIS 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.

The SQIS meets at least 4 times per year and is chaired by the VP of Operations or designee. Members may designate surrogate attendees. A minimum of 51% of committee membership constitutes a quorum. The Chairperson of SQIS presents summary reports of committee activities to the Quality Management Committee quarterly.

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 has instituted the Principles of Ethics & Integrity ("Principles") adopted by UnitedHealth Group 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.

Report on at least a quarterly basis to the Quality Management Committee: (a) progress of implementation of the Program and Principles; (b) results of on-going monitoring, including internal audits; (c) summary of applicable regulatory changes; (d) summary of proposed changes to the Principles; and (e) summary of disciplinary actions resulting from Principles violations.

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 or Plan management.

Voting membership on the Compliance Committee is appointed by the CC Chairperson, in collaboration with the UnitedHealthcare Community & State corporate Chief Regulatory and Compliance Officer and will include, at a minimum, senior staff representing:

1. Health Services – Behavioral, Medical and Long Term Services and Support
2. Quality Management
3. Operations
4. Product Compliance
5. Legal

In addition to the members above, the Health Plan President will also be a voting member. A Compliance Committee 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.

The Compliance Committee meets at least quarterly or as often as needed and is chaired by the Health Plan Compliance Officer or designee. A quorum of the membership is necessary to conduct business. A quorum is defined as a minimum of 51% of the voting membership.

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

G. Cultural Competency Subcommittee (CCS)

The Cultural Competency Subcommittee is a standing subcommittee established by the Quality Management Committee. Its purpose is to foster a robust cultural competency program by identifying and eliminating 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, including annual required training for all Health Plan staff, for its achievement to provide a culturally competent work environment and an external service approach within manageable, but concrete timelines.

The subcommittee will also provide information, training and appropriate tools to staff and practitioners to support culturally competent communication.

The subcommittee will sponsor a project to identify a specific health care disparity to reduce. Measurement will be tracked year over year via HEDIS rates.

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 staff and education for providers who interact with members;
3. Determine cultural needs of our members based on information from community demographics, surveys, forums, and community leaders; Two reports are utilized, one from the data warehouse that is based on data from the 834 file and one from CareOne that is based on the self-reported race, ethnicity, language (REL) and disability data that is documented as

part of the REL and disability verification and data collection plan. The REL data collection plan serves as a method for validating the accuracy of the report from the data warehouse.

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 member communications and member 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.
9. Provide a summary report of subcommittee activities to the QMC.

Voting membership on the CCS is appointed by the CCS Chairperson, in collaboration with the Health Plan President and the Chief Medical Officer, but will include, at a minimum:

1. Health Services Staff – two from physical health, two from behavioral health and two from CHOICES.
2. Community Outreach
3. Network Management
4. Compliance
5. Quality Staff
6. Marketing and Communications

Ad hoc Health Plan 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. Members may designate surrogate attendees. The CCS reports at least 4 times per year to the QMC.

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 Plan Behavioral Health Advisory Committee is comprised of at least fifty one percent (51%) consumer and family representatives, of which the majority shall include individuals and/or families of those who may meet the clinical criteria of a priority enrollee.

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 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 Plan 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 Plan 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 their 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.

I. 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 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 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 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

1. A $50 stipend is paid to members, family members and personal representatives who are Advisory Group members when they attend a face-to-face Advisory Group meeting.
2. The Health Plan reimburses CHOICES Advisory Group stipend eligible CHOICES members, family members and personal representatives for travel costs to and from face-to-face Group meetings. Mileage is determined using the standard federal mileage reimbursement rate.
3. 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.

Community and State National Committees:

A. National Quality Management Oversight Committee (NQMOC)

The National Quality Management Oversight Committee (NQMOC) directs the QI programs for UHC at the national level and interfaces with other National and Health Plan Committees, as applicable. The Board of Directors has delegated responsibility for the oversight of Health Plan quality improvement activities to the NQMOC. The NQMOC interfaces directly with the Health Plan QMC. The responsibilities of the NQMOC include:

1. Define state and national/regional accountabilities for patient safety, quality improvement, and accreditation.

2. Approve national quality policies and procedures, as applicable, for Quality Management and Performance activities, including handling of quality of care and service complaints.
3. Oversee referral, tracking and management of quality of care issues.
4. Review and approve national delegation oversight reports.
5. Approve and monitor corrective action plans for national delegates, as appropriate.
6. Review and approve oversight reports for inter-segmental partners (OptumHealth Behavioral Solutions (OHBS), UnitedHealth Networks (UHN), OptumHealth Physical Health.
7. Approve and monitor corrective action plans for inter-segmental partners, as appropriate.
8. Review and approve reports from Committees:
    a. National Medical Care Management Committee (NMCMC): Oversight of Medical Management/Utilization Management (UM) activities, including review and approval of UM Program.
    b. National Credentialing Committee (NCC): Oversight of all credentialing decisions.
    c. National Integrated Behavioral Health Steering Committee (NIBHSC): Oversight of enterprise-wide strategy to foster and improve continuity and coordination of medical and behavioral health care.
    d. UnitedHealth Group National Pharmacy and Therapeutics Committee: Oversight of pharmacy services
9. Review and approve all program documents, materials and reports integral to program operations and corporate accreditation requirements that may include, but not limited to:
    a. National QI Program Description.
    b. National Credentialing Program Description.
    c. National Patient Safety Program Description.
    d. Reports on clinical guideline performance.
    e. Evaluation of Population Health programs.
    f. Annual Health Plan Healthcare Effectiveness Data and Information Set (HEDIS®)[3])/CAHPS®[4] reports to include analysis and development of action plans to improve performance.

The membership of the NQMOC may include, but is not limited to, the individuals below:

1. National VP Medicaid Quality (Chair)
2. Regional Medical Directors

3. Health Plan Medical Directors
4. National VP Pharmacy Management
5. Director, HEDIS Improvement
6. CMO, C&S
7. RQDs
8. EVP Clinical Services

The Committee is chaired by the National VP of Quality or his/her designee. The Committee meets at least quarterly or more often as determined by the chairperson.

B. National Credentialing Committee

The National Credentialing Committee's (NCC) purpose is to conduct initial credentialing and recredentialing of practitioners and organizational providers, that may provide care and services to a UHC customer as indicated in the UnitedHealthcare Credentialing Plan. The NCC responsibilities include:

1. Implementation of the UnitedHealthcare Credentialing Plan
2. Review of practitioners' and organizational providers' credentialing or recredentialing file information to make decisions to approve or to deny credentialing or recredentialing. Review and provide input on the UnitedHealthcare Credentialing Plan and Policies.
3. Review of follow-up or/or pended issues from previous meetings.

The NCC membership may include, but is not limited to:

1. A Medical Director from a UHC Health Plan serving as Committee Chairperson. The Committee Chair votes only in the event of a tie
2. A minimum of seven (7) licensed independent practitioners representing different specialties
3. Other representatives as requested by the Committee chairperson

The NCC meets a minimum of one time per month.

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. Develop a strategy across UnitedHealth Group for medical policy development.
2. Promote the consistency across UnitedHealth Group of medical policy decisions.

3. Develop clinical policies and procedures for UnitedHealth Group related to quality of care issues, credentialing and other processes in which clinical input is required.

EMPC membership may include but is not limited to:

1. Individuals functioning in roles designated as CMOs for UHC Employer and Individual, UHC Medicare and Retirement, UHC Community and State, National Accounts, OptumHealth and OHBS. These clinical leaders may designate others in their respective organizations to participate in their place.
2. National medical directors and other clinical leaders in various areas of medical management.
3. Representation from UHCP and OputmRx.
4. Representation from Legal Departments of UnitedHealth Group businesses.
5. Representation from Compliance Departments of UnitedHealth Group businesses.
6. Other representatives as requested by the Committee chairperson

The EMPC meets on a quarterly basis.

