May 2025

Utilization Management Program Description

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I. Introduction

Medical Mutual's Utilization Management Program is designed to ensure and facilitate the delivery of medically necessary, evidenced-based, high quality, cost-effective healthcare services in the most appropriate setting for its members. The program delivers utilization management and case management services to the health plan members of Medical Mutual and its subsidiaries.

Medical Mutual is the largest health insurer headquartered in the state of Ohio, with a total membership of approximately 1.1 million members. The lines of business include Commercial, Marketplace, and Medicare Advantage plans, offering a range of HMO, POS, and PPO products.

The Utilization Management Program Overview section provides a description of the structures, functions and processes that apply to both the Utilization Management (UM) and Case Management (CM) Programs. Individual aspects that are unique to the individual UM Program or CM Program are described in subsequent separate, distinct sections.

II. Utilization Management Program Overview

A. Organizational Structure and Oversight

The Utilization Management organizational structure and program resources are applicable to all Case Management and Utilization Management programs described in this document. The program operations are highly integrated with shared structures and resources.


CQHS Division Management Team

Chairman, President & Chief Executive Officer (CEO)
The Chairman, President & CEO is the senior executive who is responsible for all Medical Mutual products. Positions reporting to the CEO include the Executive Vice President, Chief Medical Officer. The Chief Medical Officer reports to the Executive Vice President, Chief Medical Officer.

EVP & Chief Medical Officer
The Chief Medical Officer (CMO) reports to the CEO and has responsibility for providing the medical direction for MMO's corporate quality strategy, direction, and oversight of all clinical aspects of the Utilization Management program, and oversight of all physician activities. Reporting to the CMO are the Medical Directors who are responsible for oversight of the medical and behavioral health utilization management and quality programs. The CMO is responsible for the leadership of strategic medical management activities which contribute to the performance of Medicare Advantage, Marketplace and other Commercial lines of business and promote quality of care for members. These responsibilities include development and implementation of medical programs/policies, enhancing relationships with providers and facilities, plan sponsors and regulatory agencies and acts as a key business partner in network development, product design, and strategic planning.

Manager, Utilization Management (UM) Medical Director
The Manager, UM Medical Director position is responsible for providing clinical expertise and day-to-day oversight of utilization management programs to promote the delivery of high quality, customer responsive and cost-effective medical care. The Manager, UM Director reports to the Chief Medical Officer and responsibilities include oversight over all Assistant Medical Directors (AMD) and contracted physician reviewers who review actual and proposed medical care services against established CMS, Medical Mutual and other nationally recognized and accepted guidelines. The Manager, UM Medical Director contributes to the achievement of clinical excellence, quality ratings improvement, appropriate inpatient and outpatient utilization, affordability, compliance, growth, and focused improvement.

Medical Directors and Physician Reviewer Resources

Medical Mutual employs Medical Directors, AMDs, and contracts with individual physician reviewers, representing a range of primary care and specialty care clinical specialties. AMDs and physician reviewers provide consultation and review of utilization and case management cases and report directly to the Medical Directors.

Medical Mutual also contracts with two organizations, Allmed, and MES Peer Review Services to provide supplemental physician review resources to support medical-surgical and behavioral health medical necessity and appeal determinations. Both organizations are URAC accredited as Independent Review Organization: Comprehensive (IROC).

Vice President, Pharmacy Manager
This position reports to the EVP & Chief Medical Officer and is responsible for all clinical and operational issues relating to the Pharmacy and Clinical Drug Management department. The VP, Chief Pharmacy Officer is accountable for oversight of delegated utilization management activities related to pharmaceutical and medical drug management. Reporting to the VP, Chief Pharmacy Officer are four management positions that oversee Clinical Pharmacy Programs, Medicare Part D and Pharmacy Services and Medical Drug Management. This position also serves on the Pharmacy & Therapeutics Committee and the CQRM Committee.

Vice President, Clinical Services & Operations
This position reports to the EVP & Chief Medical Officer and is responsible for population health management activities and is responsible for the design and execution of clinical strategies targeted to improve health outcomes and to ensure such strategies are integrated with the care delivery system and community partners. This position is also responsible for advancing evidence-based policies, protocols, and practices to ensure efficient use of health care services and working to optimize member benefits across the care continuum.

This position is also responsible for optimizing clinical systems, developing efficient processes to investigate and effectuate medical appeals and medical claim reviews and to identify trends and analyze root causes to reduce avoidable appeals and pended claims. This position is also responsible for creating courses and curricula and facilitating training for all job positions within CQHS to develop the requisite knowledge and skills for onboarding new employees as well as supporting ongoing professional development.

Vice President, Medicare Stars and Quality Improvement
The Vice President of Medicare Stars and Quality Improvement reports to the EVP and Chief Medical Officer and is responsible for leading quality improvement efforts and advancing continuous quality improvement understanding and competencies across the organizations. This position is also responsible for leading Medicare Star efforts and working to ensure collaboration across departments and with management to direct initiatives that advance star performance. Last, this position is responsible for leading NCQA accreditation surveys and working to ensure that standards are integrated into business processes throughout the organization.

B. Relationship to Quality Committees

All Utilization Management (UM) activities report into the Clinical Quality & Resource Management Committee (CQRMC). The CQRMC provides strategic direction and oversight to all committees and work groups focused on the quality and safety of clinical care.

C. Information Processing and Storage Resources

The UM Program maximizes the effectiveness and productivity through HIPAA compliant electronic systems which are used to provide data, facilitate information collection and/or automate the decision-making for utilization management and case management functions. Access is via secure profiles to allow the user view or entry capabilities dependent on their role. The key electronic systems are described below.

MedCommunity

MedCommunity is the electronic web application that allows comprehensive management of medical information and its secure exchange between Medical Mutual and providers. It is available 24-hours per day/7days per week via our website. Registered users of MedCommunity submit requests and electronically communicate information regarding inpatient admissions and discharge planning for

behavioral health, medical or surgical, acute inpatient rehabilitation, long term acute care, inpatient skilled nursing facility cases and select imaging procedures. Over 85% of authorization requests are submitted electronically. Use of MedCommunity streamlines the utilization review process, decreases the need for telephonic communication, takes advantage of the provider's electronic record system by allowing information to be copied and pasted into the system. MedCommunity has a bidirectional interface with the MedCompass application.

MedCompass

All clinical teams, including Prior Authorization, Utilization Management, Case Management, Medical Drug Management and Appeals, are all working in the MedCompass platform. Unlike traditional CM and UM platforms that keep information siloed, MedCompass integrates care management, utilization management, and medication therapy management into a member centric record. This record can be accessed by Medical Mutual staff, customer care representatives and Providers so all points on the care continuum can both contribute and coordinate the member's care.

MedCompass is integrated with data from all Medical Mutual's other systems including membership files, provider network information, claims, risk stratification data, clinical data from other providers gathered through our HIE connections, lab data, pharmacy data, and prior authorizations. The clinical workflows, from identification through reporting and analysis, are driven by a powerful rule engine in MedCompass. Rules will alert users, create tasks, schedule contacts and more. Since all members of the Care Team have access to MedCompass they also benefit from automated actions-such as alerts about gaps in care, emergency department visits and acute admissions which provides an opportunity to engage and address care needs with each member touchpoint.

From a workflow perspective MedCompass emphasizes automation, collaboration, and integration. Let's consider an example: a new member is identified with diabetes and the risk tool stratifies her as being high risk- the MedCompass rule engine will route the case to a work queue for assignment or directly assign it to a nurse care manager. The rules engine is highly configurable so it can send engagement and assessment tasks and even choose a workflow based on whether the risk score was new or a change in member needs. Any data entered or updated in MedCompass can be used to trigger a rule action.

Engagement of the member can be done through multiple channels in MedCompass. Just as important, when the clinical reviewer first opens the member record the "Member 360" will provide a quick, easy to use summary of what we know in MedCompass about this member. That summary includes data from all the systems with which MedCompass is integrated. Also, MedCompass keeps data for all member authorizations within the Member Record including acute and post-acute care and services subject to Prior Authorizations. This "Member 360" view fosters intensive collaboration between clinical teams in support of continuity of care for the members.

Assessments will be completed throughout a member's tenure in a CM program. MedCompass integrates these assessments with the Care Plan. Answers from any assessment, from an SDoH survey to an HRA, generate problems, goals, and interventions. Member specified goals and interventions can be added when reviewed with him/her.

Interventions to address care plan problems may involve referrals to community resources. MedCompass is integrated with the SDoH platform so that users can manage those referrals from the member record, once again keeping information visible for all Care Team members.

Cohere Health and the Rhyme LiveAuth™/Prior Auth Automation

Cohere works with health plans to digitize and automate the end-to-end authorization process, enabling faster, better clinical outcomes and decreased administrative burden through their web-based portal or through the Rhyme application. Cohere uses UM Clinical Analytics based on information the provider submits or from EMR (Rhyme) to provide real-time decisioning or will pend to UM for additional review. It is available 24-hours per day/7days per week. Registered users of Cohere submit requests and electronically communicate information regarding a variety of services such but not limited to surgical

procedures, durable medical equipment, diagnostic services, home health care services as well as other outpatient procedures and services. In addition, prior authorization requests for radiation oncology services can be submitted through Rhyme's EMR application, or through eviCore.

CareWebQI

CareWebQI (CWQI) is a web-based tool that utilizes an application programming interface (API) to integrate CWQI into the MedCompass system at the member level. CWQI provides access to MCG evidence-based guidelines and resources. It also facilitates a streamlined care workflow to document medical necessity, discharge planning and capture clinical documentation.

MCG InformedBy

InformedBy Chronic Care guidelines address chronic conditions to help the case management team evaluate needs, identify goals, develop personalized care plans, and support effective self-care for people with chronic diseases or complex care issues. The modular design supports quick and efficient assessments and enables you to manage multiple comorbidities and behavioral health.
Designed for people needing telephonic or in-person support, high-intensity disease guidelines consist of various modules to create comprehensive assessments and care plans, including:

- Enrollment
- Start of care
- Self-management
- Psychosocial (including social determinants of health assessments)

OnBase

OnBase is a secured document imaging and electronic records management system. It is used to store documents used in the care management process which were originally received as paper/hard copy or via Retarus Fax. These documents may include prior approval requests, appeal documentation, and/or medical records. OnBase is integrated into MedCompass at both the patient and case level, with a hyperlink to access the stored documentation.

Impact Pro™

Impact Pro is a multi-dimensional, episode-based predictive modeling and care management analytics system. It provides readily accessible clinical, risk, and administrative individual member profile information to help clinical staff target healthcare services to those members who will benefit most. Impact Pro interacts with MedCompass at the patient level, via a hosted interface to access the member-specific information.

Online Certificate Book System

The Online Certificate Book system allows the user to search for and view the Certificate/Benefit Book for active groups by entering their 9-digit group/section number. An additional component of the system allows the user to search for and view Books Provided by the Employer Group by selecting the corresponding Group Name/Plan Title. The Online Certificate Book system is accessed from the corporate intranet site.

Coding Support Tools

Coding support tools are available online to staff and provide English-to-Code and Code-to-English searches for both diagnosis and procedures.

SharePoint site

The SharePoint site is in a centralized online location for storing a variety of content related to the Care Management division, its departments, documents, announcements, and web links. It provides quick access to the most current version of documents referenced in daily work. Examples of content items posted to the site include:

- Policies and Procedures
- Program information and Meeting Presentations

- Accreditation Standards
- Links to CMS sites, including Medicare Coverage Center and Medicare Learning Matters
- Training Documentation.

Call Management Systems

The Call Management System consists of state-of-the art PBX software and hardware provided by Avaya. The voice infrastructure is comprised of Call Management Software (CMS) for automated call distribution, reporting and statistics gathering. The system has features which allow for real-time service observations for purposes of quality monitoring. Verint Impact 360 Recording is a software-based recording solution which provides synchronized voice/data recording and real-time. The system captures and stores every call and allows for easy retrieval to ensure compliance, quality, and coaching of staff members. Call recordings are kept for 10 years.

Medical Mutual also utilizes Microsoft Teams and Five9, a cloud-based system that simplifies phone operations and gives leadership more options to filter calls and retrieve valuable call data to use in decision making.

D. Quality Assessment and Improvement Activities

1. Quality Assurance Review

Quality Assurance Review is a process used to monitor and improve the quality of clinical care management activities. Audit tools exist for each review function and audits are performed and results reported at least annually. The quality review process is overseen by the area Supervisors. Staff are expected to achieve and maintain a score at or above the target performance goal set for the department.

The objectives of Quality Assurance Review include establishing measurable standards to evaluate the performance of the staff.

- Develop and maintain an audit tool for use in reviewing case documentation for accuracy;
- Monitor compliance with defined policies and procedures;
- Identify areas of inconsistency and track and trend findings to determine if the error was made due to knowledge deficit or performance error;
- Identity areas of opportunity for improvement of documentation of the case and utilization management processes;
- Provide individual educational feedback on audit outcomes in order to improve performance and to incorporate into individual annual performance planning.

