

SECTION 6 POPULATION HEALTH MANAGEMENT**Population Health Division****Structure and Accountability**

Health Alliance has a comprehensive Population Health Management Program administered by the Population Health Division (PHD). The PHD, formally known as the Medical Management Division (MMD), continues its focus on medical management activities. The Health Alliance Utilization Management Coordinators (UMCs) and Care Coordinators are accountable for the activities outlined in the Program Scope and Processes.

These individuals work directly with primary care physicians, specialists and other providers in the Health Alliance provider network who are responsible for coordinating the care of our members. The Chief Medical Officer (CMO) is the senior physician responsible for the activities of the PHD. Selected physician Medical Directors provide direct utilization management, and oversight for utilization and care coordination plan-wide. Local physician Medical Directors conduct utilization management activities including preauthorization, inpatient care management and medical necessity reviews pertinent to their service areas. All Medical Directors report to the CMO through the Associate Chief Medical Officer (ACMO). Utilization activities are reviewed and discussed at the Medical Directors' Committee.

Purpose

The PHD is committed to ensuring that the care delivered to our members is of the highest value. Health Alliance is committed to providing members with efficient, cost-effective and quality health care coverage. Health Alliance employees never encourage decisions that result in underutilization of care. We do not give financial inducements or set quotas for issuing denials of coverage or care; nor do we keep statistics identifying individual providers and their denial rates. Utilization decisions made by our Medical Directors, Utilization Management Nurses, Pharmacy Coordinators and Pharmacists are based only on appropriateness of care and service and the existence of coverage. There are no incentives, financial or otherwise, to encourage barriers to care and services.

Criteria

The UMCs respond to coverage requests by obtaining all necessary clinical information, researching benefit plan descriptions and applying established medical necessity criteria. The PHD uses clinical guidelines from nationally respected vendors, such as InterQual® and eviCore, which are based on best practice, clinical data and medical literature. Where vendor guidelines are incomplete or absent, internal medical policies are developed by the Medical Policy Committee and approved by the Medical Directors Committee.

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Medical Technology reviews are performed on new technologies to ensure we stay current with the latest standards of care.

InterQual®, eviCore and Health Alliance medical policies are available on our website. You may request a paper copy of any Health Alliance medical or behavioral health criteria by contacting your Provider Relations Specialist (PRS). Medical necessity reviews beyond the scope of current coverage criteria are referred to a Medical Director, who is then accountable for review and determination of coverage. Decisions made using any criteria are based on each member's clinical status and assessment of the local delivery system.

Program Scope and Processes

The following are the PHD activities and processes that encompass the Utilization Management Department and the Care Coordination Program. Each case is evaluated, and the established medical criteria appropriate to each case are applied. Individual patient circumstances and the capacity of the practitioner and provider delivery systems are considered. This includes the consideration of alternate settings when needed. Factors such as age, co-morbidities, complications, progress of treatment, psychosocial situations and home environment (when applicable) are factors that are reviewed when applying criteria.

Utilization Management

A. Preauthorization Review (Prior Authorization Review)

Preauthorization or prior authorization is a screening review process to ensure the medical necessity of selected services. This review provides for an enhanced matching of patient need with medical necessity and the appropriateness of the location of service. Clinical documentation to support the medical need of the service must be submitted with the review request. UMCs perform the preauthorization function and any request that falls outside the approved guidelines is forwarded to a Medical Director for review and coverage determination.

Preauthorization occurs prior to the delivery of service, and is subdivided into four categories:

1. Screening of selected elective services (e.g., inpatient rehabilitation facility or a skilled nursing facility).
2. Screening of selected procedures/diagnostic testing based on internal and external data showing significant practice variation.

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3. Screening of all physician referral requests to out-of-network and tertiary specialists, based on patient need and availability of service in the primary network for plans with only in-network benefits; and for plans with out-of-network benefits if the member is requesting in-network coverage.
4. Screening of requests for other medical services, such as durable medical equipment or other specified services, to ensure clinical appropriateness.