D. National Medical Technology Assessment Committee

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

1. Development of evidence-based position statements on selected medical technologies and assessments of the evidence supporting new and emerging technologies.
2. Review and maintenance of externally licensed guidelines.
3. Consideration and incorporation of nationally accepted consensus statements and expert opinions into the establishment of national standards for UnitedHealth Group.
4. The promotion of consistent clinical decisions about the safety and efficacy of medical care across all products and businesses.
5. Adoption of specialty society guidelines.

The MTAC meets at least 10 times per year. The membership of the MTAC may include, but is not limited to, the individuals below:

1. CMO UHC Employer and Individual (Committee Chairperson).
2. Health Plan and UCS Medical Management Medical Directors with diverse specialty backgrounds.
3. Medical Policy staff.
4. Guest physician specialists as required.

The MTAC reports at least quarterly to the EMPC and the NMCMC and reports are made available to the Medical Advisory Committees (MAC), as needed.

E. National Medical Care Management Committee

The NMCMC is responsible for overseeing the development, implementation and evaluation of the UHC Medical Management (MM) /Utilization Management (UM) Program for all entities within the program's scope as outlined in the National UM Program Description (UMPD). The NMCMC is guided by the medical policies of UnitedHealthcare. Functions of the NMCMC include, but are not limited to:

1. Review and approve the UM Program Description at least annually
2. Oversee implementation of the Utilization Management Program
3. Evaluation the Utilization Management Program no less than annually.
4. Review and approve medical criteria and guidelines recommended by the MTAC.
5. Approve UnitedHealthcare Clinical Services Utilization Management/Utilization Review (UM/UR) operational policies.
6. Oversee activities of the Document Oversight Committee which recommends UM/UR operational policies that impact multiple departments, and approve functional area procedural documents.
7. Oversee activities of the Training Steering Committee which is responsible for the development, implementation and evaluation of the UHC Utilization Management Program training and process improvement activities.
8. Monitor and evaluate call center metrics, denial rates, clinical appeals including top clinical diagnosis, overturn rates, and overturn reasons, and consumer concerns about the UM/UR process.
9. Monitor and evaluate, at least annually, the efficiency and effectiveness of UM/UR processes through analysis and review of under- and over-utilization and satisfaction with UM/UR processes.
10. Maintain approved records of all committee meetings.
11. Provide feedback and recommendations to the UM/UR process and UM quality improvement activities.
12. Promote compliance with regulatory and accreditation requirements, including oversight of market conduct corrective actions, as applicable.

Membership of the NMCMC may include the individuals below:

1. Executive Vice President, UCS (Vice Chairperson)
2. National Vice President, UCS (CCR) (Chairperson)
3. Regional CMO and/or designated alternate
4. National Vice President, UCS (Appeals & Grievances/Quality of Care)
5. National Vice President, UCS (Operations)
6. National Vice President, UCS (Strategy & Business Operations)
7. National Medical Director, UCS (Medical Policy)

8. Chief Medical Officer, UnitedHealthcare Employer and Individual
9. Chief Medical Officer, UnitedHealthcare Medicare and Retirement
10. Chief Medical Officer, UnitedHealthcare Community and State
11. National Medical Director OptumHealth Solutions
12. Ad hoc members as requested by the chairperson

The NMCMC meets at least quarterly and a physician serves as chairperson. The NMCMC reports to the NQOC at least annually.

F. UnitedHealth Group National Pharmacy and Therapeutics Committee

The UHG National Pharmacy & Therapeutics (P&T) Committee serves as an advisory body to UnitedHealth Group, its pharmacy benefit manager, United Healthcare benefit businesses and their respective clients by providing consultation for the clinical evaluation of drugs for placement on prescription drug lists (PDLs), preferred drug lists and/or formularies and clinical programs associated with drug management. As necessary, the P&T Committee reviews and evaluates medical criteria, standards and educational intervention methods in the process of developing clinical recommendations for drugs and drug management. The Committee's role and functions are to make, review, evaluate, update, develop and approve clinical recommendations regarding the following:

1. Business Unit Formularies and/or PDLs and inclusion or exclusion of therapeutic classes at least annually;
2. Clinical guidelines and/or criteria and procedures related to the timely use of and access to medications at least annually;
3. Business Unit medication policies, quality initiatives and other clinical pharmacy interventions; and
4. Policies that guide utilization management tools for Formulary and/or PDL management at least annually.

The Committee is composed of internal and external members and may include the following:

1. External physicians selected based on specialty, clinical expertise, geographic and demographic penetration
2. An ethicist
3. Two pharmacists, one of which possesses expertise in geriatrics
4. Representatives from UnitedHealthcare Pharmacy and from internal business units.

Only external members are voting members. The UHG National P&T Committee shall meet no less than quarterly. The CMO of OptumRx chairs the committee.

G. National Integrated Behavioral Health Steering Committee

The National Integrated Behavioral Health Steering Committee (NIBHSC) is responsible for driving meaningful and measurable collaboration between the UHG business partners with a focus on demonstrating improved care and service for members by using evidence-based medicine guidelines related to behavioral health. The functions of the NIBHSC may include but are not limited to:

1. Development and oversight of an enterprise-wide strategy to foster and improve continuity and coordination of medical and behavioral health care, including but not limited to:
    a. Exchange of information;
    b. Appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care;
    c. Appropriate uses of psychopharmacological medications;
    d. Management of treatment access and follow-up for members with coexisting medical and behavioral health disorders; and
    e. Primary or secondary preventive behavioral health programs.
2. Oversight of strategies to improve outcomes related to behavioral health. Specific areas of focus may include:
    a. Anti-depressant medication management;
    b. Treatment of Attention Deficit/ Hyperactivity Disorder;
    c. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment;
    d. Follow-up After Hospitalization for Mental Illness; and
    e. Depression Screening.

The NIHBSC membership may include, but is not limited to, the individuals listed below:

1. Senior Director of Quality Management and Improvement (QMI) Optum (behavioral), Co-Chairperson
2. National Accreditation Manager, UHC Employer& Individual (E&I) Co-Chairperson
3. Vice President, QMI, Optum (behavioral)
4. Vice President, Quality Management and Performance, UHC E&I
5. Senior Director, HEDIS,UHC E&I
6. National Accreditation Directors
7. Vice President, Quality Management & Performance, UHC Medicare & Retirement (M&R)
8. National Accreditation Managers
9. Chief Pharmacy Officer, UHC Pharmacy
10. Senior Directors (QMI), Optum (behavioral)
11. Performance Improvement Director, Behavioral Network Services, Optum
12. Executive Director of Clinical Program Integration, Optum (behavioral)
13. National Director of Specialty Programs, Optum (behavioral)
14. Optum Care Solutions (Audit & Accreditation Team)

15. Medical Directors from UHC and Optum on an ad-hoc basis
16. Regional Quality Director(s), and/or his/her designee
17. Vice President, Quality Management & Performance, UHC Community and State (C&S)
18. Representative from UCS
19. Ad Hoc Members as necessary

The NIBHSC meets at least four times per year and reports to the NQMOC.

H. National Joint Operating Committee (NJOCs)

The National Joint Operating Committees (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 potential national delegations.
2. Receive and evaluate reports and audit results on a regular basis, as required by the various regulatory and accreditation agencies.
3. Oversee IAPs.
4. 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 MDOC. The NJOCs activities and meeting minutes are presented to the NQMOC.