The Medical Directors perform quality review for physician reviewers utilizing monthly activity reports. Components of physician reviewer quality review include timeliness, and the number of review decisions reversed on peer to peer and appeal.

2. Interrater Reliability

Interrater reliability is performed to ensure consistent processes and outcomes in clinical decision making. Interrater reliability studies are completed at least annually by nurses and physicians who are involved in utilization management activities. Online interrater testing tools are used to evaluate the consistency in which criteria is applied in decision making.

3. Call Monitoring

The Verint Impact 360 Call Recordings are retained to ensure compliance, quality, and coaching of our staff. Management selects random calls and reviews with each nurse for opportunities to provide optimal service and evaluate the accuracy of information related to the caller. Documentation of each coaching session is included in the annual employee evaluation and incorporated within the employee's performance goals.

4. Case Consultation and Case Rounds

Case consultation and rounds provide an opportunity for input from peers and physicians regarding the clinical management plan of care. Case consultation with a physician reviewer is available on any case where input on quality, clinical management and care planning is needed. Case rounds are conferences attended by medical and behavioral health inpatient care managers, case managers, social workers, and the Senior Medical Officer, Assistant Medical Directors and/or physician reviewers. Cases are selected due to medical complexity, psychosocial issues, or unusual disease states. Additional case conferences are held at intervals for quality improvement and care planning purposes. These include:

- Neonatal/Pediatric case rounds
- High Dollar/Complex case review/Extended Length of Stay case rounds
- Medicare Advantage case rounds

5. Policy and Procedure Development

Well-defined policies and procedures provide a mechanism to ensure consistent delivery of processes and services as well as a means to monitor individual adherence. Policies and procedures are reviewed at least annually and updated as required to reflect necessary changes. Policies and procedures may be line of business specific or comprehensive general policies applicable to all lines of business.

E. Training and Development

New hires are provided with a multi-week orientation experience that consists of training facilitated by assigned departmental trainers. A combination of online and classroom training is utilized for this orientation with a focus on topics that are specific to their respective departments. Examples of topics covered in the orientation include a detailed overview of the Clinical Quality Health Services (CQHS) division, divisional and departmental policies and procedures, and an overview of the various systems used within CQHS. The Corporate Learning & Development department provides new hires with an orientation session on their first day on the job which includes an overview of important Company-wide information, such as corporate policies and processes. Corporate Learning also provides additional classroom training to new hires on key topics such as customer service, diversity and problem solving.

Clinical staff have ongoing access to a variety of professional development opportunities to enhance their knowledge and clinical skills and earn continuing education credit either through Relias Learning or Case Management Society of America (CMSA). Ongoing educational opportunities are provided and led by Medical Directors and other clinical leaders and may focus on clinical management or product-specific training such as Medicare Advantage. Additionally, access to a comprehensive employee development program that includes online and classroom-based training for building professional and technical skills is available through the Corporate Learning & Development. All staff is provided at least annual updates of the following programs:

- Information Security Awareness: Provides a basic overview of the policies and procedures that secure the Company's data, premises, and employees.
- HIPAA Privacy Awareness: Provide an overview on how all employees must keep private, personal health information that they encounter every day in the course of doing business.
- Code of Conduct: Provides an overview of the company's code of conduct policy
- Diversity, Equity, and Inclusion (DEI): Initiatives, programs and practices to foster a diverse, equitable and inclusive workplace. Each year we examine our DEI efforts through Greater Cleveland Partnership's Organizational Assessment and score high in the best practices throughout the Company.
  - Oversee the Employee Engagement AIP Goal
  - Facilitate Experience Inclusion
  - Provide guidance to the Business Resource Groups
  - Promote our companywide 2025 Commemorative Month and Day Observances
  - Support our community with time and resources
  - Engage older adults in our community through events

- Connect with DEI-focused organizations (such as Greater Cleveland Partnership, Ohio Diversity Council, The Diversity Center of Northeast Ohio and Plexus LGBT & Allied Chamber of Commerce) to assess ourselves and exchange best practices
- Partner with departments throughout the Company to ensure inclusive practices and procedures are in place

- Medicare Advantage training related to fraud, waste, and abuse and for MA staff, organizational determinations, grievances and appeals.

F. Integration with Key Functional Areas

Integration and coordination with other functional areas is critical to the operation of the utilization management and case management functions within the Utilization Management Program.

1. Clinical Quality Improvement

Clinical staff who identify potential quality of care issues during the course of their clinical review and case management activities enter the specific quality indicator in the MedCompass system. Quality issues may be related to individual members, providers, diagnoses, procedures, or any combination of issues. Quality issues warranting further investigation are routed via MedCompass to the Clinical Quality department for detailed investigation and tracking and are addressed by the Chief Medical Officer, or designee, and the CQRMC as applicable.

2. Benefit Administration

Evaluation and assessment of new applications of existing technology may include sufficient evidence of demonstrated medical efficacy to allow the technology to be included in current standards of care within the medical or behavioral health community. If the result of the technology assessment includes a recommendation to include coverage of the services in Medical Mutual's basic benefit packages, the Medical Policy Department works with the Benefits Administration Department to ensure availability for its members.

3. Claims Operations and Adjudication

Coordination with the Claims Operations area is accomplished by collaborative ad hoc teams and system integration processes.

There are three key online systematic communication processes which interface with claims adjudication.

- Medical Authorization File (MAF): The claims adjudication system is programmed to identify those services that are required to have an authorization prior to claims payment and suspend any claim without a Medical Authorization File record on file for review of medical necessity. Medical necessity review outcome details for services requiring authorization are extracted from MedCompass and build a MAF viewable in the CS Lite system. This MAF file interfaces and is accessed during claims processing. The file indicates to the claim processor to approve, partially deny, or deny the entire service.
- Medical Claim Initial and Appeal Review: MedCompass Service Authorization records are created via interface from the claims system when claims are pended for medical necessity review. MedCompass Appeal records are interfaced from the CORS system when claims are appealed by providers. MedCompass captures the outcome of the medical necessity review and supplies that information for claims adjudication to approve, partially deny or deny the entire service. Information regarding review outcome determinations for authorizations and claims automatically interfaces from the MedCompass system to the claims payment system.
- Focused Review Parameters (FRP): A process known as Focus Review Parameters allow criteria to be set to evaluate specific claims. The FRP operates between the claims adjudication system and the MedCompass system. The parameters set can be read by claims system during adjudication to assign a specific action to the claim. The purpose of an FRP is to provide flexibility in processing to manage an unusual or specific claim.

4. Customer Care

Customer Care staff can access limited information on the MedCompass system. This view developed specifically for non-clinical areas is called CS Lite. Available information addresses most issues related to UM, such as the status of a prior approval request, questions regarding claims payment resulting from UM decisions and appeal status. Departmental supervisors may be contacted for assistance with care management issues.

Complaints that are received by the Customer Service area are entered into the Contact On-line Reporting System (CORS). Cases that require clinical intervention are then interfaced to MedCompass and a Service Authorization is generated, and a specific quality indicator is entered and routed to the Quality Department for evaluation and processing.

G. Confidentiality

The UM Program information generated or presented, including all related data and documents, is strictly confidential and is accessible only by those with authority and as required by certain governmental agencies. UM and CM activities are conducted in a manner that protects the confidentiality of the member and the provider. Methods to ensure confidentiality of information include the following:

- Confidentiality provisions or requirements are included in provider and consultant contracts;
- Signed confidentiality attestations are required for all employees, including temporary employees, interns, and consultants;
- Confidential documents are secured in locked files;
- Security clearance is required for access to member information housed in the MedCompass system, as well as for other data collection and the claims processing system;
- Compliance is maintained with Corporate and departmental confidentiality policies, in accordance with accreditation standards and applicable regulatory requirements, i.e., HIPAA; and
- The identity of involved individuals is protected except when identification is needed to conduct UM or CM activities.

III. Utilization Management Program

The Utilization Management Program (UM Program), an integral part of the Clinical Quality Health Services, is an ongoing, comprehensive program that establishes a formal process for developing, implementing, and continuously evaluating an effective utilization management process. UM Program provides information and tools to its constituents that empower members, support providers and manages healthcare expenses for its customers.

Medical Mutual strives to ensure that its members receive care consistent with professionally recognized standards of medical practice through its networks of hospitals and inpatient facilities, primary care and specialty care physicians, behavioral health providers, and ancillary providers. The UM Program is designed as a comprehensive system that identifies opportunities to improve the health and safety of its members, while enhancing effective and efficient use of healthcare resources.

A. Goals and Objectives of the Utilization Management Program

The following goals and objectives have been adopted to support the mission of the UM Program:

Goals

- Respond to the needs and expectations of internal and external customers by establishing, maintaining, and continuously assessing utilization management processes and outcomes.
- Ensure that Plan benefits are offered uniformly to all members residing in the service area.
- Comply with all CMS, State, and other regulatory requirements in the delivery of the utilization management and case management activities.
- Ensure UM Program integrity by providing coverage for only those medically necessary services that reflect current scientific data, medical knowledge, and current clinical practice standards.
- Ensure parity in the administration of the UM program for medical and behavioral healthcare

services.
- Ensure the provision of safe, appropriate, and necessary medical and behavioral healthcare services to members by identifying and investigating quality issues and opportunities within the UM Program and employing continuous quality improvement processes and methods to achieve both UM Program and organizational goals.
- Protect the confidentiality of personal health information of all members in accordance with Company policy, national accreditation standards and all applicable regulatory requirements.

Objectives

- Provide consistent and timely medical necessity determinations which accommodate clinical urgency.
- Comply with National Committee for Quality Assurance (NCQA) standards and with all applicable regulatory requirements.
- Manage member healthcare services and monitor to identify issues of over/under use and the misuse of healthcare services that are inconsistent with medical evidence.
- Maintain processes to support timely communication with healthcare providers.
- Promote effective resource management by directing member care to accessible cost-effective network providers and services at the appropriate level of care.
- Ensure appropriate utilization of emergent and urgent care services through the education of members and providers.
- Implement programs to prevent potentially avoidable admissions and readmissions.
- Ensure that all member complaints and appeals related to the UM Program receive thorough, appropriate, and timely resolution and are evaluated for opportunities to improve UM Program performance.
- Maintain processes that support member and provider satisfaction with UM Program activities and processes.
- Maintain processes to identify members with complex or specialized needs, and refer them to case management, as appropriate.
- Maintain processes to identify and refer healthcare provider potential quality of care issues to the Clinical Quality Improvement department for investigation and follow-up.

B. Scope of the Utilization Management Program

The UM Program is designed to monitor the clinical appropriateness and cost-effectiveness of services to members in Commercial, Marketplace, and Medicare Advantage products. The UM Program is administered through the activities of following departments:

- Acute and Post-Acute Care
- Prior Authorization
- Case Management
- Medical Policy
- Clinical Appeals
- Clinical Claim Review and,
- Pharmacy and Clinical Drug Management

To effectively achieve the UM Program goals and objectives, the departments are comprised of employed and contracted licensed health professionals including nurses, social workers, physicians and other educated professionals and administrative support personnel. Non-licensed administrative staff support the business operations of the various departments. Nurse reviewers (registered and licensed practical nurses) or behavioral health clinical care managers (registered nurses and licensed independent social workers) hereafter collectively referred to as 'clinical reviewers' perform prospective, concurrent, and retrospective review functions that require clinical judgment. Licensed physicians oversee UM determinations. Each department includes staff and management who oversee day-to-day UM activities, staff training, appropriate criteria application, and documentation consistency.

The Chief Medical Officer and the physician team are available daily for case consultation onsite, by phone/Web and/or confidential email.

Utilization management activities are carried out through an internal program and through the delegation of utilization functions to other entities for select services. Medical Mutual maintains oversight of all delegated functions.

The scope of the UM Program includes medical-surgical and behavioral health services. The services subject to clinical review include the following:

- Inpatient care at acute care facilities, skilled nursing facilities, acute inpatient rehabilitation facilities and long-term acute care facilities;
- Inpatient and residential behavioral health services;
- Select outpatient services; specified imaging studies; therapy including speech, occupational, physical, and chiropractic; certain durable medical equipment and select outpatient procedures, such as those which may be deemed cosmetic or experimental/investigational;
- Evaluation of emergency services for determination of the benefit coverage level;
- Pharmacy and medical drug management services; and
- Professional medical services claims.

The UM Program includes a prior authorization gold-carding strategy which aims to increase quality outcomes and positive member & provider experiences while decreasing the administrative burden on the organization. This strategy allows for the exemption from the prior authorization process for certain providers that meet performance standards regarding approval rates and quality measures. In this way, providers that have high prior authorization approval rates can bypass these requirements for a certain period. Gold Carding can then curb overutilization and ease the provider burden. The end goal of Gold Carding is to improve clinical results while streamlining the prior authorization process. Clinical oversight and audit processes are in place as control measures to ensure continued provider adherence to the gold card requirements. Audit results are shared semi-annually with the participating providers and Medical Mutual reserves the right to remove providers from the gold card process based on performance.