B. Inpatient Concurrent Review (ICR) for Medical, Surgical, and Behavioral Health Care Admissions

For patients admitted and discharged during non-business hours, retrospective review will be performed if notification and clinical information are received within 10 business days post discharge. Please note the following:

- If no medical information is received after admission notification is received or through concurrent review efforts, the UMC will make two good-faith calls to the facility. Upon the second call, the UMC will advise that no coverage will be granted for continued stay until clinical information is received.
- If a claim is submitted for an inpatient stay in which no admission notification was received, the claim will be disallowed. The facility/provider can submit an appeal if inaccurate insurance information was presented by the member upon admission along with medical documentation for review. Retrospective review will not be granted for any other reason.
- Members will be held harmless in all instances in which the facility/provider did not comply with the Health Alliance policy and procedures outlined in facility/provider contract.

Admission review is conducted within one (1) business day of being notified of the admission so the necessity of an admission can be determined and concurrent review can be initiated. Notification of admission by phone is required within 24 hours or the next business day. Please call (800) 851-3379 or fax (217) 902-9750 to notify Health Alliance of an inpatient admission.

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ICR is a process conducted by assigned UMCs and Medical Directors to assess the need for continued inpatient care for a member who has been admitted to a hospital, skilled nursing facility (SNF), acute inpatient stay in a behavioral health care facility, or physical rehabilitation facility. The UMCs will communicate the required frequency of medical necessity reviews, and they will use clinical notes provided by the facility. This review is performed to determine if the level of care continues to be medically appropriate or if care can be transitioned to a lower level of care.

UMCs provide Inpatient Utilization Management through a variety of activities. This is done formally in census meetings and informally as needed. During these meetings, complex cases are discussed, potential referrals to Care Coordination are identified and variances (medically unnecessary days/avoidable bed days) are assigned by the Medical Director. When indicated, the Medical Director contacts the attending physician to discuss the medical necessity of an inpatient stay, and/or the appropriate disposition, i.e., transfers, SNF, sub-acute care, and home care. Health Alliance uses the InterQual® Behavioral Health for reviewing medical necessity for behavior health services. In addition, InterQual® ASAM Criteria Navigator provides the American Society of Addiction Medicine Standards for our reviews around Substance Use Disorder. Behavioral Health inpatient reviews not meeting medical necessity criteria are reviewed by a Medical Director who is a board-certified in psychiatry. Health Alliance also has a contract with an independent review company, Prest & Associates. Prest offers immediate access to Behavioral Health providers who are able to perform clinical reviews and provide an opinion regarding medical necessity. When Prest is consulted, a local Medical Director makes the final coverage decision after reviewing the recommendations of the Prest reviewer. Potential medical quality of care issues and sentinel events are identified and forwarded to the Quality Management Department.

Discharge planning and coordination of care by the UMC begins upon admission. Individual reviews are performed to analyze each case for special needs and to consider availability of local health care resources. UMCs and the facility discharge planner work with the attending physician to ensure the member receives care at the most appropriate level. When warranted, the facility's Inpatient Care Coordinator meets with the patient and family members as early in the hospital stay as appropriate to discuss potential health care needs and coverage (this may not be indicated for short uncomplicated hospitalizations). If the member has complex issues or health care needs, they are referred for Care through Health Alliance for evaluation and potential enrollment.

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In circumstances where the member's benefits have been exhausted but medical needs still exist, the Care Coordinator will assist the member by providing information about other resources. This may mean informing the member or family about ways to obtain continued care through other sources such as community and government agencies. A referral to Care Coordination is also made.

C. Behavioral Health

The behavioral health components of the UM program are limited to inpatient review, out-of-network referral review, and selecting and updating medical necessity criteria. Behavioral health practitioners are involved in the UM program in a variety of ways. Practitioner involvement includes a Medical Director who is board certified in psychiatry, consultation with practicing psychiatrists and addiction medicine physicians associated with Carle Physician Group and with Prest & Associates' affiliated behavioral health practitioners.

Input from behavioral health physicians is solicited and considered when new behavioral health criteria are selected, as well as when substantive changes to existing criteria have been made. A psychiatrist is also a member of the Medical Policy Committee, a committee comprised of actively practicing practitioners that review all of the Health Alliance annual updates to the criteria, policies for applying the criteria and technology assessments.