I. 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;
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. Promotion of the collection and review of racial and ethnic data through eligibility and enrollment processes, vital statistics data, birth records, and member-supplied information;
4. Promotion of analysis of data to identify geographic pockets of healthcare disparities;
5. Collaboration on targeted interventions to improve services to identified populations;
6. Support of the establishment of relationships with community and national resources;
7. Establishment of a consistent source of education for staff and network providers to learn about cultural diversity;
8. Review and analysis of outcomes of interventions;
9. Facilitation of ad hoc groups, as needed, to work on specific projects; and

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. Committee meetings are held at least semiannually or more often at the discretion of the Chair. The Committee reports to the NQMOC at least two times per year.

OptumHealth Behavioral Service National 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. 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 is required for all meetings. If not otherwise specified in a separate Committee Charter, a majority of members (51%) present constitutes a quorum

B. Committee Minutes

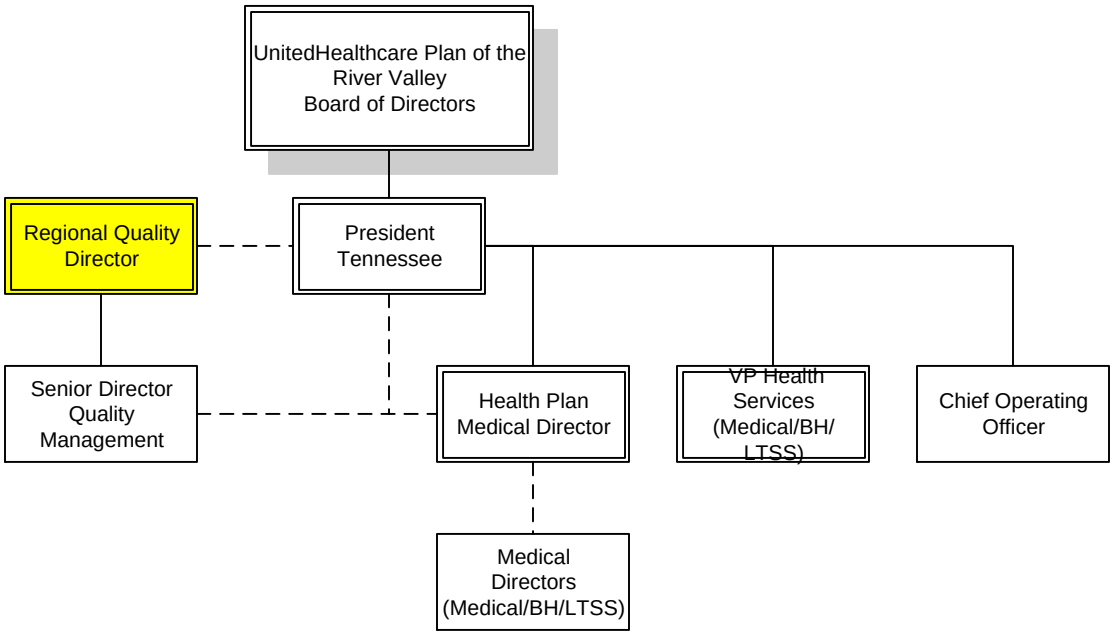
Confidential minutes are recorded within a reasonable time frame by a committee facilitator and distributed, as appropriate. Minutes will reflect the name of the committee, the date and duration of the meeting, the members present and absent, and the names and titles of guests. The minutes will reflect discussions, recommendations, and the status of action items.

C. Robert's Rules of Order

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

VI. QUALITY IMPROVEMENT PROGRAM

Organizational Structure and Roles



A. Health Plan President

The Health Plan President is responsible for oversight of the implementation of the Quality Improvement Program and chairs or designates the chair for the QMC. The President is responsible for monitoring the quality of care and service UnitedHealthcare Community Plan provides and ensuring the appropriate level of resources are available for the QI Program. The President also ensures that fiscal and administrative management decisions do not compromise the quality of care and service UnitedHealthcare Community Plan provides to members.

B. Chief Medical Officer for Medical Health

The Health Plan Medical is a Tennessee licensed physician who is responsible for implementation of the QI Program. The Chief Medical Officer reports to the Health Plan President and provides the medical direction for clinical and quality programs. The Chief Medical Officer or designee chairs both the Quality Management Committee and the Provider Affairs Subcommittee. The Chief Medical Officer participates in various QI committee activities including the credentialing and recredentialing process for the Health Plan and coordinating

peer review with the PAS. The Chief Medical Officer oversees and implements activities to measure health services efficacy. The Chief Medical Officer, 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. Chief Medical Officer for Behavioral Health

The Health Plan Medical for Health is a Tennessee licensed Board Certified Psychiatrist who is responsible for providing clinical leadership to the health plan and is accountable for establishing utilization and quality outcomes of the plan membership. The Chief Medical Officer for Behavioral Health reports in a matrix reporting fashion to both the Executive Director for Behavioral Health and the Chief Medical Officer to provide medical direction for behavioral health clinical and quality programs. The Chief Medical Officer for Behavioral Health participates in various QI committee activities including the credentialing and recredentialing process for the Health Plan and peer review with the PAS. Additionally, the Chief Medical Officer for Behavioral Health involved in the implementation of the behavioral health utilization management program and is responsible for setting utilization management policies and reviewing utilization management cases.

D. CHOICES Medical Director

The CHOICES Medical Director must maintain a current non-restricted license to practice medicine in the State and demonstrate adequate education, training and clinical experience in geriatric or long term care setting. The CHOICES Medical Director is responsible for developing clinical strategies for the CHOICES Program to improve policies, procedures, processes and outcomes and overseeing clinical decision making activities of Care Coordination staff. The CHOICES Medical Director facilitates grand rounds and case conferences and is the liaison to network management for network development related to nursing facility/ HCBS services. Additional responsibilities include support for all Clinical Quality initiatives including Critical Incidents, Performance Improvement Projects and peer review process and maintaining credentialed status with UnitedHealthcare Community Plan.

E. Regional Quality Director

The Regional Quality Director is responsible for supporting UnitedHealthcare Community Plan in implementing the Quality Improvement Program consistent with federal and state requirements, NCQA standards, and the UnitedHealthcare strategic plan. The Regional Quality Director acts as a liaison between local staff and national resources to assist in fully implementing and continuously improving the quality improvement structure.

F. Senior Director of Quality Management

The Senior Director of Quality Management (QM), under the direction of the Chief Medical Officer for Medical Health, is responsible for oversight of the implementation of the QI Program, including monitoring the quality of care and service complaints and evaluation of quality improvement initiatives involving member and provider outreach. The Senior Director of Quality Management is also responsible for oversight of activities including but not limited to HEDIS improvement activities, submissions of quality regulatory reports, QI studies and patient safety initiatives, grievance and appeals, and delegated relationship, preparation of the annual QI program documents, and managing the Health Plan Quality Improvement infrastructure. The Senior Director of Quality Management is responsible for the CAHPS Surveys and Provider Satisfaction 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 and Quality Improvement Activities 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 for Medical Health and the Regional Quality Director. The Quality Management Director consults with National Quality Management staff who are subject matter experts in program design and statistics and with other business units as needed.

G. Behavioral Health Quality Director

The Quality Director 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 Director is also responsible for regulatory reporting, as well as supporting the Health Plan's NCQA survey and annual regulatory surveys. The Quality Director reports to the Regional Director of Quality Management regarding all quality management functions.

H. Director of Special Projects

The Director of Special Projects reports to the Sr. Director of Quality and is responsible for coordinating and generating the annual Quality Improvement Program Description and for reviewing and updating clinical practice guidelines annually or whenever they are updated. The Director of Special Projects is also responsible for implementation and oversight of interventions associated with members enrolled in the Wellness and Health Risk Management programs for Population Health, oversight of the investigation and follow up of critical incidents for CHOICES members receiving Home and Community Based

Services and quality of care and quality service complaints for all CHOICES members as well as the CHOICES performance improvement projects.