The UM Program also includes a technology evaluation and assessment review process which examines the utilization of drugs, biologics, medical devices, durable medical equipment, diagnostic or therapeutic procedures, evaluation and management services and other products or issues which may be related to the clinical care of members. Emphasis is placed on new technologies and on evolving applications of established modalities. A component of the evaluation process for new technologies involves the determination of benefit availability and medical necessity.

Ongoing monitoring, review and evaluation of UM Program activities are conducted. Annual evaluation is detailed in the UM Program Evaluation.

The UM Program operates without a referral program component. There are no referrals required for specialty care in the Commercial, Marketplace or Medicare Advantage products. Members can directly access specialists within the network or non-network specialty care (when allowable under the benefit plan design).

C. Annual Utilization Management Program Evaluation and Updates

The UM Program is evaluated at least annually and revised as necessary, to ensure that the UM Program remains current and achieves its desired objectives. The Vice President, Clinical Services & Operations, is responsible for coordinating the UM Program evaluation. All medical leadership and department Directors involved in the UM Program contribute to the evaluation.

The UM Program Evaluation includes but is not limited to:

- Consideration of member and provider experience data with the UM Program;
- Assessment of the involvement of physicians, including senior-level and designated behavioral health, in the UM program;
- The overall structure of the program; and
- The scope of the program, processes and information sources used to determine benefit coverage and medical necessity.

Modifications to the UM Program are made in response to monitoring the program and to changes in healthcare services, practice patterns, member needs, Medical Mutual policies, accreditation standards and regulatory requirements. The UM Program Description is updated to reflect changes in the UM Program for subsequent years.

The UM Program evaluation and Program Description are reviewed and approved annually by the UMCM Committee and CQRM Committee.

D. Utilization Review Methodology and Support

1. Decision Support Criteria and Guidelines

Decision criteria are designed to assist UM staff in assessing the appropriateness of care and/or length of stay for medical or behavioral health situations encountered most frequently in regular practice. Application of the criteria is not absolute but is referenced as a guide in the review of individual healthcare needs of the member in accordance with the member's specific benefit plan and the capability of the healthcare delivery systems.

The intent of using established screening and decision criteria is to promote consistency of evidence-based reviews. Medical Mutual applies the following criteria for utilization management screening and decisions in accordance with the member's specific benefit plan.

1.1 MCG

MCG contains evidence-based criteria, goals, optimal care pathways, and other decision-support tools serving as a resource for case review, assessment of members facing hospitalization or surgery, and for proactive care management. MCG criteria is used for acute, post-acute and behavioral health care.

- MCG Acute Care Guidelines include Inpatient & Surgical Care, General Recovery Care, and Multiple Condition Management.
- MCG Post-acute Care Guidelines include Ambulatory Care, Recovery Facility Care, and Home Care.
- MCG Behavioral Health Care provide optimal care criteria for mental health and substance abuse populations across all levels of care.

1.2 Medical Mutual Corporate Medical Policies (CMP)

Corporate Medical Policies are developed by Medical Mutual's Medical Policy Department for non-prescription drug services, and the Pharmacy and Clinical Drug Management Department for prescription drugs covered under the medical benefit. The aim of the CMP is designed to address complex and emerging technology. The principal work is to review new technology and procedures and to determine if they meet Medical Mutual's *Healthcare Technology Assessment* criteria. The conclusion of the process encompasses policy areas including, but not limited to medical necessity, investigational, experimental, and cosmetic services.

Corporate Medical Policy is designed to serve as a guideline and reference point for nurse and physician reviewers when making medical necessity determinations and benefit coverage decisions. The policies largely focus on emerging, complex healthcare technologies, but also address select pharmaceuticals, medical devices, medical, surgical, or behavioral health services and procedures. In some instances, the medical necessity of established technologies, services or procedures may also be included, e.g., modified surgical techniques or existing medical devices with new indications and updated guidelines or protocols.

Medical Mutual employs a healthcare technology evaluation and assessment review process that is defined in Medical Mutual's *Healthcare Technology Assessment Program Description for the Development of Corporate Medical Policy*. This evidence-based process incorporates nationally recognized standards of care and practice, current professional peer-reviewed literature, and reports and recommendations published by organizations, such as Hayes Inc. and the Centers for Medicare and Medicaid Services (CMS).

CMPs are reviewed at least annually and are updated as standards of practice or technology change. The CMPs are posted on the corporate website and are supplied to members and providers on a case-specific basis or on

request. CMPs are codified into the clinical claims editing system for processing within the TOPPS claims workflow.

1.3 Medical Mutual Departmental Policies and Procedures

Policies guiding the application of the criteria are reviewed and revised on an annual basis by the Directors in the UM Program.

1.4 Medicare Coverage Guidelines

Medical Mutual applies National Coverage Decisions (NCD), general Medicare guidelines, and the written coverage decisions of local Medicare contractors (LCD), as applicable, for Medicare Advantage case reviews. In addition, CMS coverage manuals also serve as a source of guidance, and these may include but not limited to the Medicare Managed Care Manual, Medicare Benefit Policy Manual, and Medicare Program Integrity Manual.

2. Review Process and Information Sources

Clinical review is conducted to confirm the medical necessity of treatment and/or the appropriateness of the setting by evaluating specific clinical information against criteria. The process may be applied prospectively, concurrently, or retrospectively.

Information used to make medical necessity determinations is accepted from any reasonable, reliable source (including medical records, responsible family members and/or healthcare professionals) and is received electronically through a web-based application, via mail, fax or telephonically through a nurse or physician conversation. Initial clinical reviews of this information are performed by clinical reviewers. The information collected is limited to the essential information needed to determine the eligibility, benefit interpretation, and the medical necessity of the service. This information includes relevant:

- Patient demographic information including any cultural, racial, ethnic and/or linguistic needs and preferences;
- Diagnosis and co-morbidities;
- Reports of physical examinations, consultations, test results, prior treatment, and current treatment plan;
- Prescribed medication, frequency, and dosage;
- Progress of treatment, including any complications;
- Psychosocial history;
- Level of urgency;
- Home environment and local delivery system, when applicable; and
- Member eligibility and benefits, including limitations and exclusions.

Non-clinical administrative personnel support the UM program, but do not participate in making determinations of medical necessity. Clinical reviewers approve services that meet established criteria. Nurses do not issue denials of care based on medical necessity, but instead refer cases to physician reviewers.

Medical Directors and physician reviewers make denial decisions on all medical-surgical and behavioral health services and prescription drugs under CMPs based on benefit coverage and medical necessity. These physician reviewers may seek consultation with board-certified specialists in complex clinical situations or cases outside their area of clinical expertise. A list of board-certified specialists is maintained to facilitate the consultation process. Determination timeframes meet accreditation standards and all other applicable regulations.

Providers are notified, as applicable, of the availability of an appropriate reviewer to discuss a medical necessity denial determination if the decision was made without a physician-to-physician reviewer conversation. This discussion affords the provider the opportunity to confer about a utilization management determination prior to the initiation of an appeal.

Medical Mutual makes utilization management decisions as soon as possible within the following decision timeframes (unless otherwise specified by state or federal laws):

- Urgent concurrent and Urgent preservice determinations are made within 72 hours/ 3 calendar days of

receipt of the request.
- Non-urgent pre-service determinations are made within 15 calendar days (Commercial and Marketplace) or 14 calendar days (Medicare Advantage) of receipt of the request.
- Post-service determinations are made within 30 calendar days of receipt of the request.

Medical Mutual provides access to UM staff for providers and members seeking information about the medical necessity review processes and authorization of care. Staff is available at least eight hours a day for inbound calls via a toll-free phone line and confidential voicemail is available outside of business hours.

3. Appeal Process

A formal appeal process is available if a member or provider is dissatisfied with the review determination. The appeal process is the mechanism by which members and providers may request a review of medical necessity denial determinations. Once submitted, the appeal is entered into the MedCompass system, where it is tracked by the level, age of receipt and category.

The appeal process for Commercial and Marketplace members is governed by Corporate-Wide Appeals Policy 2004.003 and Member Appeal Procedure 2011.003, included as Appendix A and Appendix B respectively. It provides for urgent, prospective, and retrospective appeals, and applicable federal and state mandated independent external reviews. The reconsideration appeal processes for Medicare Advantage are outlined in the Medicare Advantage Expedited Reconsideration and Part C Standard Member Reconsiderations Policies.

E. UM Program Activities

To support providers in their role of managing clinical care rather than administrative processes, clinical review is performed on cases in which this oversight is likely to have a positive impact on improving quality and/or controlling cost.

1. Prior Authorization

Prospective or pre-service clinical review is a process by which clinical information and requests are reviewed to determine medical necessity prior to care being rendered. The prior approval process is applied to select services in the following categories:

- Behavioral health procedures;
- Chiropractic therapy;
- Diagnostic procedures, including genetic testing;
- Durable medical equipment;
- Prescription drugs;
- Imaging procedures;
- Radiation/Oncology services
- Inpatient admissions, elective;
- Medical and surgical services, such as cosmetic or reconstructive surgery, bariatric or oral surgery; and
- Physical, occupational and speech therapy.

Prior Authorization review cases are screened for potential patient safety issues and when detected, potential safety issues are addressed through to resolution. Medical Mutual informs the provider about the services that require prior approval, through the Provider Manual and through the Prior Approval (Commercial and Marketplace) or Medicare Advantage Prior Authorization list published on the corporate website.

2. Concurrent Review

Inpatient concurrent review involves an ongoing course of treatment to be provided over a period of time. Concurrent review is applied for inpatient stays for both acute, post-acute, and residential care as well as applied to a course of care involving several treatments. A concurrent request for coverage of services is made while the service is being rendered, even if the prior care had not been approved. Concurrent review is applied to the following settings:

- Acute inpatient medical-surgical;

- Long-term acute care;
- Skilled nursing facility;
- Acute inpatient physical rehabilitation;
- Acute inpatient and residential behavioral health; and

We utilize industry leading MCG to assist in determining medical necessity. These guidelines include ambulatory care, acute care, post-acute care and discharge planning. The guidelines address medical, surgical and behavioral health and are designed to assist the Utilization Management staff in assessing the appropriateness of care and/or length of stay. These guidelines are augmented with internally developed corporate medical policies. The purpose of using established screening and decision-making criteria is to optimize patient outcomes by ensuring that patients receive the most appropriate treatment while reducing unnecessary utilization and cost. We apply the criteria as part of our utilization management review, taking into consideration member benefit, individual circumstances, and the capability of the local healthcare delivery system. MCG provides clinical indications for admission and recovery milestones that assist with discharge planning for members that require an inpatient admission, while corporate medical policies cover criteria for procedures and treatments to ensure approved standards of care are applied.

Medical necessity review determinations for initial admissions and continued inpatient care are based on the medical information received at the time the review is conducted. Concurrent review is conducted by clinical reviewers using MCG Criteria, Corporate Medical Policies, or internally developed guidelines. During the concurrent review process, cases are screened for potential safety issues. This includes but is not limited to contraindicated treatment; conservative treatment not addressed or ruled out; adverse drug reactions or inappropriate treatment. Any issues discovered are referred for evaluation and action by the physician reviewer and investigated as part of our patient safety initiatives.

Clinical reviewers conducting the concurrent review have access to appropriately licensed physicians for consultation. For any case that does not meet the medical necessity criteria applied by the clinical reviewer, or when a decision cannot be made due to lack of information, the case is referred to a physician reviewer for determination.

When applying criteria to a given individual, the organization considers the individual's age, comorbidities, complications, treatment progress, psychosocial situation and when applicable, home environment. The member's individual health care needs, and an assessment of the local delivery system are taken into consideration when medical necessity determinations are made. This includes the availability of post-acute care services within the service area to support the member after hospital discharge or the availability of local care facilities to provide recommended health care services including those necessary to meet specialized needs.

The frequency of review for the extension of initial services is based on the severity and/or complexity of the member’s condition or on needed treatment, expected length of stay and discharge planning needs.

Cases that do not meet established criteria for medical necessity are referred to physicians trained in evidenced based guidelines, standards of care and Clinical Quality and Health Services policies and procedures. Physician reviewers may initiate and seek consultation with board certified specialists in complex clinical situations or cases outside their area of clinical expertise. A list of board-certified physician reviewers is maintained to facilitate the consultation process. Practitioners from appropriate clinical areas are utilized as necessary, for review of denial of care based on medical necessity, including the following:

- Physicians, for all types for medical, behavioral health, pharmaceutical, dental, chiropractic and vision cases
- Doctoral-level clinical psychologists or certified addiction medicine specialists for behavioral health denials
- Pharmacists for pharmaceutical denials
- Oral surgeons for dental denials

Practitioners are informed of the process for contacting the physician reviewers via provider manuals, provider newsletters and copies of denial notices. Physician reviewers are available by telephone to discuss review decisions with attending physicians or other ordering providers. Attending or ordering physician may request a peer-to-peer phone conversation within 14 calendar days of the denial.