D. Skilled Care

Health Alliance requires preauthorization for a skilled level of care at a skilled nursing facility. Utilization Coordinators will continue to review the beneficiary's condition and progress periodically at the SNF during the covered skilled stay and work with staff at the SNF to monitor the beneficiary's condition. Reviews are conducted by phone and may also occur on site at the facility. Health Alliance staff will issue the appropriate notification to the beneficiary when services are ending. Appeal rights will also be provided to the beneficiary.

SNFs are required to:

Provide all requested clinical updates and pertinent information regarding the beneficiary's progress and discharge planning as requested by Health Alliance Utilization Management.

Denial of Coverage (or Authorization)

If the requested or received service does not fall within the scope of the approved PHD criteria, the case is referred to a Medical Director for review. The Medical Director reviews all the medical information to make a coverage determination and additional information is requested if needed. The Medical Director may contact the requesting physician to discuss the case further. When necessary, the Medical Director confers with a specialist. After review of the case facts, the Medical Director makes a coverage determination of approval or denial, using his/her medical judgment, experience, and skill, as well as professionally recognized medical standards for treatment.

For all denials, the member, the member's representative and the requesting practitioner are notified in writing of the determination. The denial notice includes the rationale for the denial, the criteria used to make the determination, the appeal process and instructions on how the practitioner can contact the Medical Director to discuss the denial. The practitioner may also contact (800) 851-3379.

Requests for benefits that clearly fall outside the member's benefit package may be denied by the UMC. Any denial decisions for services that are, or that could be considered, covered benefits are determined by the Medical Director as previously described.

All appeals are forwarded to the Member and Provider Resolutions Unit for processing and resolution. See Member Complaints and Appeals in the Appeals section of this manual for additional information.

Turnaround Time Frames For Coverage Requests

The time frames explained below are our goals for notifying you of coverage decisions. Utilization Management adheres to the Department of Labor (DOL) and state Department of Insurance (DOI) regulatory requirements and takes into account the medical urgency of each member's condition. Please note that additional time (within DOL and DOI/state maximum time frames) will be taken if needed to perform a comprehensive review.

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Department of Labor Maximum Time Frames

Type of Review	Initial Time Frame (starts from date of initial request)	Extension Period	Second Time Frame (starts when information is received or extension expires)
Preservice (nonurgent)	5 calendar days	45 calendar days	5 calendar days*
Preservice (urgent)	48 hours	48 hours	24 hours

*Second time frame ends 5 calendar days from when information is received.

Standard (nonurgent) preservice requests: Our goal is to provide coverage decisions within five (5) business days of receiving a complete request that contains all the necessary medical documentation.

Urgent preservice requests: Our goal is to provide coverage decisions within one (1) business day of receiving a complete request. Please mark requests “urgent” only when there is an urgent medical need to receive the services within the shortened time frame. “Urgent” should not be used for scheduling conveniences. Marking requests “urgent” that are not truly urgent results in processing delays for all requests. **Urgent care is defined as any request for care or treatment with respect to which the application of the nonurgent time period for making a determination could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, based on a prudent layperson’s judgment, OR in the opinion of a practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.**

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Please submit complete requests. Supporting documentation is always necessary in making coverage decisions. A lack of complete clinical information may delay our review decision. In some cases, we may have to initiate a review extension by sending you a letter explaining what specific information is needed and the time frame for the extension (the Health Alliance member will also receive a copy of this letter). Once the information is received or the extension period is exhausted (whichever occurs first), we will complete the review and notify you of the coverage decision within 5 calendar days (standard request) or 48 hours (urgent request).

You can greatly impact the time it takes for a review to be completed by supplying complete medical information when submitting a request for coverage and by promptly responding to requests for additional information should the original request be insufficient.

Care Coordination Programs

The Care Coordination Programs are primarily telephonic and conducted on an outpatient basis. Care Coordination integrates the health team by including the member, the family, physician and ancillary providers in conjunction with the health plan. A team effort between all the involved parties allows for better continuity, consistent treatment planning and transition of care from one level to another when indicated. Care Coordinators assess, coordinate and in medical situations assist with the authorization of services for identified high-risk members. This coordination of care includes efforts to identify opportunities for cost effective treatment while maintaining or improving the quality of services available under the member's plan. The careful monitoring of these members alerts the Care Coordinator to changes in health status and allows for proactive communication with the primary care physician or treating physician to provide early intervention, if warranted.