I. 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 for Medical Health 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 Chief Medical Officer, Health Services, Medicaid Operations, and Administrative management to ensure appropriate resolution of quality of care issues throughout the Health Plan. The PAS provides oversight of these activities.

J. 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 Director 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 Chief Medical Officer, 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.

K. 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, and monitoring and reporting on the Centers for Medicaid and Medicare (CMS) - 416 screening rates.

L. 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 initiatives designed to ensure members receive timely preventive health services and work with National and Health Plan HEDIS® staff, and others throughout the Health Plan to effectively coordinate initiatives. The TENNderCare Prevention and Wellness Education Quality Analysts are responsible for leading the TENNderCare program, collaborating on the development and coordination of health education for members under age 21 enrolled in the health risk management program for Population Health and coordinating collaborative initiatives with the Health Plan Community Outreach staff and community organizations. Oversight of these activities is reviewed by COS.

M. 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 Regional 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 performed by PAS and QMC.

N. 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 Chief Medical Officer, 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 interaction with internal staff, service providers and the FEA regarding quality investigations and issues, and 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. The PAS provides oversight of these activities.

O. Director Health Services CHOICES Long Term Services and Supports

The Director of Health Services for CHOICES provides strategic clinical direction to the clinical team in partnership with the CHOICES Medical Director and Supervises the Care Coordinator staff, including Managers and Regional Directors. The Director of Health Services for CHOICES represents the CHOICES clinical program to the executive team to assist in business decisions.

P. CHOICES Care Coordinator

Care Coordinators are registered nurses or social workers who facilitate coordination, continuity and appropriateness of care and services in the long term care setting. Care Coordinators collaborate with member's health care delivery team and assess members' clinical and psychosocial needs, develop plans of care in conjunction with the member and member's health care delivery team. Care Coordinators are advocates for members. They provide health education to members, facilitate open communication and service coordination between the member and the Health Plan, the member's practitioner and appropriate community agencies. They provide practitioners with disease specific clinical information regarding CHOICES HCBS members. They identify barriers to optimal care and outcomes or clinical concerns and communicate with members

and providers to formulate action plans to address and monitor pregnancies and assess for development of complications or concerns that warrant follow up with the member and practitioner.

VII. 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 Quality Improvement 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. Credentialing and Re-credentialing

All participating practitioners, providers and Nursing Facilities participating in the CHOICES program 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, providers and Nursing Facilities undergoing initial credentialing and triennial re-credentialing 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 and/or member satisfaction issues identified at the provider level. Final decisions are made by the Health Plan PAS. 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. A report monitoring Credentialing activity is presented to the NQMOC.

CHOICES Providers of Home and Community Based Services, including Assisted Living Facilities, are not credentialed through NCC but instead go through the verification/reverification process outlined below:

1. Verify license via Tennessee.gov website
2. Office of Inspector General (to verify disclosure)
3. Medicaid identification verification – verify via provider's letter or via TennCare
4. NPI (not all HCBS are required to have this)
5. Assessment

The re-verification for HCBS occurs annually with the exception of Pest Control, Assistive Technology and Minor Home Modifications. Those providers must be re-verified at a minimum every three years.

B. Peer Review

Peer review is the mechanism to review potential 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 and/or federal 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.

C. Practitioner Accessibility and Availability Monitoring

Practitioner accessibility and availability monitoring is conducted on an ongoing basis to measure performance against established standards for reasonable geographic location of practitioners, number of practitioners, appointment availability, provision for emergency care, and after hours service. The cultural, ethnic, racial, linguistic needs of its members are assessed on an ongoing basis and formally evaluated at least annually. Monitoring activities may 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 care practitioner panels. Specific deficiencies are addressed with a corrective action plan and follow-up activity is conducted to reassess compliance. Data from practitioner accessibility and availability activities are presented to the Health Plan SQIS by QMP staff for final recommendations.

D. 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. These are maintained as originally issued for a period of five (5) years for Program Integrity purposes.

The guidelines are reviewed by the Medical Technology Assessment Committee (MTAC) and approved by the National Medical Care Management Committee (NMCMC). The Health Plan PAS also reviews and approves these guidelines as well as the behavioral health clinical practice guidelines. The MTAC 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.

E. Population Health Management

UHCCP operates an integrated Population Health Program which is designed to promote healthy behaviors and disease self-management as well as to provide care coordination and intense case management as needed as supported by evidence-based medicine and national best practices. Our Population Health Program touches Members across the entire care continuum and emphasizes primary and secondary prevention, medication adherence, identification of and closure of gaps in care and promotion of healthy lifestyle behaviors such as tobacco cessation, weight management, exercise and nutrition.

To ensure that Members are receiving interventions at the appropriate level and intensity all non-pregnant Members, both Non CHOICES and CHOICES, are systematically restratified each month into one of three (3) Levels using our predictive modeling software. Additional information gained through Assessments is used to manually restratify Members into the appropriate Level based on health risks identified. The following is a high level description of the three risk levels utilized:

Level 2 Approximately 3% of non-pregnant Members. These Members are managed either in chronic care management or complex case management. Members identified for the Level 2 programs must agree to participate or opt in. If a Member chooses not to participate they are either enrolled in the Level 1 Health Risk Management Program or they may be enrolled in Care Coordination in order to meet identified acute health needs or risks.

Level 1 Health Risk Management: Members are managed in one of three sub stratification categories based on predictive modeling risk. These are non-pregnant Members identified as having a chronic condition who don't fall into Level 2. At a minimum , Members who have been diagnosed with asthma, bipolar, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure, diabetes, major depression and schizophrenia are enrolled in health risk management as well as Members who are identified as having modifiable health risk behaviors such as tobacco or substance use or weight management issues. This is an opt out program; therefore, all identified Members are enrolled unless they specifically ask to be excluded.

Level 0 Wellness: Non pregnant Members who are not in Level 2 and who do not have a chronic condition or who have no claims history

Pregnant Members are stratified into one of two Levels, either High Risk Level 2 or Low Risk Level 1 based on the results of the obstetrical assessment. Members who are identified as substance abusers or who use tobacco are stratified as high risk. Members who meet criteria for high risk but who choose not to participate are enrolled in the low risk maternity program.

CHOICES:

CHOICES Care Coordinators will retain primary responsibility for population health interventions for CHOICES Members. HCBS CHOICES membership will be re-assigned to an RN coordinator for those identified as Level Two. For Health Risk Management Level 1, CHOICES members will remain assigned to their Care Coordinator (either RN or LMSW) for all population health interventions and touch points. Care Coordination staff will have access to refer for RN consult and access to health coaching and materials and retain primary responsibility for those referrals and follow up. The Care Coordinator will coordinate all Population Health activities medical, behavioral and long term care

services. This will ensure Population Health focus remains member-centric as "one face" to the member.

COS is responsible for monitoring activities associated with Population Health. Quarterly and annual reports are presented to COS.

Further details about the Population Health Program may be found in the Population Health Program Description.

F. Accountable Care Community

The Accountable Care Community Program involves a partnership between UHC, a physician practice, and that practice's local healthcare community with the purpose of driving improvement in patient care and population health by sharing timely, relevant and actionable clinical data.