2.1 Expert Physician Panels

To support clinically appropriate and relevant care, we employ or contract with a panel of physicians with multiple specialties to participate in reviews. Specialties include cardiothoracic surgery, emergency medicine, radiation oncology, internal medicine, psychiatry, addiction medicine, geriatrics, cardiology, preventive medicine, general surgery, family medicine, obstetrics, gynecology, pediatrics, orthopedics and sports medication and occupational medicine. Our provider panel has combined decades of clinical and managed care experience.

2.2 Geographic Approach with a Physician/Nurse Dyad

Geographic-based alignment is defined by actuarial territories throughout the state of Ohio based on the zip code of Medical Mutual membership. There are 10 actuarial territories; assignments that may include more than one territory, depending on the size of the membership in each geographic region. The Geo team approach provides assignments based on the member's zip code and drives accountability for regional outcomes. Our physical presence in the communities in which we serve also enables creativity in the identification of issues and opportunities that may reflect local care delivery dynamics. Some assignments are also made based on higher volume facilities to allow for relationship management and building partnerships.

Each Geo team is managed by a Physician and Nurse leader in this high touch member-centric UM model who are responsible for the identification and collaborative discussion of high-risk and/or complex members to ensure appropriate discharge planning and care plans. The Physician-Nurse leadership dyad oversees and coordinates their respective teams of Physician Reviewers, Nurse Reviewers, Social Workers, and non-clinical administrative staff. Additionally, each team is supported by Case Managers, Pharmacists and Healthcare Information Management and Analytics (HIMA) analysts, as appropriate. The Physician-Nurse leadership dyad is responsible for managing utilization, cost, and quality targets, using evidenced-based criteria for medical necessity decision making and facilitating care transitions to achieve optimal clinical outcomes for the holistic well-being of that Geo population.

Huddle Meetings are held at least 2-3 times per week with UM, CM, Social Work, and physician teams.
Types of cases typically identified include:

- High Risk
- Complex discharge planning
- Readmission
- Long Lengths of stay
- High Dollar

The physician leadership may also use huddles for educational opportunities with the Geo team, to share information on medical conditions, treatments, or opportunities to improve clinical outcomes through our collaboration with members and providers.

2.3 Inpatient Risk Stratification

Members receiving inpatient services are stratified twice daily to assess their risk of rehospitalization. Members that are stratified as high risk for readmission enter our Complex Discharge Planning model. Additionally, these members are referred to Case Management for evaluation and follow-up post-discharge. Collaboration between Utilization Management and Case Management occurs prior to discharge, as needed, to facilitate safe and agreeable discharge plans.

Case Management focuses on addressing member needs by applying core components of case management across the continuum of care to identify and manage members at risk for complex, high cost and /or long-term needs. Additionally, we address health inequities and disparities to achieve optimal outcomes for the holistic well-being of the population. Case managers assess, plan, implement, coordinate, educate, monitor, and evaluate all aspects of healthcare involving members identified as appropriate for case management intervention. We empower members to take control of their health care needs across the continuum by assisting with coordination of care to assist members in navigating the health care system, facilitating discharge planning, health education and provider collaboration. Registered nurses complete a comprehensive assessment, develop an individualized care plan and

deliver interventions to assist the member and caregiver in improving the member's health for those enrolled in the program.

Case management helps round out the multi-disciplinary care team support available to our members. As part of the case management team, social worker participation is available to assist members with psychosocial concerns, community resources linkage and facilitation of discharge planning. Additionally, care navigators are available to help support, educate and assist members to navigate the complex health care system. Administrative staff are also part of the case management team in a supportive role to assist with administrative and clerical processes and do not participate in any clinical activities. Medical Directors are available to support the case management clinical team with case consultation for case planning, conferencing, and collaboration. The pharmacy team provides support related to medication management.

2.4 Complex Discharge Planning

Discharge planning facilitates the coordination of ongoing care, whether the transition is to home or another level of inpatient care. It is initiated prior to, or upon, admission and continues throughout the hospitalization. Clinical reviewers identify discharge planning needs, barriers to care transition and social determinants of health as early as possible during the initial and continued stay review processes. This ensures the efficient use of resources while providing continuity and coordination of care for members. All members are proactively assessed for discharge plans.

The Complex Discharge Planning model incorporates the basic tenets of discharge planning along with additional collaboration and decision-making with the Medical Mutual Care Team, member, preferably with family support, and the facility/provider. A multi-disciplinary healthcare team approach is employed in coordinating the member's safe transition to the next level of care. Complex discharge planning is conducted on an ongoing basis to promote appropriate utilization of services and to prevent unnecessary readmissions.

Information is collected throughout the admission to assess each member's current health and functional status. An assessment is also made of the home environment and the degree of expected family support. An evaluation is then made to determine the needs of the member and family, as well as identify any anticipated home healthcare services or durable medical equipment that may be needed in the home.

A proactive, collaborative approach is taken to facilitate discharge to the next clinically appropriate level of care. Multi-disciplinary care huddles are held internally to discuss optimal discharge planning approach and ways to overcome barriers and gaps in care. Care conferences are conducted with the member, family and facility when needed to promote shared decision making. When such candidates are identified, communications are made to the facility and/or provider's office to consider services when developing discharge plans.

The goal of discharge planning is to ensure that all members have a comprehensive plan of care, and that these members are discharged with the needed support to optimize their health status and prevent unnecessary readmission. Members who may benefit from ongoing coaching and monitoring are referred to case and disease management for evaluation and follow-up. Collaboration between Utilization Management and Case Management occurs prior to discharge, as needed, to facilitate safe and agreeable discharge plans.

Collaborative multidisciplinary teams proactively monitor daily goals to achieve expected lengths of stay. Each inpatient day has a "milestone" to meet the expected length of stay. If a milestone is missed, complex discharge planning is started. Complex discharge planning is also utilized for hospitalizations stratified as high risk.

2.5 Care Transitions

Clinical reviewers identify discharge planning needs as early as possible during the initial and continued stay review processes. Discharge planning identifies members who may benefit from a referral to case and chronic condition management or to a home healthcare service. When potential case and chronic condition management candidates are identified, a referral is electronically forwarded to that department for evaluation and follow-up.

Throughout the stay, members' current health and functional status is assessed. An assessment is also made of the home environment and the degree of expected family support. The evaluation determines the needs of the member and family, as well as any durable medical equipment or specialized services that may be needed.

To ease the member's transition from hospital to home, Medical Mutual partnered with Direction Home and the local Area Agency on Aging to help effectively transition members from the hospital to their home, assist with the coordination of follow up care activities, and teach self-care tools to help members manage their post-hospital care.

It may include a hospital visit at the bedside, a home visit soon after discharge and two (2) follow-up phone calls over a 30-day period.

Additional support services that include:

- Medication reconciliation
- Review of discharge instructions
- Physician follow-ups visit confirmation
- Action plan for exacerbation of symptoms

Information gathered by the nurse is communicated to the Primary Care Provider. The nurse works with the member and the Medical Mutual Care team to develop and facilitate implementation of the care plan.

3. Retrospective Review

Retrospective or post-service review is the process of obtaining clinical information and determining the benefit level and medical necessity for services that were previously rendered. Retrospective review is applied in focused review, emergency services review and professional medical claims review activities.

3.1 Focused Review

Focused review is a rigorous, retrospective review of a specific sample of cases selected for a more intensive evaluation. Focused review is used to assess the accuracy of information provided during various review processes. Focused review may be performed on a service (such as home health, skilled nursing, or physical therapy visits) or provider-specific basis, for a particular diagnosis or procedure across all providers, or both.

The focused review may be driven by, but is not limited to, the following:

- Identification of over/under use, and the use of healthcare services inconsistent with medical evidence;
- Routine monitoring to ensure services delivered were medically necessary;
- Identification of potential quality of care issue; and
- Variance from accepted standards of care or practice guidelines.

3.2 Emergency Services Review

Medical Mutual provides unrestricted access to the emergency department to members with a medical or psychiatric emergency or for services that a prudent layperson, acting reasonably, would have believed to be an emergency medical or behavioral health condition. Such services do not require prior approval to receive the highest level of benefit. Emergency room service review is driven by the presence of benefit level coverage differentials for a specific benefit plan.

Claims processing edits for specific benefit plans ensure that emergency room claims are reviewed to determine if prudent layperson criteria are met if the following conditions apply:

- Medical or behavioral health emergency criteria based on the discharge diagnosis codes is not met; or
- The absence of a referral from the primary care physician (PCP) for out-of-network services, NurseLine vendor or other authorized health plan representative.

An authorized representative may include any physician, practitioner, Nurse Line, or other entity affiliated with Medical Mutual or anyone with whom Medical Mutual contracts, to provide healthcare services. Any claim meeting the above conditions is pended and emergency room medical records are requested and reviewed to determine coverage.

3.3 Clinical Claims Review

Clinical claims review is the mechanism by which clinical expertise is utilized to make determinations for reimbursement of physician or other claims.

The Total On-Line Payment Processing System (TOPPS) interacts with claims editing system (CES) which is used in conjunction with benefit files, to edit professional claims for accuracy, completeness, medical necessity, and utilization of services.

The claims editing system identifies separate procedure code lines that should be combined or considered incidental to the comprehensive procedure and to identify and combine procedures listed separately on the claim that should have been bundled and billed as one procedure. The Center for Medicare and Medicaid Services' National Correct Coding Initiative edits are systematically loaded identify incidental procedures. Denial reasons are identified by three-character alphanumeric remark codes and indicate the specific rationale for the procedure code denial.
The clinical claims editing system also identifies procedures and/or services that are designated as requiring medical review prior to reimbursement, such as procedures that might be considered cosmetic or experimental/investigational in nature. Coupled with the prior approval process that is applied for these procedures, the clinical claims editing system ensures the claim is matched with its corresponding prior approval review decision and is adjudicated correctly. This process may also be utilized for procedures identified as being over utilized and/or unbundled.

For medical benefit prescription drugs, either professional or hospital outpatient, clinical claim editing is done by a vendor. This editing matches the prior approval decision to the National Drug Code, HCPCS and units requested on the claim for accuracy. If discrepancies are found the claim line is either split into an approved and denied line or denied completely. Remark codes indicate the specific rationale for the denial.

4. Oversight of Delegated UM Functions

Medical Mutual may elect to delegate select UM activities to certain external organizations. Contractual documents are in place to specify the:

- Scope of activities that are delegated;
- Delegate's accountability for those activities;
- Type and frequency of reports that must be submitted to Medical Mutual;
- Provision of member experience and clinical performance data when requested; and
- Process by which the delegate's performance is evaluated.

Medical Mutual has established accountability and oversight mechanisms which are supported by detailed policies describing the process that would be instituted should the organization fail to maintain compliance with Medical Mutual's standards, accreditation standards and federal and state regulations.

Each delegate's UM Program is reviewed annually and reports from delegates are reviewed at least semiannually. For non-accredited delegates, an audit is performed at least annually to ensure the delegate's compliance with the applicable standards of Medical Mutual, national accreditation organizations, CMS, and federal and state regulations. Deficiencies detected at the time of the monitoring audit are communicated to the delegate and a corrective action plan is developed. Delegates must submit a detailed description of their corrective action plan during the reassessment phase and at least annually thereafter, as indicated.

The CQRM, MAC, and Pharmacy & Therapeutics Committees provide oversight of the respective delegated entities. Medical Mutual has currently delegated utilization management services to:

- eviCore healthcare
- Express Scripts
- Prime Therapeutics (previously Magellan RX)
- Optum Transplant Case Management
- ProgenyHealth
- Cigna
- Strive
- Heeter
- Cohere

4.1 eviCore healthcare

Prospective review for radiation oncology is delegated to eviCore Healthcare Inc., an NCQA accredited organization. Practitioners submit treatment plans describing the member's condition and the proposed course of treatment to eviCore. The licensed clinical reviewers complete the initial review process by applying eviCore healthcare's Clinical Practice Guidelines to the proposed treatment plan to authorize services. Medical Mutual retains responsibility for appeals, control of benefit coverage decisions, member complaints and payment of claims.

This delegation includes initial coverage determinations for Commercial, Marketplace and Medicare Advantage and first level appeals for Commercial and Marketplace products.

4.2 Pharmacy Benefits Management: Express Scripts

Medical Mutual has a long-standing partnership with Express Scripts, the pharmacy benefits manager that administers its prescription drug benefits. This partnership brings members a variety of benefit options ranging from a formulary to tiered co-pay designs, mail-order, coverage (utilization) management, generic incentives, and other programs developed to help control prescription drug costs while continuing to provide access to quality medications. Express Scripts is accredited in Utilization Management by NCQA until September 10, 2027. Express Scripts' delegation is applicable to Commercial and Marketplace products as well as Medicare Advantage Part D.