Potential candidates for Care Coordination are identified in various ways, including predictive modeling software reports, referral from a disease management program, the inpatient utilization review process and other utilization management activities. Care Coordination referrals are also accepted from members, their families, discharge planners, practitioners, providers involved in a member's care and telephone advisory lines. Once identified, members are contacted and given the opportunity to participate in the program.

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Care Coordinators use evidence-based clinical assessment tools to identify gaps and barriers in care to develop a plan of care specific to the member's health status, taking into account the individual's specific needs and goals.

Members can be referred to our free program or enroll themselves via telephone by calling (800) 851-3379, ext. 28947.

A. Care Coordinators

The Care Coordination program focuses on assisting with coordination of services to ensure the member is receiving the right care, at the right time and in the right place. This includes acting as a liaison among multiple care providers, members and family. Another focus is educating members on their disease process and lifestyle changes that could impact or slow down the progression of their disease. The Care Coordination program includes, but is not limited to, the following conditions, diseases or high-risk groups:

- Acute myocardial infarction
- Cancer
- Diabetes
- Transplants
- Cardiac and/or lung disease
- Congestive heart failure
- Kidney failure/end-stage renal disease
- Multiple/repeat admissions or Emergency Department visits
- Multiple chronic illnesses or chronic illnesses that result in high utilization
- Neurological syndromes
- Pediatric anomalies
- Traumas
- Wounds
- Obesity

Care Coordinators work with the member to develop an individualized Care Coordination plan including:

- Prioritized goals
- Motivational Interviewing to enhance engagement and self-efficacy
- Identification of barriers to meeting goals, participating in or complying with the plan
- The development and communication of member self-management plans
- The development of a schedule for member follow-up and re-evaluation timeframes

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- An assessment of the member's progress toward overcoming barriers to care and meeting treatment goals
- Elicit the involvement of the member, family member, caregiver and/or providers in problem identification and prioritization, as needed
- Provide education related to specific conditions or disease states, health maintenance and prevention
- Explore community resources available to the member
- Encourage the member to communicate changes in condition with the attending physician
- Provide guidance to members and families in phases of adjustment to acute, chronic or terminal illness
- Maintain communication with the member and/or family to assure that the member understands, and is benefiting from, the care being received
- Advise attending physician(s) of any significant status changes
- Identification and resolution of Social Determinants of Health Care (SDOH) needs

Health Coaches

Health Coaching is a free service for all Health Alliance members. Our approach focuses on helping members make changes with their lifestyle in order to mitigate risk from chronic diseases like diabetes and hypertension. Primary focus involves engaging members who have a new diagnosis of diabetes and other clinical conditions that can be impacted by weight loss, improved nutrition, disease specific education and adherence to physician established treatment plans. Ongoing intention is to prevent the progression of co-morbidities and mitigate risk to the member, the health plan, employer and physician groups.

The coaching staff utilizes motivational interviewing to help member's explore their readiness to change and eliminate barriers to compliance with clinical standards. Gaps in care are addressed along with planning to assure on-going success with maintaining a healthy lifestyle post-graduation from the program.

B. Quality Program

The PHD collects and analyzes data in support of the Quality Management Program for the following initiatives: Care Coordination outcomes, continuity and coordination of care, quality of care and patient safety.

Surveys are mailed to our Care Coordination members upon graduation of our programs to gather, track and analyze feedback with our programs quarterly.

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Satisfaction Survey

On an annual basis, Health Alliance surveys a sample of our providers to evaluate satisfaction with our Population Health processes such as inpatient care coordination, outpatient care coordination, preauthorization, referral review, timeliness of decision making and communication. The results are analyzed for ways we can improve provider satisfaction. Your participation is greatly appreciated.

How to Get More Information

If you have questions about the status of a review or other Medical Management processes or would like to refer a member to our program, call Health Alliance Monday-Friday, 8 a.m. to 5 p.m., at 1-800-851-3379. After normal business hours, you may leave a message at this number and it will be returned the next business day.

Preauthorization

To request preauthorization, please log-in to Tapestry Link. Once logged-in, you can check member preauthorization lists, search particular codes to find out if preauthorization is required, and submit preauthorization requests.

If you have questions about the preauthorization process or any of the methods available to submit a preauthorization request, please contact your PRS.