The four pillars of the program are:

1. Improve access to care
   Physician practices provide transparency into their scheduling systems so that we can work together in understanding supply & demand and ensure that appropriate capacity is maintained for same-day visits.
2. Reduce avoidable ER visits
   Real-time ER discharge data is leveraged to queue up patients for follow-up and re-engagement back into primary care. Initiatives include reducing ER utilization by targeting frequent / non-emergent ER users and educating them on appropriate utilization and ER alternatives.
3. Reduce avoidable inpatient admissions
   Like with ER, discharged patients are queued up for follow-up and transition back into primary care. Initiatives include reducing unnecessary one-day admissions and promoting self-management / medication adherence to prevent future readmissions.
4. Improve high-risk patient care
   Members stratified as higher risk per Population Health (Levels 1A, 2A, and 2B) are identified and micro-managed in specific cohorts with the goal of preventing adverse events (ER and Inpatient) and improving health outcomes. In working the cohort queues, care coordinators are prompted to address Evidence Based Medicine (EBM) care opportunities and schedule quarterly PCP visits.

The Accountable Care Population Registry is the web-based platform at the core of the program. This tool consolidates data from disparate sources (payer, practice, and hospitals) and generates actionable work queues for physician practice care coordinators.

Physician practices can qualify for Clinical Integration Grants (in the form of a monthly PMPM) that help offset the cost of added care coordination efforts in working the Registry queues. They can also qualify for an annual Shared Savings Bonus (30-40% of the associated savings pool) if specific reductions in ER and Inpatient utilization are achieved.

G. Neighborhood Connections

The goal of the Neighborhood Connections Program is to engage Members in high quality Primary Care by meeting them where they live and coordinating services available through their TennCare and Medicare benefits as well as available community services. The program is designed to work with Members who are difficult to contact in order to improve their access to care, health risk, and utilization patterns, especially those driving unnecessary ER visits.

The Neighborhood Connections management work from a UHC storefront strategically located in and adjacent to neighborhoods with high concentrations of UHCCP TN high risk members. The service coordinators hired from local neighborhoods work closely with Accountable Care Community/PCMH partners and our UHCCP clinical staff to coordinate efforts appropriately. The core activities of Neighborhood Connections staff is based on intensive "feet on the street" efforts to locate hard to reach members, form relationships, assess needs, and coordinate care.

The following are program assumptions and guiding principles for the Neighborhood Connections program.

1. Active and sustained member engagement in Primary Care
2. Team members trained extensively to ensure that interactions and activities with members are effective. Training includes the following concepts:
   a. Assessment and education for Members on the fundamentals of health literacy;
   b. Assessment and support of Members with cultural differences;
   c. Recognition and support of Members through recovery and resiliency;
   d. Person-centeredness.
3. Referred Members have significant gaps in care, elevated health risk, and/or significant utilization patterns. Additionally, they are not engaged in regular or effective Primary Care, and telephonic contact efforts on the part of providers and UHC clinical programs have not been successful.
4. Optimize our member engagement efforts and clinical programs and, as such, comply with UHCCP's TN Clinical Operations Subcommittee standards.
5. Augmentation to and partner with other UHCCP Tennessee clinical programs.

6. Development and implementation of a member-centered service coordination plan.
7. CHOICES members are out of scope except for unique circumstances in which the CHOICES Medical Director and/or Executive Director have requested intervention from Neighborhood Connections.
8. Assessments are performed from a whole person perspective taking the following into account:
   a. Member's stated health and life goals;
   b. Member's cultural, spiritual, and religious perspectives;
   c. Member's living environment (e.g. safety of home structure, adequate utilities, adequate food stores, etc.);
   d. Obstacles to Primary Care engagement;
   e. Barriers to obtaining medications and medication adherence;
   f. Behavioral health needs including mental health and substance abuse;
   g. Social supports;
   h. Need for linkage to community resources; caregiver needs; care transition needs; meals; shelters.
9. Activities with members are subject to multidisciplinary (e.g. Physical Health MD, Behavioral MD, Nurse CM, Behavioral CM) clinical collaboration. Regular interactions and review through regular ongoing multidisciplinary rounds as well as ad hoc review meetings requested by Neighborhood Connections personnel will ensure ongoing process improvement.
10. Neighborhood Connections is a treatment and service coordination program and not health plan case management.
11. The safety of UHC staff, contractors, and vendors is the highest priority.

H. Telemedicine

The goal of the Telemedicine initiative is to promote integrated medical and behavioral services for members in rural areas by linking contracted primary care and community behavioral health practitioners, thus improving access to care and providing a one stop service for members. The Health Plan works in conjunction with Tennessee Primary Care Association and Community Health Network to expand these services in support of the following objectives:

a. Lower overall healthcare costs by rendering services timely and in the community
b. Increase access to care and compliance with TennCare contract terms
c. Alleviate access deficiencies in rural areas and underserved areas
d. Reduce use of emergency services
e. Promote integrated health care.

The Health Plan is also working with Vanderbilt to link their specialists through Telemedicine to Members in rural areas so they can be diagnosed and treated in

their PCP setting. A high tech stethoscope is used for early detection of diseases of the heart and arteries by a cardiologist and the pediatric specialists use Telemedicine to diagnose and treat conditions such as Type 1 diabetes.

I. Continuous Quality Improvement Process and Six Sigma

The Continuous Quality Improvement (CQI) Process and Six Sigma are problem-solving techniques that are applied to specific and measurable performance indicators. The CQI Process and/or Six Sigma are used whenever an opportunity for improvement is identified through the monitoring of quality of care or service indicators. The steps in the CQI/Six Sigma Process are summarized in the table below.

Define	• Determination of relevance to the Health Plan's population. • Evaluation of baseline measure(s)
Measure	• Analysis to identify opportunities for improvement.
Analyze	• Analysis to identify possible root causes/barriers to care or service. • Planning and implementation of strong actions to eliminate root causes/barriers.
Improve	• Evaluation of the performance and effectiveness of the interventions through re-measurement.
Control	• Analysis to determine how actions impacted performance. • Continued re-measurement to determine if impact(s) are sustained.

All steps in the CQI/Six Sigma Process are documented and results and action plans are presented to the appropriate Committee for review and approval.

J. Monitoring and Improving Quality Indicators

The monitoring of quality indicators is designed to reveal trends and performance opportunities in specific areas and facilitate plan-wide improvement. To this end, a variety of care and service indicators to monitor are derived from as many sources as appropriate including HEDIS, CAHPS, HOS (dual eligible members) and EPSDT. The quality indicators are measurable, based on research, and use current, and accepted data collection and analytical methodologies. Topics for routine monitoring and focused activities are chosen based on the demographic and epidemiological characteristics of the population. Examples of monitoring indicators may include tracking and trending of inpatient or outpatient acute or chronic conditions, access performance measurements, customer and claims service, and member satisfaction or unique specific indicators as identified from local epidemiology or demographics. QI activities are designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and service provided to our members and are presented to the appropriate committee for review and recommendation.

UHCCP collaborates with the Bureau of TennCare and other TennCare Managed Care Organizations to further clinical quality and patient safety. These activities are reported to the Clinical Operations Subcommittee and addressed in the annual Program evaluation.

K. Patient Safety

UHCCP supports the prevention and elimination of healthcare errors by our commitment to the practice of evidence-based medicine. The patient safety program also supports the Leapfrog Group's four pillars of: transparency, standardized measures and practices, incentives and rewards, opportunity rate and external collaboration.

Patient safety 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. Annually, patient safety goals are developed and integrated into the overall Quality Improvement Work Plan. Epocrates™ and ePrescribing, and adverse event monitoring provide evidence of the networks' adherence and commitment to evidence-based medicine. Our comprehensive policies and procedures address the management of sentinel events and clinical quality of care complaints to reduce clinical risk.