Prospective and retrospective reviews for medications billed through the pharmacy benefit are delegated to Express Scripts. Practitioners submit their medication prior approval requests, including a description of the member's medical condition and dose and duration of the requested medication to Express Scripts. Express Scripts' registered pharmacists, nurses and physicians apply medical necessity criteria to the proposed treatment plan to make the coverage decision. Under this delegation agreement, Medical Mutual retains responsibility for certain appeals, benefit coverage decisions and payment of certain claims.

Express Scripts provides quarterly reports (by the 45th calendar day following the end of the calendar quarter) to Medical Mutual to include the following:

- Initial determinations/coverage decisions
- Denial activity
- Appeals/ timeframes

4.3. Prime Therapeutics (previously Magellan Rx)

Prospective, retrospective, and concurrent reviews for medications billed through the medical benefit are delegated to Prime Therapeutics (Prime). Practitioners submit their medication prior approval requests, including a description of the member's medical condition and dose and duration of the requested medication to Prime. Prime is accredited in Utilization Management by NCQA until September 30, 2025. Prime delegation is applicable to Commercial, Marketplace and Medicare Advantage Part B/C.

Prime's registered pharmacists and physicians apply medical necessity criteria to the proposed treatment plan to make the coverage decisions. Under this delegation agreement, Medical Mutual retains responsibility for appeals, member complaints, benefit coverage decisions and payment of claims.

Prime also provides retrospective claim review for accuracy in professional and hospital outpatient claims by comparing the prior approval decision to the HCPCS Code, National Drug Code, and units billed on the claim. Discrepancies are identified and claim lines are either split into approved or denied. Remark codes indicate the denial reason for TOPPS to process.

Prime provides quarterly reports (by the 45th calendar day following the end of the calendar quarter) to Medical Mutual to include the following:

- Initial determinations/coverage decisions
- Denial activity
- Complaints/grievances

An audit is performed at least annually to ensure the delegate's compliance with the applicable standards of Medical Mutual, national accreditation organizations and federal and state regulations. Deficiencies detected at the time of the monitoring audit are communicated to the delegate and a corrective action plan is developed. Delegates must submit a detailed description of their corrective action plan during the reassessment phase and at least annually thereafter, as indicated.

4.4 Optum Transplant Case Management:

Transplant program case management functions are delegated to Optum Health Care Solutions effective for the following transplant phases: evaluation, pre-transplant, transplant episode, and post-transplant (365 days after the transplant). This delegation applies to Commercial (except for certain groups), Marketplace and Medicare Advantage products.

Under this delegation agreement, Medical Mutual retains the responsibilities for the following:

- Approval/disapproval of coverage for transplant procedure.
- Appeals.
- Control of benefit coverage decisions.
- Utilization management functions related to the transplant.
- Member complaints.

4.5 ProgenyHealth, Inc

Admission and Concurrent Review of Neonatal Intensive Care Unit (NICU) cases is delegated to ProgenyHealth Inc., an NCQA accredited organization, specializing in NICU Utilization Management and Care Management services. NICU providers submit admission and continued stay requests to ProgenyHealth where licensed clinical reviewers apply ProgenyHealth and MCG guidelines to render determinations regarding the most appropriate level of care. The licensed clinical peer reviewers and physicians make all non-coverage determinations. ProgenyHealth provides Case Management services for all members with a NICU admission during the first year of life. Under this delegation agreement, ProgenyHealth also provides post-payment reviews of all NICU claim submissions for authorization and reimbursement reconciliation. Medical Mutual retains responsibility for appeals, control of benefit coverage decisions, member complaints and payment of claims.

4.6 Cigna

All out-of-state prior authorization, admission, and concurrent review cases are delegated to Cigna/ Payer Solutions. Providers submit prior authorization, admission and continued stay requests to Cigna where licensed clinical reviewers apply MCG guidelines to render determinations regarding the most appropriate level of care. The licensed clinical peer reviewers and physicians make all non-coverage determinations.

Also under the delegation agreement, Cigna resolves the first level, second level and external review appeal requests submitted by members or practitioners. In addition, practitioner and member complaints are handled by Cigna. Under this delegation agreement, Cigna handles nonbehavioral and behavioral UM decisions, nonpayment related appeals and member complaints for Commercial and Exchange lines of business. Medical Mutual retains responsibility for benefit coverage decisions, payment of claims and payment related appeals.

Cigna provides semi-annual reports (by the 31st day of the month following quarter end) to Medical Mutual to include the following:

- Volume of Authorization Requests
- Authorization Requests Approved and Denied
- Timeliness of UM Decisions
- Volume of Appeals Received
- Appeals Overturned and Upheld
- Complaints/grievances
- Inter-rater Consistency (Annually not quarterly)

An audit is performed at least annually to ensure the delegate's compliance with the applicable standards of Medical Mutual, national accreditation organizations and federal and state regulations. Deficiencies detected at the time of the monitoring audit are communicated to the delegate and a corrective action plan is developed. Delegates must submit a detailed description of their corrective action plan during the reassessment phase and at least annually thereafter, as indicated.

All out-of-state prior authorization, admission, and concurrent review cases are delegated to Cigna/ Payer Solutions. Providers submit prior authorization, admission and continued stay requests to Cigna where licensed clinical reviewers apply MCG guidelines to render determinations regarding the most appropriate level of care. The licensed clinical peer reviewers and physicians make all non-coverage determinations. Also under the delegation agreement, Cigna handles all appeals and complaints. Under this delegation agreement, Medical Mutual retains responsibility for benefit coverage decisions and payment of claims. This delegation includes initial coverage determinations for Commercial and Marketplace and first level appeals for Commercial and Marketplace products.

4.7 Cohere

Cohere is an additional delegated organization for prospective review for physical, occupational, speech chiropractic therapy, radiology/imaging, cardiology, sleep, and gastrointestinal services Cohere is a NCQA accredited organization and is applied to select benefit plans with unlimited benefits. Practitioners submit treatment plans describing the member's condition and the proposed course of treatment to Cohere. The licensed clinical reviewers complete the initial review process by applying Cohere's Clinical Practice Guidelines to the proposed treatment plan to authorize a clinically appropriate number of visits. The licensed clinical peer reviewers and physicians make all non-coverage determinations. Under this delegation agreement, Medical Mutual retains responsibility for control of benefit coverage decisions, member complaints and payment of claims.

4.8 Heeter Printing Company, Inc

Heeter Printing is delegated for print and mail services. Heeter prints and mails Medical Mutual's UM decision letters and appeal decision letters.

5. Assessing Utilization Management Experience

Member experience is assessed annually using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The CAHPS surveys contain questions which are used to assess a member's experience with the UM process. Additionally, provider surveys are conducted annually and contain questions which are used to evaluate provider experience with the UM Program.

The results of the member and provider surveys, as well as complaints, are analyzed and used to formulate action plans that contain specific interventions that address the identified sources of dissatisfaction. Annual surveys are conducted following the interventions to determine their effectiveness. The UM Evaluation considers the results of the member and provider surveys.

IV. Case Management Program

The Case Management (CM) Program focuses on addressing member needs by applying core components of case management across the continuum of care. Case managers assess, plan, implement, coordinate, educate, monitor, and evaluate all aspects of healthcare involving members identified as appropriate for case management intervention. The program is to identify and manage members at risk for complex, high cost and /or long-term needs. The purpose is to empower members to take control of their health care needs across the continuum. This is achieved by assisting with coordination of care so that the right members receive the right interventions that are effective, efficient, and focused, at the right time resulting in quality outcomes, safety and satisfaction that contribute to the goal of improved health and wellness.

Medical Mutual CM Program is a comprehensive program that identifies opportunities to improve the health and safety of its members while enhancing the effective and efficient use of healthcare resources.

A. Goals and Objectives of the Case Management Program

The following overall goals and objectives have been adopted to support the CM Program:

- To help members regain optimum health or improved mental or physical capability in the right setting and in a cost-effective manner through the following:
  - Align identified members with the intensity of case management services determined by their individual needs.
  - Advocate for the member's right to be fully informed of treatment options and accept or refuse care.
  - Complete a comprehensive assessment of the member's condition, including social determinants of health, identification of barriers, available resources, and benefits.
  - Promote quality, safe, and cost-effective care.
  - Assist with navigating the health care system to promote effective care during transitions.
  - Promote utilization of available resources to achieve optimal clinical and financial outcomes.
  - Provide education for condition self-management.
  - Promote the use of evidence-based care to ensure appropriate access to services.
  - Work collaboratively with the member/caregiver, physician, providers of healthcare and others to develop and implement a plan that meets the individual's needs and goals.

- Promote a self-management plan in collaboration with the member/caregiver.
  - Ensure effective transition of members between care settings.
  - Emphasize importance of medical drug management including medication adherence and reconciliation.
  - Develop a plan of care that respects the member's cultural and spiritual beliefs.
  - Enhance safety, productivity, satisfaction, and quality of life.
  - Assure that appropriate services are generated in a timely and cost-effective manner.
  - Coordinate a plan of care that is consistent with the member's level of health literacy.
  - Utilize process and outcome measurement, evaluation, and other management tools to improve efficiency and quality performance.

- Evaluate member outcomes.

B. Scope of the Case Management Program

Medical Mutual has adopted the definition of Case Management from CMSA, "Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes." (CMSA Standards of Practice 2022).

The case managers are registered nurses with current Ohio licenses who possess a minimum of three years of clinical nursing experience. Case managers working with members who have a permanent address outside the state of Ohio must be licensed in the state of the member's residence if the state is not part of the Nurse Licensure Compact to provide case management services. Case managers, when eligible, are expected to obtain and maintain Certification in Case Management (CCM).

The Case Management Program is administered through the activities of the case managers which include medical/surgical and behavioral health care needs of the adult, infant, child and adolescent members across the continuum of care.

1. Case Management Services Offered

The Case Management Program offers telephonic case management to members to assist them in navigating the health care system, facilitating discharge planning, health education and provider collaboration. Registered nurses complete a comprehensive assessment, develop an individualized care plan, and deliver interventions to assist the member and caregiver in improving the member's health for those enrolled in the program.

As part of the case management team, social worker participation is available to assist members with psychosocial concerns, community resources linkage and facilitation of discharge planning. Additionally, care navigators are available to help support, educate and assist members to navigate the complex health care system. Health coaches can help set wellness goals and objectives and provide the structure and motivation needed to achieve these. A Certified Diabetes Care and Education Specialist (CDCES) can provide education and resources to diabetic members to enhance their quality of life. Integrative Behavioral Health CM nurses assess and develop care plans for members with BH and/or substance use disorder and assist with self-management of the member's condition, identification of community and healthcare resources, and medication reconciliation and management. Administrative staff are also part of the case management team in a supportive role to assist with administrative and clerical processes and do not participate in any clinical activities.

The Physician team is available to support the case management clinical team with case consultation for care planning, conferencing, and collaboration. The pharmacy team provides support related to medication management.

2. Oversight of Delegated CM Functions

Medical Mutual may elect to delegate select CM activities to certain external organizations. Contractual documents are in place to specify the:

- Scope of activities that are delegated.
- Delegate's accountability for those activities.
- Type and frequency of reports that must be submitted to Medical Mutual.
- Provision of member experience and clinical performance data when requested.
- Process by which the delegate's performance is evaluated.

Medical Mutual has established accountability and oversight mechanisms which are supported by detailed delegation agreements, and policies describing the process that would be instituted should the organization fail to maintain compliance with Medical Mutual's standards, accreditation standards and federal and state regulations.

Each delegate's CM Program is reviewed annually and reports from delegates are reviewed at least semiannually. For non-accredited delegates, an audit is performed at least annually to ensure the delegate's compliance with the applicable standards of Medical Mutual, national accreditation organizations, CMS, and federal and state regulations. Deficiencies detected at the time of the monitoring audit are communicated to the delegate and a corrective action plan is developed. Delegates must submit a detailed description of their corrective action plan during the reassessment phase and at least annually thereafter, as indicated.

C. Eligibility Criteria and Program Definitions

Medical Mutual offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in the organization's Chronic Condition Management program. Medical Mutual has several Case Management Programs which include the following:

Return to Home (RTH)

A short-term CM program to monitor targeted inpatient members who have a high readmission risk score of tiers 1-4 (see *Inpatient Readmission Risk Tiers*) or who have been identified as having significant needs. These members are managed for 30-45 days once they have been discharged to home. This program utilizes a specialized and comprehensive assessment and plan of care. The focus is to reduce post-discharge readmission risk and provide interventions to prevent an avoidable readmission to the hospital during the first 30 days post discharge.

Complex NCQA Case Management (CM)-Commercial CM Only

A CM program for members identified as high risk during an inpatient admission, are engaged in CM and have ongoing needs after completion of a 30-day post-discharge period in the RTH program. All members in Strive's Intensive Case Management Program are considered Complex NCQA. Additionally, all transplant cases and all members/caregivers who request CM services are considered for Complex NCQA CM. Eligibility for Complex NCQA CM begins upon completion of the RTH program or the day a

member/caregiver calls to request CM services. Enrollment occurs when the member has provided consent to receive Complex NCQA CM services. See Table 1 for examples of referral types.