L. Continuity and Coordination of Care

An annual analysis is conducted to review the continuity and coordination of medical care provided to UHCCP members across settings and / or during transitions of care. The scope of activities includes transitions in care including changes in management of care among practitioners, changes in settings including inpatient and ambulatory location or other changes in which practitioner's partner to provide ongoing care for a member. The primary activities may include but are not limited to

1. Prescription of controlled substances.
2. Post discharge medication review
3. Member satisfaction with continuity and coordination of medical care.
4. Provider satisfaction with coordination of medical care.
5. Steerage to transplant centers of excellence.
6. Postpartum care.

Additionally, an annual analysis is conducted to review the continuity and coordination between medical care and behavioral care. The scope of activities includes exchange of information, appropriate diagnosis, treatment and referral of behavioral healthcare disorders commonly seen in primary care, appropriate use

of psychopharmacological medications, management of treatment access and follow-up for members with coexisting medical and behavioral disorders, and primary or secondary preventive behavioral healthcare program implementation.

M. REL/Disability Initiative

The Health Plan uses the REL/Disability assessment in CareOne to assess both new Members and those receiving telephonic outreach from the clinical staff. As part of the verification process, if the Member reports information that is different from that received in the 834, the corrected data is displayed on the summary page of the Member's record to assist Health Plan staff to immediately recognize the Member's preferences related to REL. The REL and Disability data is also queried, aggregated and reviewed by the Cultural Competency Committee to identify ways to serve potentially underserved Members. The disability data is reviewed to identify Members with disabilities that would not be identified using claims data alone. This data also serves as a framework for decisions regarding topics for Member Newsletters.

N. Medical Record Review (MRR)

The objectives of Medical Record Review activities are to:

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

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 aged 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, a TENNderCare Medical Record Review audit tool and a 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.

O. 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, evaluate and effectively resolve member concerns in a timely manner.
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. Quality of care and service concerns are primarily identified by the Customer Care Department(s), but can be identified by any department, member, or practitioner. 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 identify potential quality of care/service issues. They facilitate the investigation and resolution process. They also coordinate with other DSNP organizations to ensure that QOC/QOS issues reported by dually eligible members are investigated by the primary payer of the service in question. 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 complaints is presented to the PAS, for review of aggregate trends and identification of actions for improvement

P. 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.

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

Q. Practitioner and Practice Manager Satisfaction

Practitioner and practice management satisfaction surveys are designed to:
1. Assess which services are important to Health Plan practitioners
2. Determine practitioner and practice manager satisfaction with Health Plan processes, including the utilization management process.
3. Assess satisfaction with continuity and coordination of care

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

R. 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.

S. Pay for Performance Program

The Health Plan has two pay for performance programs 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.

   A pilot, known as the Basic Quality Program (BQP), offers provider groups with a panel size of 150 Members an opportunity to earn a PMPM incentive payment for improving their quality scores for selected HEDIS measures. Practices that participate in the program can achieve a PMPM

incentive payment if they successfully improve their quality scores in 3 measures by 5% to 10% over their baseline scores in those measures. The statewide program is targeted to practices that are not in the inital list of practices targeted for Accountable Care Community.

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 delivery of the most clinically appropriate services in the least restrictive setting for our members
   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.

T. 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 of clinical PIPs are reviewed and approved by the COS. Results of evaluations and recommendations of service PIPs are reviewed and approved by SQIS. Current PIPs are defined in detail as part of UnitedHealthcare Community Plan annual QI Work Plan.

U. 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 of which they might otherwise be unaware. 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 TENNderCare Members.

The Health Plan conducts outreach to providers as part of its TENNderCare 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 TENNderCare 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 TENNderCare program in its provider orientation, the provider Town Hall meetings and the TENNderCare Provider University course.

The Health Plan TENNderCare 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 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 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.

V. 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., TENNderCare, lead screening, immunizations, cervical cancer screening, breast cancer screening, chlamydia screening, and flu vaccine).
2. Chronic care (e.g. diabetes, cholesterol management, treatment of asthma)
3. Access/ availability of care.

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 preventive health screening 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.

U. Pain Management

The pain management program focuses on patient safety by targeting providers who have prescribed an unusually high number of narcotics. Each quarter the Regional VP of Pharmacy and Fraud and Abuse staff review the list of providers received from TennCare to determine whether any of the providers are already under investigation. The updated list is then forwarded to the Quality team who conducts provider visits to perform pain management assessments. These audits assess whether providers are following required protocols for pain medication management, such as periodic drug screening, pill counting, and referral to specialists as needed. Audit results are presented to the Provider Affairs Sub-Committee to determine which providers need further intervention (and possible termination). Efforts are successfully creating a network with greater safeguards against inappropriate prescriptions.

V. Emergency Department Outreach

The Emergency Department (ED) Outreach program uses Registered Nurse Health Coaches to follow up with members following an Emergency Room visit. Initially the program used claims to identify members for outreach; however, the hospitals now provide Admission/Discharge/Transfer data directly to the ED Outreach team so that follow-up can occur more timely. The focus of the calls is to offer assistance with obtaining physician appointments, arranging transportation, discussing options for service as an alternative to the ED and PCP assignment changes if needed.

W. Long Term Services and Supports (LTSS)

The program goals of the program include the following:

1. Improving access to LTSS services
2. Expediting the process for enrollment to LTSS services
3. Enhancing and increasing the Home and Community Based Services available to members
4. Integrating the primary, acute, LTSS and behavioral services for Medicaid members
5. Developing community based alternatives that allow members to age at home, including adult care homes, HCBS in rural communities, adult day care facilities, and,
6. Modifying nursing home admission criteria to encourage members to stay at home longer with community support services
7. Coordinating Medicare benefits administered by the MCO or other DSNP providers for medically necessary 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 for CHOICES 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.

V. Pharmacy and Therapeutics (P&T)

Pharmacy services are administered by Magellan Health Services which has a direct contract with the Bureau of TennCare.

VIII. UTILIZATION MANAGEMENT PROGRAM

Introduction

A. Accountability and Organizational Structure

The Chief Medical Officers along with the Quality Management Committee (QMC) and the Health Plan Clinical Operations Subcommittee (COS) are responsible for implementation and oversight of the Utilization Management 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 Population Health 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 Care Manager, a Transition Care Manager, 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 Officers are responsible for the implementation and oversight of the Utilization Management program.

Members of the team include the following medical and behavioral staff:

1. Chief Medical Officers
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 United Clinical Services
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 Field Care Management
11. RN's (Utilization Management and Care Management)
12. Social Workers
13. Behavioral Health Practitioner
14. CHOICES Care Coordinator
15. Support Staff

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 Officers. 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 Work Plan in collaboration with Sales, Marketing and UHN staff.

C. Staff Qualifications and Responsibilities

Chief Medical Officer for Medical Health

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) components of the Utilization Management and Population Health Program;
4. Develop clinical strategies to improve Utilization Management and Population Health Program policies, procedures, processes and outcomes;
5. Oversee clinical decision making activities of Utilization Management and Population Health Program 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.

Chief Medical Officer for Behavioral Health

1. Maintain a current non-restricted license to practice medicine in the State;
2. Maintain Board Certification as a Psychiatrist in order to provide clinical leadership to the Health Plan and be accountable for establishing utilization and quality outcomes for the Health Plan membership.
3. Reports to the Executive Director for Behavioral Health and the Chief Medical Officer for Medical Health and provides medical direction for behavioral health clinical and quality programs.
4. Participates in various QI committee activities including the credentialing and recredentialing process for the Health Plan and peer review with the PAS.
5. Involved in the implementation of the behavioral health utilization management program
6. Responsible for setting utilization management policies and reviewing utilization management cases.

Physician Reviewer

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;
6. Become and maintain credentialed status with UnitedHealthcare Community Plan.

Medical Director

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;
9. Become and maintain credentialed status with UnitedHealthcare Community Plan.

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/Population Health (PH) Program;
4. Develop operational strategies to improve UM/PH, procedures, processes and outcomes;
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/Population Health (PH) Program;
4. Develop operational strategies to improve UM/PH, procedures, processes and outcomes;

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 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
6. Monitor cases for quality of care;
7. Involve Field Care Management and Choice Care Coordinators as needed to ensure member receives appropriate care.

Clinical Pre-certification Reviewers Responsibilities

1. Maintains current license in Tennessee (registered nurse, licensed practical 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.

Behavioral Health Discharge Specialists

1. Telephone contact with providers to ensure that appropriate plans are in place for discharge follow-up treatment;
2. Telephone contact with members to ensure understanding of aftercare discharge appointments, discuss community resources, and promote recovery;
3. Assist members in overcoming any potential barriers to keeping aftercare appointments;
4. Contact providers to verify initial aftercare appointment attendance by members;
5. Identification of signs of risk or symptoms that may require intervention by a Care Manager;
6. Provision of member and provider education related to discharge follow-up issues and resources;
7. Monitor timely discharge plans for psychiatric inpatient and residential discharges;
8. Participate in clinical group rounds specific to members with frequent hospital recidivism.

Transition Coach Responsibilities

1. Contact member while still in hospital;
2. Manage member's transition from hospital to home;
3. Perform assessment of member specific health needs;

4. Focus member engagement on medication management, PCP relationship, signs and symptoms of change in condition, knowledge of red flags, development of response plan and Personal Health Record;
5. At end of transition period, about 30 days, perform HRA to determine need for transition to complex case management or chronic care management.

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 Care Managers

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.
7. Educate providers and members regarding available benefits.

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 their health and wellbeing. This might include educational materials for specific conditions or referrals to community resources;
3. Focus on closing gaps in care, medication adherence, changing modifiable behaviors that are detrimental to their health, encouraging PCP relationship and empowering member to self-manage condition;
4. Provide ongoing education for members based on individual needs identified through HRA and other assessments, questions or conversations, while paying attention to special cognitive issues with members.

D. Purpose of Utilization Management

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 MCG USA guidelines, a nationally recognized set of evidence-based guidelines formerly known as Milliman Care Guidelines. Behavioral Health Utilization Management involves making medical necessity determinations for inpatient, intermediate and outpatient levels of care with the goal of having members served in the least restrictive most clinically appropriate setting. Behavioral Health clinicians utilize Optum Level of Care Guidelines (LOCGs) along with ASAM PPC-2R criteria for all Substance Abuse services to conduct medical necessity reviews of requests for services as they apply to available Behavioral Health benefits.

The UM, medical and behavioral, consults with the hospital/facility utilization management team or attending physician to discuss the clinical documentation relevant to the appropriate level of 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 or other members, who are considered high risk for readmission or who have complex discharge planning needs, are referred by UM staff for appropriate post-discharge Population Health program. Paid claims data and authorization 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.

E. Scope of Utilization Management

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:

1. Ensure that health care services provided are medically necessary.
2. Ensure that health care services are provided in the most appropriate setting.
3. 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.
4. Manage medical and behavioral health benefits resources effectively and efficiently while ensuring quality care is provided.
5. 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
6. Support the establishment of a medical home and coordination of care with the PCP among various health care settings for members
7. Provide a Multi-disciplinary team approach to address the member's needs from the acute care phase through the post-acute care phase
8. Identify effects of underutilization as well as over-utilization.
9. Identify and coordinate with QI Department in the management of quality of care issues or trends.

F. 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.

G. Utilization Management Objectives

The objectives of Utilization Management are to:

1. 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
2. Monitor and evaluate the quality of hospital care, outpatient procedures and selected high volume, high cost services for appropriateness, necessity, efficiency and quality.
3. Establish utilization goals and monitor variance from goals through Utilization Management data collection and reports
4. 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.
5. Identify, assess and refer members to appropriate level of Population Health and assist member in post-acute phases of illness.
6. Ensure confidentiality of member and practitioner information.
7. Identify patterns of care in which outcomes may be improved through efficient utilization management and implement actions to improve performance.
8. Ensure timely responses and resolution to appeals and complaints.
9. Maintain ongoing integration through systematic communication between medical care management and behavioral health utilization managers to ensure the most holistic approach to member care.
10. Integrate Utilization Management activities with the Quality Improvement activities through the committee process and joint representation in performance improvement teams.
11. Establish and /disseminate evidence-based guidelines that promote quality/cost effective care.
12. Ensure the Utilization Management decisions, including adverse decisions, meet established turn-around time standards that meet or exceed regulatory and accreditation requirements.
13. 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.
14. Identify potential over and underutilization of Health Plan services.
15. Collaborate with local health delivery systems to align initiatives and facilitate program success.
16. Annually, measure and improve member and provider satisfaction with the UM/PH process.

H. 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.

Multi Disciplinary 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.

I. Criteria

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

1. TennCare Medical Necessity Criteria (Grier)
2. MCG USA Guidelines (to estimate length of stay)
3. OptumHealth Level of Care Guidelines (LOC)
4. American Society of Addiction Medicine Guidelines (ASAM)
5. TennCare Applied Behavior Analysis criteria (for applied behavior analysis)

These guidelines are integrated into the CareOne clinical information system.
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The Health Plan uses MCG USA 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 Policy and Procedure Committee. All guidelines are then reviewed and approved by the Health Plan PAS. The Health Plan also uses MCG's USA Guidelines for the following areas where applicable criteria or guidelines exist:

1. Hospice

2. Home health care
3. Skilled nursing facility
4. Inpatient rehabilitation

United Healthcare Community Plan currently utilizes Optum Level of Care Guidelines (LOCGs) to conduct medical necessity reviews of requests for services as they apply to available Behavioral Health benefits, and ASAM PPC-2R criteria are currently utilized for all Substance Abuse services.

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.

For Long-Term Services and Supports coverage of benefits is described in the TennCare guidelines (1200-13-01). Additionally a member specific Functional Assessment is utilized by the CHOICES Care Coordinators to determine the type and level of services needed by each individual CHOICES member. Each CHOICES member is involved in the Plan of Care process to determine member's available natural support and those services that will allow the member to maintain community living safely. The cost cap or expenditure cap logic is applied to ensure each member receives the appropriate type and level of services and to work with the member to determine the most appropriate setting for the services. This includes the option of using consumer directed services in the home.

J. Medical Policies and Guidelines

The Chief Medical Officer for Medical Health 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:

1. Current medical literature and peer reviewed publications
2. 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.uhccommunityplan.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.

K. 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.

L. 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 and Performance for review, tracking, trending and follow-up. QOC/QOS reports are presented to the PAS Committee.

Quality issues and trends identified by UM are measured and reported to the Clinical Operations Subcommittee. Areas that are measured and may be reported include but are not limited to:

1. Appeals Metrics
2. Prior Authorization and Intake reports
3. Physician and ICM Inter-rater Reliability reports
4. Sox Reports
5. Medical and Behavioral admissions/readmissions report
6. NICU reports

M. Review Types

1. 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, 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 or email.

2. 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/provider 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.

3. 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:

a. Coordination and facilitation of continued care after hospital discharge. Short-term discharge planning follows the member for up to 30 days
b. Initiation of discharge planning upon admission and monitoring through concurrent reviews.
c. 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.
d. Identifying members at high-risk for hospital readmission
e. Referral of members to the multidisciplinary team if it is determined that the member needs more complex services past the 30 days. The team members begin to manage the care and make 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:

a. Define expectations for discharge planning by hospital staff
b. Officially change discharge planning accountability for members in care management to CMs and CHOICES members to their care coordinator

4. 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:

a. Continuity of care issues exist
b. 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.