Complex NCQA case management is the coordination of care and services provided to members who have experienced a critical event or diagnosis requiring an extensive use of resources. These members need help navigating the system to facilitate appropriate delivery of care and services, including community resources. The goal is to assist members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up. Complex NCQA cases are typically managed for 90 days.

Table 1: Referrals for Complex NCQA CM (*denotes NCQA PHM 5A 1-4)

Referral Types	Examples	Referred By
Medical Management Program Referral *[1]	Members identified as high risk during an inpatient admission to include referrals from the RTH program. Medical Director requesting CM during IP stay	MMO Clinical Team Medical Director
Discharge Planner Referral *[2]	Discharge planner at hospital requests CM services	External Discharge Planner
Member or Caregiver Referral *[3]	Member/caregiver calls requesting CM	Member Caregiver/Family
Practitioner Referral*[4]	Transplants	Provider

Ambulatory (High Risk)

A CM program for members who are not eligible for Complex NCQA and who may benefit from CM services of care coordination, education, and care collaboration. These members are identified through the following sources:

- Prior Authorization
- Member requests CM outreach
- Customer Care
- Vendor (e.g., WellBe for MA, Direction Home)
- Provider
- Quality Campaigns
- Health Risk Assessment (HRA)
- Predictive Modeling
- ED Utilization Report
- Large claims activity (Commercial only)
- Employer Groups (Commercial only)

Ambulatory (High Risk) programs can be transitioned to Surveillance, which provides long term oversight to members identified as having significant medical conditions that may have high dollar cost, poor prognosis, and high utilization of medical services. These members would benefit from case management services, but do not require or will not participate in case management contacts at least monthly. Members do not start out in Surveillance but rather are transitioned to Surveillance status from the Ambulatory (High Risk) program.

The goal is to provide ongoing monitoring and interventions for these members to reduce the likelihood of unplanned hospital admissions, ER visits and avoidable complications of their health conditions. These cases are typically managed for longer than 6 months.

Clinical Ambassador Relationship Experience (CARE)

A program that offers a single point of clinical contact to members through a multidisciplinary team

approach to member experience, with representatives across multiple functions all working together to achieve the same care goals. Members of select Commercial employer groups as well as the disabled, dual and LIS Medicare Advantage populations are automatically enrolled in the CARE Program and assigned to a subprogram and an ambassador (clinical point of contact) based on their risk level.

NICU-Commercial CM Only

ProgenyHealth is a delegated vendor program for select lines of business, is NCQA accredited and provides services for members with a NICU admission during the first year of life. The goal is to deliver better outcomes for infants and their caregivers.

High Risk Neonates are managed by nurses with a background in neonatology who collaborate with the health care team to coordinate care and promote a safe discharge to home. These nurses also provide education to caregivers and deliver interventions as it relates to long term care needs of neonates transitioning to home. Members not delegated to Progeny are managed in this program.

High Risk Maternity

A specialty program for expectant mothers who have been identified as being high risk. The focus is on preventing complications such as premature delivery. Specialized assessments and screening tools are utilized. It offers resources and services for women with gestational diabetes, pre-term labor and other high-risk factors. This program offers education and support to help members maintain a safe and healthy pregnancy and postpartum period. It features exclusive access to a specially trained nurse who can provide the valuable knowledge needed for a safe and healthy pregnancy, including customized educational materials regarding:

- Nutrition and healthy eating
- What to expect during pregnancy
- Preparing for labor, delivery, and a new baby
- Post-partum Care

Wildflower, a digital application, is available for all pregnant members to provide further information and support.

Optum Transplant

This delegated program works closely with members, caregivers, and the healthcare team during the following transplant phases: evaluation, pre-transplant, transplant episode, and post-transplant (365 days after the transplant). This delegation applies to Commercial (except for certain groups), Marketplace and Medicare Advantage products.

Strive

This delegated program works closely with members with chronic kidney disease (CKD) and end stage renal disease (ESRD), their caregivers and healthcare team. The Strive program supports members across the kidney care spectrum. Strive's nurse practitioners, RN care managers, social workers, dietitians, and care coordinators work closely with our members and their providers to deliver disease management, care coordination, education, nutritional coaching, and other support. Strive's program supports Medical Mutual's mission to make a lasting difference in our member's health and well-being, while also reducing hospital admissions, emergency room visits and total patient cost of care. This delegation applies to members who are over 18 years of age and enrolled in fully insured, Marketplace and Medicare Advantage products, as well as select ASO customers.

Palliative/Hospice Care

A dedicated team of nurse case managers work to address the member's progression to palliative and/or hospice care. This team utilizes a specialized and comprehensive assessment and plan of care to work with members impacted by a serious illness as well as their families and caregivers. These services focus on comfort and quality of life.

Carelon is a vendor partner program available for members of select lines of business to assist members with end-of-

life management. Carelon's team provides comprehensive home-based palliative care for members facing serious illness and includes specialized nurse practitioners, nurses, social workers, and chaplains led by a board-certified palliative care physician. Medical Mutual case managers may work in conjunction with Carelon Health to achieve member goals.

Direction Home

This is a program available for members of select lines of business that utilizes the Area Agencies on Aging to transition members from the hospital to the home care setting. The key components of the program include education, empowerment, physician feedback, medication reconciliation, fall risk assessments and connection to community resources. It may include a hospital visit at the bedside, a home visit soon after discharge and two (2) follow-up phone calls over a 30-day period. Medical Mutual case managers may work in tandem with Direction Home to achieve member goals.

WellBe-Medicare Advantage Only

A program available for MA members who are identified as being in the highest risk 10% of MMO's MA populations. Members are targeted based on historical experience which includes data on rising costs and MLR. Members can only be referred to WellBe if identified as targeted (eligible) as noted on MedCompass member Alert: WellBe-Targeted. WellBe assumes 100% risk for the member's cost of care. This program offers concierge care services to improve outcomes through the following:

- Earlier interventions
- PCP services
- Geriatric care team that can function adjacent to an established PCP
- In-home visits
- Reduction of emergency care and readmissions
- Closure of care gaps
- Acting on Star Measures

WellBe provides complete management of the engaged (on service) member, that includes case management and social work services.

- WellBe **engaged** members do not receive referrals to MMO CM as WellBe is fully managing the member's care.
- WellBe **targeted** members are referred to MMO CM as they are not yet on service with WellBe and MMO CM will promote/refer to WellBe to increase member engagement with WellBe.

Behavioral Health

Medical Mutual strives to maintain coordination of care for members' physical and behavioral health, while recognizing that one or the other may be a dominant factor in quality of life. A dedicated team of experienced behavioral health nurse case managers and social workers ensure that behavioral health conditions are targeted just as intensely as physical health conditions through condition specific programs. Specialized assessments and screening tools are utilized to aid members in positive outcomes and self-management of behavioral health condition(s).

Medical Mutual encourages a collaborative approach between behavioral health and physical health practitioners, to ensure positive overall member well-being and to support whole person health. Medical Mutual treats behavioral health benefits equal to medical/surgical benefits and does not impose greater restrictions(s) on behavioral health benefits.

Integrative

A dedicated team of registered nurses experienced in behavioral health and medical case management work with members who have behavioral health and chronic medical conditions to ensure holistic cost-effective care. Specialized assessments and screening tools are utilized.

D. Chronic Condition Management Programs

We provide health coaching internally through a blend of digital and telephonic programs facilitated by Medical Mutual clinical and wellness team members for members with Asthma, Chronic Obstructive pulmonary Disease (COPD), Coronary Artery Disease (CAD), Heart Failure (HF), Diabetes, and Hypertension. In addition, we utilize our vendor partner, Lark Health (Lark), for health coaching of members with rising risk and specific chronic conditions. Lark provides cutting edge AI and wi-fi enabled health monitors that collect and track real-time data regarding member vital signs. The program tools have the capability to alert Medical Mutual nurses regarding abnormal results as well as provide personalized support and counseling directly to the members through the application.

1. Digital Coaching

A. Lark

Lark's programs include unlimited access to 24 hours a day, seven days a week AI coaching facilitated by automated weight logging, nutrition logging, counseling, physical activity tracking, weekly behavior change challenges, tobacco cessation coaching, and stress management coaching. Lark currently offers the following programs on its AI coaching platform: Wellness, CDC Recognized Diabetes Prevention, Diabetes Care and Hypertension Care.

Medical Mutual has customized the Lark experience with a series of check points and escalations to monitor the experience and help individuals get support beyond the digital coach based on customized escalation criteria. This includes the ability to connect an individual who may indicate an area of concern (e.g., a high-risk clinical value, depression screening score) with their physician, a member of our care team, and/or 24/7 support services such as our 24/7 nurse line.

B. Sword

Members with musculoskeletal conditions, such as chronic low back, neck, shoulder, and most types of arthritis pain can receive digital/virtual physical therapy through Medical Mutual's partnership with Sword Health. The physical therapy, programs and practitioners Sword offers are outside a group's regular physical therapy plan benefits and no additional fees are charged to the member. In addition to digital/virtual physical therapy, Sword offers Bloom, a program specifically for women and individuals with vaginal anatomy (regardless of gender identity) that offers care for pelvic health issues.

2. Telephonic Coaching

Chronic Condition Management Program offers telephonic coaching and support to members from rising risk through the multi-chronic and high complex stages of health. Our telephonic coaching is designed to provide extra support to help participants manage a chronic condition and make progress toward personal health goals through telephonic coaching sessions.

As demonstrated, participants enrolled in this program typically work with a nurse, some of which are certified diabetes health educators, over a 90-day period to make health improvements. They also have access to a team of professionals from our care team, including certified health educators, dieticians, Medical Directors, pharmacists, and social workers.

Proactive outreach occurs on a frequency that is customized to the member's needs and agreed upon by the member. Members are stratified according to their disease severity at enrollment and re-stratified on each telephone contact. The clinical health coach ensures that the member actively participates in establishing the plan of care and works with the member to monitor adherence, including medications if applicable. By building a relationship of trust, the coach works collaboratively with the member to set realistic and attainable goals. Our health coaches are trained in motivational interviewing and use a variety of assessments including the patient activation measure to gain clarity on each member's health status and the level of which a member is activated in their own care. The health coach provides motivation through education, including how proper condition management can improve the member's quality of life and help to achieve personal goals. Positive reinforcement is given for even small improvements toward behavior change goals. Provider involvement is

also an integral component of our Chronic Condition Management Program to ensure coordination of care with the treating physician.

3. Provider Remote Home Monitoring

Medical Mutual's provider remote monitoring component of our Chronic Condition Management leverages specialized equipment, daily digital check-ins, and as-needed telephonic coaching from a nurse to regularly monitor key health indicators with a goal of helping individuals avoid further complications and progress toward improving their health.
The program targets multi-chronic and higher complex individuals who need a deeper level of support and monitoring from their home and works in close partnership with their provider / care team. We deliver this program through a series of partnerships with leading health systems and providers across the state.

The goal of the remote monitoring program is to:

- Help participants understand the relationship between their biometrics and lifestyle behaviors that positively or negatively impact their health.
- Improve the timeliness of clinical care should a patient's condition require immediate attention.
- Stabilize the members current health situation, help them make improvements, and eventually transition to a program of lower intensity as their health and ability to better manage themselves improves.

Individuals enrolled in the program participate in daily monitoring via devices such as scales, blood pressure cuffs, pulse oximeters and glucometers along with a patient facing digital application. Member data is securely transmitted via wireless data technology equipment in real time to a health coach or nurse who monitors participants' progress and adherence to their care plan.

Medical Mutual's Population Health Programs team is closely integrated with each provider remote monitoring team. Program oversight is provided through quarterly program performance reviews and weekly or bi-weekly clinical interdisciplinary discussions with our internal clinical services liaison and remote monitoring partners to keep alignment and offer additional support. This oversight includes transitioning members to the appropriate next program to progress to their ability for self-management success.

Our partners delivering this service are also integrated and sharing data with the participant's providers across our network. For example, a negative escalation in daily imputed biometric data is reported directly to the member's provider(s) for early intervention via treatments such as medication adjustments and/or the scheduling of expedited appointments including face to face or telehealth visits or deploying a home health nurse to evaluate the patient in their home.

This program leads to an increased quality of life of our participants by giving them the support and knowledge they need to take control of their chronic condition self- management. Participants are evaluated every 90 days to determine if they have progressed to the point where they can transition to a program of lower intensity in our Chronic Condition Management Program.

4. Quarterly Check in Surveys

Medical Mutual's electronic Quarterly Check in Surveys are designed to support those members who have graduated from a higher touch program and are successfully managing their chronic condition in collaboration with their providers. A secure individual link is emailed to each member with questions regarding how they are managing their chronic condition. If additional support is needed, the survey contains an option for the member to request contact from one of Medical Mutual team members. Completion of the surveys enables members to continue to qualify for participation incentives, when applicable. A telephonic option is available for members who cannot be supported via email.

E. Behavioral Health

1. Behavioral Health Program Description

1.1 Goals and Objectives for the Behavioral Health Program:

To assist members with all levels of risk with mental health and substance abuse conditions to achieve their highest level of functioning, improve the quality of their lives, and develop a plan for long term success and wellness.

1.2 Scope of the Behavioral Health Program:

The Behavioral Health Program consists of a multimodal approach of providing support to members based on their risk level. Additionally, telehealth options are available for support to members for psychiatric and counseling services. Members that are stratified as high-risk will receive services from a dedicated team of specially trained behavioral health (BH) nurse case managers, social workers, and care navigators to ensure that members with mental health and substance abuse conditions receive quality, cost-effective care. Specialized assessments and screening tools are utilized to aid members in positive outcomes and self-management of their conditions.

1.3 Case Identification Process

Sources of Referrals: members are referred to the BH Program from various sources, which include, but are not limited to:

- MMO Clinical Team (from another CM program, Management Team, Clinical Liaison)
- Utilization events such as inpatient or ED visits
- MMO Discharge Planner (APAC)
- Member/CG/Family
- Customer Care
- In Home Assessment (MA only)
- Employer Group
- Provider (Hospital, Physician, High Need Meetings)

1.4 Eligibility Criteria and Program Definitions:

- In addition to the referral sources noted above, data is analyzed, and members may be considered High Risk as a result of the following factors:
    - A behavioral health claim that has:
    - A definite diagnosis (more than one claim that lists that diagnosis as primary that has occurred on different days and that has occurred at least once every three months)
    - A behavioral health disorder category that has persisted for at least one year or more (medium-term a disorder spanning more than one year but less than 3 years or long-term persistent: is defined as a disorder with claims spanning more than 3 years)
    - A disorder that has increased in severity (Serious and Persistent Mental Illness (SPMI)))

Targeted Conditions include, but are not limited to:

- Anxiety Disorders
- Eating Disorders
- Mood Disorders
- Psychotic Disorders
- Substance Use Disorders

Targeted ED Utilization:

- Members with a BH related ED visit will receive a letter
- Potentially Avoidable ED visits
    - 3-11 visits in the previous year
    - Greater than 12 visits in the previous year
    - Referred to High Risk Ambulatory CM Program

1.5 High Risk Category

Once the member has been referred to the BH CM Program, the CM assesses the member's current status and history and outreaches to the member within 2 business days from the time the referral was made.

Programs Available:

- **Return to Home (RTH):** A short-term CM program to monitor targeted inpatient members who have a high readmission risk score of tiers 1-4 or who have been identified as having significant needs. These members are managed for 30-45 days once they have been discharged to home. This program utilizes a specialized and comprehensive assessment and plan of care. The focus is to reduce post-discharge readmission risk and provide interventions to prevent an avoidable readmission to the hospital during the first 30 days post discharge.
- **Complex NCQA CM:** A CM program for members identified as high risk during an inpatient admission, are engaged in CM and have ongoing needs after completion of a 30-day post-discharge period in the RTH program. Additionally, all members/caregivers who request CM services are considered for Complex NCQA CM. Eligibility for Complex NCQA CM begins upon completion of the RTH program or the day a member/caregiver calls to request CM services.
- **Ambulatory (High Risk):** A CM program for members identified through **targeting methods** that include but are not limited to inpatient and ED utilization, cost, large claims activity, or by referrals from providers, employer groups, who are not eligible for Complex NCQA. These members may benefit from CM services of care coordination, education, and care collaboration.
- **Integrative:** A dedicated team of registered nurses experienced in behavioral health and physical health conditions to ensure holistic cost-effective care. Specialized assessments and screening tools are utilized.

Interventions:

Regardless of which high-risk program the member is enrolled in, the following interventions are performed (see *Care Management Interventions* for complete list):

- Confirm member has primary provider and BH provider
- Evaluate member/provider relationships & assist member with ongoing follow-up
  - Educate member on importance of follow-up after hospitalization
  - Follow-up after ER admission/ER visit for mental illness/substance abuse
  - Referral support to members and providers for coordination of care
- Medication review
  - Evaluate medication adherence
- Complete screening assessments as appropriate and share results with provider
- Evaluate for weight and metabolic monitoring for children and adolescents on antipsychotic medications (glucose and cholesterol testing combined)
- Evaluate for follow-up care for children (6-12 years of age) prescribed ADHD medication
- Evaluate for SDOH (e.g., economic stability, education, neighborhood)
- Evaluate member's support system
- Evaluate for a written treatment (self-care and crisis) plan from provider
- Refer for SW Team Member consult if appropriate
- Refer for telehealth services (e.g., SonderMind)
- Evaluate the need for BH specialty referral (e.g., Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR))

1.6 Telehealth Services:

The provision of behavioral health services through real-time video or phone teleconferencing:

- Provides a way to decrease barriers and improve access to care
- Offers alternative treatment option to promote mental wellness
- Convenient way to monitor and manage symptoms
- Available to all members regardless of risk

2. Avoidable Emergency Room Utilization Program Description

2.1 Goals and Objectives of the Avoidable Emergency Room Utilization Program:

To move more members to moderately managed per the Milliman Benchmark across all lines of business. To also decrease potentially avoidable Emergency Room utilization per 1000 across all lines of business. The various interventions are planned education, individual evaluation, removal of barriers and collaboration with the member's providers.

2.2 Scope of the Avoidable Emergency Room Utilization Program

The program is administered through reporting, Case Management team members (case managers, care navigators, health coaches, CDCES and social workers) interventions, Joint Operating Committee (JOC) clinical team collaboration, and Quality initiatives.

Program Components:

- Members who have utilized the ED in the last month and were discharged to home or were discharged to home with home health care services will receive a letter explaining alternatives to obtain care
- Case Management telephonic program targeting of members with high utilization and superhigh utilization.
- Provider collaboration with JOC/VBC provider groups. Monthly collaboration with clinical teams.

2.3 Case Identification Process

Members are identified by the HIMA team for interventions based on the program components listed in 2.2.

- ADT data collected via report for the week prior for all members admitted to ED for any reason and discharged to home with home health services for all lines of business. On a weekly basis, the report is compiled by HIMA and sent electronically to the DOCSS system with letter generation and mailing via DRS team to the members. All letters are captured in OnBase system for viewing by all clinical teams in the MedCompass clinical platform. If members have already received a letter within the past 30 days, a duplicate letter is not sent.
- Members are identified via report developed by the HIMA team. Report pulls active members with primary Medical Mutual coverage with care management eligibility. The report includes all lines of business. Members are identified by number of treat and release status for potentially avoidable ED admissions. Potentially avoidable conditions are identified by ICD10 codes on all paid and rejected claims. Additional databases utilized include Enterprise Data Warehouse (EDW), Impact Pro and MedInsight. Additional tools utilized include PHEA SDoH and 2010 USDA RUCA scores. (e.g., SVI, isolation category, Rural/Urban Tract data, food deserts, etc.).

  The report contains the following variables; member name, subscriber ID and dependent code, health ID#, date of birth, age, gender, last ED visit date and condition, number of visits (last 12 months), line of business, group name and ID number, regions, clinical team GEO,PCP name, VBC, IPro health category, CM program and sub-program, assigned MMO CM team member, member program status, address, do not contact flag notation, care intervention group (IPro), cost driver (IPro), category (12+ ED visits in 12 month period, and 3-11 ED visits).
- On a monthly basis, a report of members with potentially avoidable ED visits that are attributed to the ACO/VBC provider status is produced. The report is listed by ACO/VBC. Each individual VBC report contains the following information:
  - Subscriber ID number and dependent code, member name, address, date of birth, age, gender, PCP name and practice, CM program name and sub program name, CM team member name, case status and a filter that indicates if member is new to the report.

The reports are accessed on the HIMA SharePoint site by the Population Health Team's Clinical Liaison team members and are reviewed at the monthly JOC clinical team meetings. Each member is discussed as appropriate and a plan for addressing their ED utilization is developed. Documentation will be included in the MMO clinical platform.

- Evaluation of an alternative program that is targeted for the highest risk members regarding ED utilization is underway. The goal is to determine if a different approach might support decreased utilization amongst the group of members with 12 or more avoidable visits per year. Dispatch Health has a regional program regarding high ED education that has a clinician visit the member in their home and provide education to them on the appropriate utilization of the ED.

2.4 Eligibility Criteria

Eligibility for the telephonic program includes:

- Active Medical Mutual policy
- Primary insurance coverage with Medical Mutual
- Eligibility to participate in Care Management programs
- No system flag indicating they do not want to participate in care management programs
- ED visit(s) within the recent 12 months and have been discharged to home or home with home health care services

2.5 Risk Categories

Potentially Avoidable ED visits:

- 3-11 visits (High Utilization)
- Greater than 12 visits (Super High Utilization)
- Members in both targeted groups are referred to Ambulatory (High Risk) CM Program

2.6 Telephonic Case Management Assessments and Interventions

The CM team that is assigned a member for clinical outreach due to high ED utilization completes an assessment (e.g., pediatric or adult, maternity, behavioral health) that relates to clinical history, medications, SDoH and other barriers, provider(s) utilized and reasons for using the ED. They also conduct various clinical screenings as necessary. A template is utilized to capture specific elements of the member's experience and history for utilizing the ED. The assessment is documented in MedCompass clinical platform. The template is completed and included within the goals section of the member's care plan. Once the assessment, ED Utilization template and the various screenings are completed, an individualized care plan is developed. The care plan consists of problems, goals, interventions, and barriers. Within the care plan, interventions for the MMO team are included based on the specific goals. A case note is included with a summary of the member outreach. An ED utilization guide has been developed and is utilized as a guide by the CM team when working with members who have high ED utilization, to provide a uniform experience. Outreach cadence is dependent on the member acuity and their individual needs. Outreach to the member's provider is part of the overall interventions as well.

2.7 Case Management Reference Guide for telephonic program

Referrals related to High ER Utilization are assigned to Case Management Team Members based on the member's use of the Emergency Department.

Outreach to the member/parent/caregiver associated with the High ER Utilization referral requires a Motivational Interviewing approach for education as well as interventions implemented by the Case Management Team Member based on the member Care Plan for behavior change to occur.

Goals of the Case Management Team Member include:

- Identifying reason for ER use (health management, education regarding preventative care and symptom management, Serious Mental Illness [SMI], financial barriers and SDOH barriers)

- Educating the member on appropriate levels of care (send Healthwise Care Support Pages)
- Assisting the member with establishing care with a Primary Care Provider (PCP)/Specialty/BH Provider
- Decreasing ER utilization (share in network PCP and Urgent Care Providers near member)
- Increasing the member's health knowledge and understanding of continuity of care for best outcomes
- Educating the member regarding:
  - Health plan benefits (i.e., Nurse Line, My Health Plan, Roundtrip [MA Only])
  - Community resources (i.e., FindHelp)
  - Network provider use (including sending provider listings for PCP and Urgent/Express Care options)
  - Care opportunities and preventative care (i.e., establishing care w/PCP, mammogram, colonoscopy, medication compliance, follow-up care post IP stay discharge)
  - Vendor benefits (i.e., Dispatch Health, Carelon, Maternity App)

  (See *High Emergency Room (ER) Utilizer Referral Guidelines* for additional information)

2.8 Provider Joint Operating Committee Collaboration with JOC/VBC Clinical Team

Collaboration with our member's provider partners is an important part of the Avoidable Emergency Room Utilization Program. Monthly reports by JOC/VBC providers have been developed based on member attribution. The reports provide information about members that include demographics, provider(s) and member specific ED utilization. Report information will be shared by the Clinical Liaisons prior to the joint clinical team meeting. Medical Mutual clinical team members will evaluate each member scheduled for joint discussion at the monthly meetings. Conferencing on each member will occur during the monthly meeting with a plan for each member regarding clinical outreach and interventions as well as next steps and assigned clinical responsibility by team member. Clinical notes will be documented in the MedCompass clinical platform. Ongoing member discussion will occur as indicated.

2.9 Avoidable Emergency Room Utilization Oversight Committee

The ED Utilization workgroup that consists of CQHS departmental team members meet quarterly to review ED utilization data and trends. Established reporting will be evaluated as well and discussion and implementation of any required reporting modifications and outcomes of the data will be shared with the CQHS executive leadership.

2.10 Reporting

ED Utilization reporting will consist of ED visit volumes and ED trend reporting from the HIMA team. It will also include metrics regarding the number of referrals to the CM telephonic programs, the ACO/VBC member discussions and the ADT generated member ED Utilization letters.