5. 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, medical and behavioral, 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.

7. 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, the Health Plan in conjunction with the claims division institute this type of business rule to be used in order to allow for claims payment to occur.

N. Decision Timeframes

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

	Decision Turn Around Time	Practitioner notification of approval	Written practitioner/member notification of denial
Non-urgent Pre-service	14 calendar days of receipt of request	Within 14 calendar days of the request	Within 14 calendar days of the request
Urgent/Expedited Pre-service	72 hours of receipt of request	Within 72 hours of the request	Within 72 hours of the request
Urgent Concurrent Review	24 hours of receipt of request	Within 24 hours of the request	Within 24 hours of the request
Post-service Decision	30 calendar days of receipt	Within 30 calendar days of the request	Within 30 calendar days of the request

O. Adverse Determinations

The adverse determination letter includes the following information:

1. The specific reason(s) for the denial, in easy to understand language;
2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial was based;
3. 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;
4. 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;
5. If the denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeals process;
6. That a Health Plan Medical Director is available to discuss the denial determination with the practitioner.

P. Denial Process

The process of review, utilizing established criteria, involves the first level review by appropriate clinical reviewers. The Health Plan Medical Director or UM 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:

1. The first level review assesses medical necessity against established medical necessity criteria and the member's benefit package and limitation;
2. If criteria are met, the services are approved;
3. If the service(s) does not meet criteria or if the criteria specifically require physician authorization, the reviewer submits the case for review;
4. All denial decisions are followed with written notification to the requesting practitioner and member;
5. 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

Q. 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 any time during the appeals process.

R. 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.

S. 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.

T. 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, Population Health 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.

U. 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.

IX. 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 as well as credentialing to the following provider groups: Highlands Wellmont, Health Choice, LLC, Health Choice, LLC, UTMG – Memphis, St. Jude Children's, Research Hosp., University Physicians' Association, Vanderbilt University Hospital, March Vision. 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 improvement action plans (IAP) at any time to address deficiencies in the delegated organization's performance. Failure by the delegate to comply with or address the IAP may lead to revocation of the delegation agreement. National delegation is monitored by the Medicaid Delegate Oversight Committee. Delegation specific to UHCCP is monitored by the Quality Management Committee.

Annual Evaluation

An annual evaluation of the QI Program is conducted to assess the overall effectiveness of the Health Plan's quality improvement processes, including activities to improve safety of clinical care. The evaluation reviews all aspects of the Program described in the prior year's QI program description and Work Plan, focusing on the overall effectiveness compared to goals and objectives. The results of the annual evaluations are used to develop and prioritize activities for the next year's annual work plan. The annual evaluations include:

1. A quantitative analysis and trending of measures.
2. The identified potential and actual barriers to achieving our goals.
3. The recommendations for QI Program revisions based on the evaluation.
4. A summary of the adequacy of resources, committee structure, physician participation and leadership involvement.

The annual evaluation is reviewed and approved by the QMC and the Board of Directors. 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 activities related to clinical care, service and patient safety for the upcoming year. The QI Work Plan includes program scope, measurable objectives, anticipated time frames and the accountable staff member. 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 and monitor the QI Work Plan 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.

Policies and Procedures

National and Health Plan policies are reviewed bi-annually and are available to all Health Plan employees through a shared Intranet location.

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 Population Health 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 Population Health 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. **HENRI - Health EducatioN Registry of Interventions** is the database for member health education interventions, including mailings, non-interactive and interactive voice response outreach calls.
9. **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.
10. **Provider Portal:** CommunityPlan*Online* is an innovative practice tool that allows for a wealth of information and resources to be available to providers at any time.
11. **View 360:** Is a provider portal that allows contracted physicians to access actionable information to aid in the identification of patients who may be candidates for specific treatments or screenings, consistent with preventive and clinical practice guidelines.
12. **CareOne:** Is our clinical information system housing medical, behavioral and Long Term Care Services and Supports 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 Population Health staff working in concert. Additionally, the documentation of verification of member demographics, including race, language, ethnicity and disability is stored in CareOne.
13. **Sharepoint(s):** SharePoint sites are established to house documents such as policies and procedures as well as major projects which staff may need to access collaboratively.
14. **VIPs/Med Measures:** Is used for profile data and HEDIS®
15. **National Committee for Quality Assurance – Quality Compass®** comparative data is utilized when setting benchmarks and performance goals.
16. **State Agencies** – Data from the State of Tennessee are utilized to supplement Health Plan data.

Confidentiality

The Program is designed to comply with the Enterprise Policies of UnitedHealth Group related to Ethics and Integrity. Through application of the policies related to Privacy, the Program seeks to retain the trust and respect of our members and the public in handling of private information including health, financial, and other personal information.

All employees, contracting practitioners/providers, and agents of UnitedHealth Group are required to maintain the confidentiality of protected health information, including, but not limited to, member demographic information, medical record content, peer review and quality improvement records. All information used for QI activities is maintained as confidential in accordance with federal and state laws and regulations, including HIPAA Privacy requirements. This information is not considered discoverable.

UHC policy limits access to protected health information to the minimum necessary to conduct Health Plan operations. QI reports and other materials containing protected health information are shredded after they are no longer required for Health Plan operations. Committee records are available only to authorized personnel in accordance with local, state, federal and other regulatory agencies. Each external committee participant must understand and agree to comply with these confidentiality policies and sign a Committee Member Confidentiality Statement.

HEALTH PLAN APPENDICES

Quality Management Work Plan
HEDIS®, Clinical Performance Work Plan

GLOSSARY

The following abbreviations are used in this document:

BHAC	Behavioral Health Advisory Committee
CAG	CHOICES Advisory Group
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CC	Credentialing Committee (Behavioral Health)
CC	Compliance Committee
CCS	Cultural Competency Subcommittee
CMS	Centers for Medicaid and Medicare Services
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)
HENRI	**H**ealth **E**ducatio**N** **R**egistry of **I**nterventions
ICM	Inpatient Care Managers
IRR	Inter-Rater Reliability
LTSS	Long Term Services and Supports
JOC	Joint Operating Committee
MDOC	Medicaid Delegated Oversight Committee
MDT	Multi-Disciplinary Teams
MM	Medical Management
MRR	Medical Record Review
MTAC	Medical Technology Assessment Committee (Medical)
NCC	National Credentialing Committee (Medical)
NIBHSC	National Integrated Behavioral Health Steering Committee
NJOC	National Joint Operating Committee
NPSC	National Provider Sanctions Committee
NMCMC	National Medical Care Management Committee
NQMOC	National Quality Management Oversight Committee
OHBS	Optum Health Behavioral Services
PAS	Provider Affairs Subcommittee
PDSA	Plan, Do, Study, Act quality improvement cycle
PIP	Performance Improvement Project
PPC	Policy and Procedure Committee (Behavioral Health)

QMC	Quality Management Committee
QIP	Quality Improvement Program
QI	Quality Improvement
QM	Quality Management
QMC	Quality Management Committee
QMP	Quality Management and Performance
SQIS	Service Quality Improvement Subcommittee
UHCCP	UnitedHealthcare Community Plan
UM	Utilization Management

APPROVALS

_____ **Date:**_____

Scott Bowers
President
UnitedHealthcare Community Plan

_____ **Date:**_____

Joel Bradley, M.D.
Chief Medical Officer
UnitedHealthcare Community Plan

_____ **Date:**_____

Joel Bradley, M.D.
Chair, Quality Management Committee
UnitedHealthcare Community Plan

_____ **Date:**_____

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