- ED visits per 1,000 (avoidable and emergency)
- Urgent care vs per 1,000 as appropriate
- Professional vs per 1,000 as appropriate
- Dispatch health utilization as appropriate

2.11 Evaluation of Program Outcomes

- Short term outcomes will demonstrate decreasing potentially avoidable ED visits per 1000 for all lines of business
- Long Term outcomes will demonstrate an increase in the number of members rated as moderately managed per Milliman Benchmark for all lines of business
- Measures of success (members with potentially avoidable ED visits):
  - Overall number of those who had a PCP and if not, did they acquire one? (Enrolled vs. not enrolled)

- Overall number of correlated specialists for their ED visit. If member did not have a specialist, did they acquire one? (Enrolled vs not enrolled)
- Medication adherence rates for those requiring specialty care (BH, cardiology, etc.)

3. High Dollar Program Description

3.1 Goals and Objectives of the High Dollar Program:

To promote cost-effective and appropriate modes of care for members with high-cost health conditions while maintaining quality of care.

3.2 Scope of the High Dollar Program:

The High Dollar Program consists of a multidisciplinary approach of providing telephonic support to members based on the reason for their high-cost claims. Members that are identified as high dollar will be referred to case management as appropriate to ensure that they receive quality, cost-effective care. The focus of the program is to address barriers to care and potential cost savings opportunities.

3.3 Case Identification Process

Sources of Referrals: members are referred to the High Dollar Program from various sources, which include, but are not limited to:

- Monthly HIMA report of members incurring > $100K in the previous month
- Weekly Pharmacy Prior Auth Report for Medical Drugs
- Weekly report of Potential High Dollar Notification (HDN) members
- Ad hoc high dollar summaries of members completed by designated case managers

3.4 Eligibility Criteria

- Eligibility for the telephonic program includes:
- Active Medical Mutual policy
- Primary insurance coverage with Medical Mutual
- Eligibility to participate in Care Management programs
- No system flag indicating they do not want to participate in care management programs
- Have incurred or have potential to incur high-cost claims

Eligibility Detail:

Program eligibility is further determined from:

- Monthly HIMA report of members incurring claims > $100K in the previous month
  - Exclude FCA members
  - Exclude members already assigned to a CM
  - Prioritize CARE groups
  - Prioritize members with the highest dollar amounts
  - Weekly Pharmacy Prior Auth Report for Medical Drugs
  - Exclude FCA
  - Exclude members already assigned to a CM
  - Prioritize CARE groups
- Weekly report of Potential High Dollar Notification (HDN) members
  - Identified by UM from IP clinical information
  - Identified by Prior Auth upon claim review
  - Identified by Transplant Case Manager upon transplant approval
  - Exclude MMO employees (handled by a different HIPAA sensitive process)
- Ad hoc high dollar summaries of members completed by designated case managers
  - Initially identified as high dollar by MMO Sales and Underwriting Departments
  - Assessed to be clinically appropriate for CM referral

High-Cost Conditions include, but are not limited to:

- Severe traumas
- Transplants (actual/potential)
- Neonates
- Ventilator for an extended time
- Major organ failure
- Admission that results in new long-term outpatient dialysis
- Oncology cases (new cancer, new metastasis, new/change in treatment plan)
- Surgeries with major complications
- High-cost pharmaceuticals (chemo, Keytruda, Kymriah, CAR-T)
- Complicated sepsis

3.5 High Risk Category

Once the member has been identified for CM, they can be enrolled in any of the following programs. The CM then assesses the member's status and history and outreaches to the member within 2 business days from the time the referral was made.

Programs Available

- **Return to Home (RTH):** A short-term CM program to monitor targeted inpatient members who have a high readmission risk score of tiers 1-4 or who have been identified as having significant needs. These members are managed for 30-45 days once they have been discharged to home. This program utilizes a specialized and comprehensive assessment and plan of care. The focus is to reduce post-discharge readmission risk and provide interventions to prevent an avoidable readmission to the hospital during the first 30 days post discharge.
- **Complex NCQA**: A CM program for members identified as high risk during an inpatient admission, are engaged in CM and have ongoing needs after completion of a 30-day post-discharge period in the RTH program. Additionally, all members/caregivers who request CM services are considered for Complex NCQA CM. Eligibility for Complex NCQA CM begins upon completion of the RTH program or the day a member/caregiver calls to request CM services.
- **Ambulatory (High Risk)**: A CM program for members identified through targeting methods that include but are not limited to inpatient and ED utilization, cost, large claims activity, or by referrals from providers, employer groups, who are not eligible for Complex NCQA. These members may benefit from CM services of care coordination, education, and care collaboration.
- **Integrative**: A dedicated team of registered nurses experienced in behavioral health and medical case management work with members who have behavioral health and chronic medical conditions to ensure holistic cost-effective care. Specialized assessments and screening tools are utilized.
- **High Risk Maternity**
- **Behavioral Health**

Assessments and Interventions:

Regardless of which high-risk program the member is enrolled in, the following interventions are performed, the assigned case manager:

- Completes an assessment (e.g., pediatric or adult, maternity, behavioral health)
- Evaluates the clinical history, medications, SDoH and other barriers, and provider(s) utilized
- Completes various clinical screenings as necessary
- Develops an individualized care plan consisting of problems, goals, interventions, and barriers
- Collaborates with other MMO Team Members such as Pharmacy, CDCES and/or SW, as appropriate
- Refer member to alternate community resources, or vendors (e.g., Sword, Dispatch Health) as needed
- Performs outreach at a cadence that is dependent on the member acuity and their individual needs
- Collaborates with the member's provider as needed

- Documents the assessment, screenings, and interventions in the MedCompass clinical platform

F. Member Identification Process

Eligible members for CM services are identified by various modalities. Multiple referral avenues can minimize the time between identification of a need and delivery of case management services.

Table 2: Other CM Program Referrals (*denotes NCQA PHM 2A 1-6)

Referral Types	Example	Referred By	Reason for Referral
Medical and Behavioral Claims or Encounters *[5]	ImpactPro generated reports based on claims data and Risk Score	System-Data Feed	Predictive Modeling/Claims
	High dollar claims report	Employer/Group	
Pharmacy Claims *[6]	Referrals that are generated from pharmacy reporting/claims	Pharmacy	
Laboratory Results *[7]	Referrals that are generated from lab reporting/ claims	System-Data Feed	Predictive Modeling/Claims
Health Appraisal Results *[8]	Data from Health Assessment tool	System-Data Feed	HRA
Electronic Health Records *[9]	Currently no Complex NCQA Case Management relevant EHR data available. When available, Clinical Systems will use triggering process to auto-generate CM referrals in MedCompass	EHR	
Health Services Programs Within the Organization*10	Referrals from Medical or BH Nurse Line data Referrals from health screening data Referrals from prior authorization data Referrals from MMO Maternity App	Nurse Line Wellness MMO Clinical Team Vendor Partner	

G. Case Management Methodology and Supporting Evidence

1. Evidence used for the Case Management Program

Medical Mutual has licensed MCG which are evidence-based clinical guidelines that are utilized to develop case management assessments and care plans and assist the nurse in evaluating member's health conditions and barriers to care as well as developing an individualized, priority-based care plan for the member. MedCompass includes automated features that provide accurate documentation of staff name and the date and time of each action and/or entry in the members' case.

- Examples of Assessments include:
  - General Adult
  - Comprehensive Adult/Pediatric
  - Palliative Care
  - Post Discharge
  - Maternity
  - SDOH
  - Chronic Condition Management assessments (e.g., Diabetes, Hypertension)
- Examples of Screening Tools include:

- HRQOL-Health-Related Quality of Life
- Patient Activation Measure (PAM)
- Katz- Activities of Daily Living
- Lawton Brody- Instrumental Activities of Daily Living
- PHQ9-Depression

2. Case Management Process

Once cases are referred to case management, the nurse reviews clinical information from inpatient admissions, post discharge calls, previous case management activity as well as risk factors and/or care gaps identified in Impact Pro. Additional information is obtained from the member, caregiver, family and/or healthcare providers to complete the assessment.

Case managers complete a comprehensive assessment, identify available benefits and resources, and work with practitioners, including the primary care provider (PCP), specialists and the member and family to develop and implement the case management treatment plan. This plan includes establishing individualized member goals, identification of barriers to meeting goals, self-management plan, monitoring for compliance, and follow-up. Periodic assessments of progress against goals are conducted and modifications to the plan are made as needed.

The initial and ongoing engagement and participation with the Case Management process addresses:

- Initial assessment of members' health status including condition-specific issues
- Documentation of clinical history (ex: condition onset, inpatient stays, previous surgeries, medications, etc.).
- Initial assessment of the activities of daily living (functional status related to eating, bathing, and mobility, etc.).
- Initial assessment of behavioral health status, including cognitive functions (ex: psychosocial factors, cognitive functions such as communication, understanding instructions and process information about their illness).
- Initial assessment of social determinants of health (current housing, access to local food markets, social support).
- Initial assessment of life planning activities (wills, living wills, advanced directives, and health care power of attorney).
- Evaluation of cultural and linguistic needs, preferences, or limitations.
- Evaluation of visual and hearing needs, preferences, or limitations.
- Evaluation of caregiver resources and involvement (family involvement and adequacy of other involvement).
- Evaluation of available benefits and whether they are adequate to meet the member's needs over the next 3-6 months.
- Evaluation of community resources.
- Summarization and documentation of the meaning or implications of the above assessment factors to the member's situation so that this information can be utilized in the member's case management plan.
- Development of an individualized case management plan, including prioritized goals, that consider the member's and caregiver's goals, preferences, and desired level of involvement in the case management plan (personalized, prioritized, timeframes, appropriate level of care and resource utilization, planning for continuity of care, transitions of care if applicable, collaboration with providers and others, providing educational materials).
- Identification of barriers to meeting goals or complying with the plan (language, literacy, lack of or limited access to transportation, lack of understanding of their condition, lack of motivation, financial or insurance issues, cultural or spiritual beliefs, visual or hearing impairments and psychological impairment).
- Facilitation of referrals to resources as well as ongoing follow up for actual utilization of resources.
- Development of a schedule for follow-up and communication with members.
- Development and communication of member self-management plans (maintaining a prescribed diet, charting daily readings, changing a wound dressing as directed.).
- A process to assess progress against case management plans for members (Includes reassessment and adjusting the care plan and its goals as needed).
- All Medicare Advantage members are evaluated for digital literacy

Complex NCQA case management is an opt-out program: All eligible members have the right to participate or to decline to participate. All case management activities maintain the member's privacy, confidentiality,

and safety. The case manager advocates for the member and adheres to ethical, legal, and accreditation/regulatory standards while reinforcing the member's rights and responsibilities.

A key factor in improving member and caregiver outcomes is member engagement, a concept that combines a member's knowledge, skills, abilities, and willingness to manage his/her health with interventions designed to increase activation and promote positive behavior. Medical Mutual further defines and measures member engagement using the following criteria: the member has connected with the case manager via email or phone; has consented to participate in the CM program; and has agreed to work with the CM on goals related to the individualized care plan.

There may be occasions when the case manager is unable to contact the member/caregiver but has determined the member may benefit from case management intervention. In these instances, the case manager may be involved for care coordination. The case manager continues to attempt to contact the member/caregiver at least three times in a two-week period to obtain consent.

The case manager develops a plan of care, in collaboration with the member, member's caregiver and healthcare providers, which includes prioritized goals and interventions. Once the plan of care is established, the case manager will coordinate services utilizing network providers whenever possible and deliver interventions toward the achievement of goals.

Members with complex psychosocial needs may be referred to a social worker as part of the CM plan. The social worker will outreach telephonically to the member, caregivers and/or providers to assist with issues such as complex discharge planning, psychosocial assessment, access to community resources, moderate to complex behavioral health issues, transportation assistance, and financial resource referrals. Participation with the social worker is voluntary and is at no additional expense to the member.

H. Case Management Integration

The Clinical Quality and Health Services division, which includes case management, is highly integrated as described in Section I including through the member centered MedCompass platform. All users can view relevant content related to the member care.

Case managers collaborate via phone, letter, or case conference meetings with individual practitioners (including the PCP and specialists), healthcare providers and outside vendors to ensure coordinated care is delivered to the member. Additionally, case managers may collaborate with MMO Senior Medical Officer and the physician team regarding recommendations for care planning, evaluation and to obtain input regarding the appropriateness of the member's treatment plan.

V. Review and Approval Signatures

Dee Ann Bialecki-Haase MD	05/23/2025
Dee Bialecki-Haase, M.D Vice President, Chief Medical Officer	Date
	5/23/2025
Christian Corzine, RN, BSN BA Vice President, Clinical Services & Operations	Date
	5/23/2025
Marko Blagojevic, PharmD Vice President, Pharmacy Management	Date

Appendix A

Corporate Appeal Policy

2004.003

Appendix B

Member Appeal Procedure
2011.003

Appendix C

Medicare Advantage Expedited Reconsiderations Policy

MA-CCM-0102

Appendix D

Part C Standard Member Reconsiderations Policy