MEDICAL ASSOCIATES
HEALTH PLANS

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION
MEDICAL ASSOCIATES HEALTH PLANS
2021

AUTHORITY
Medical Associates Health Plan, Inc. and Medical Associates Clinic Health Plan of Wisconsin (collectively doing business as Medical Associates Health Plans and hereafter referred to as MAHP) have entered into contractual relationships or services agreements to make provision for medical and hospital services to members. Medical Associates Health Plan, Inc. is licensed to do business as a health maintenance organization in the state of Iowa, Illinois, and Nebraska.

Medical Associates Clinic (sole shareholder of Medical Associates Health Plan of Wisconsin, and hereafter referred to as Clinic) has agreed to establish standards and procedures to assure the quality of health care rendered to health care providers, at the request of the Board of Directors of Medical Associates Health Plan, Inc. and Medical Associates Clinic Health Plan of Wisconsin. The Utilization Management Committee (UMC) is delegated by the Clinic Board of Directors to carry out utilization management duties. The members of the Committee are appointed by the Chief Medical Officer, report to the Quality Improvement Committee (QIC), and are responsible to the Clinic Board of Directors. Members are appointed on a rotating basis so that a portion of the membership remains each year to assure the continuity of the quality improvement process.

OBJECTIVES/GOALS
Objectives and Goals of the Medical Associates Health Plan and Utilization Management (UM) Plan are:
• To provide a monitoring system to assure that services are delivered to our members at the appropriate level of care in a timely, effective, and cost-efficient manner.
• To continually improve the quality of care and resource allocation within the organization.
• To analyze patterns of patient care and health service utilization to improve patient care and outcomes, educate medical staff, administration, and consumers regarding the containment of cost
• To evaluate advancing medical technologies to determine the level of coverage provided to our members.

COMMITTEE STRUCTURES
The committee consists of the following persons:
• Medical Associates Clinic Chief Medical Officer (CMO) or physician designee. Throughout this document, physician designee can be implied where CMO is stated.
• Director of Quality and Health Care Services
• Manager of Utilization Management
• Care Coordination Manager
• On-Site Clinical Pharmacist
• At least six other practitioners representing various specialties, appointed and re-appointed by the CMO based upon plan need for areas of focus, provider specialty, willingness to serve and understanding of managed care principles. Practitioners must be Health Plan Providers. As a member of the UMC, a designated behavioral healthcare physician or a doctorate level behavioral health practitioner is responsible for implementation of the behavioral health aspects of the UM program and review of the BH policies or new policies. (pgs.4&5) The behavioral healthcare practitioner must be a physician or have a clinical PhD or PsyD.

Members will serve a three-year (3) term with one-third of membership rotating each year. Attendance is expected at 75 % of the meetings and excused absences count as attendance. Members not meeting this minimum attendance requirement will be subject to replacement as determined by the MAHP CMO.

Only practitioners may vote on matters concerning medical judgment and make an adverse determination relative to medical care delivery. No Committee member will be asked to review any case in which he/she is professionally involved. Consultation with non-Committee Board-Certified practitioners may be utilized if deemed necessary by the Chairperson. The Chairperson shall be the CMO.
COMMITTEE OPERATION
Meetings are held quarterly or more frequently if deemed necessary by the CMO. The CMO will report quarterly to the QIC, the Clinic Board of Directors and the Medical Associates Health Plans Board of Directors. The CMO will be involved in the implementation, supervision, oversight and evaluation of the program.

Utilization management activities apply to all MAHP members and providers. MAHP Medicare members must abide by the Medicare coverage guidelines. Local Coverage Decisions (LCD) and National Coverage Decisions (NCD) will be taken into consideration during the decision-making process for these members. However, review efforts may be focused on utilization management trends and identified problem areas. Trends of utilization concerns are identified and become the focus of committee review and intervention as necessary. If the Committee determines that there are no problems, certain conditions, practitioners and procedures may be exempted from review. Such exemptions must receive prior Committee approval.

Results of prospective, concurrent and retrospective data collection will provide this evidence. Minutes and records will be considered confidential and available only to the Committee, the Clinic Board of Directors, the MAHP Board of Directors, and external review organizations or accrediting agencies. Minutes will contain attendance records indicating those physicians present and those absent. The Utilization Management Committee Minutes will reflect all committee decisions, summary of discussions, and actions. Minutes are signed and dated by the person taking the minutes when they are completed. Minutes will be produced and distributed prior to the next Utilization Management meeting and are approved by the Utilization Management Committee. All review work sheets will be maintained in locked files for the purpose of confidentiality. Such MAHP cases will be reviewed for medical necessity, appropriate level of care for admission, continued stay and timely discharge, unless data collection justifies exempting review of this specific category as listed above.

COMMITTEE SCOPE/FUNCTIONS
The functions of the Committee may be executed by the entire Committee, a subcommittee, or by delegated members as deemed appropriate by the Committee. The Committee responsibilities and functions include but are not limited to:

- Assist in the development of policies and procedures as they relate to the functions of the MAHP and provide recommendations for implementation and evaluation to the QIC and Clinic Board of Directors.
- Review utilization reporting and UM work group recommendations for improvement of population health.
- Review requests for the MAHP coverage of new medical technologies and advancements and make recommendations to the QIC and Clinic Board of Directors.
- Review, monitor and measure success of quality improvement initiatives.
- Review and monitor hospital admissions involving all MAHP members in accordance with applicable statutes and regulations. This will be done by concurrent or retrospective auditors.
- Monitor compliance of all providers with the pre-admission and referral processes. Make recommendation for action when non-compliance occurs.
- Review and monitor all out-of-plan referrals. The Committee should analyze practitioner referral patterns for appropriateness and recommend action to the Clinic Board of Directors.
- Review and monitor emergency room utilization and make recommendations for the correction of utilization concerns.
- Monitor the volume of and rationale behind the issuance of MAHP non-certifications of coverage.
- Review Pharmacy data quarterly to establish and maintain an effective drug utilization review system including member utilization, practitioner prescribing patterns, pharmacy utilization, generic drug utilization, and the monitoring of formulary compliance.
- Review and monitor Health Care Services Case Management and Utilization Management medical necessity decisions. The CMO will be available on an ongoing basis to the Health Care Services Case Managers for daily consultation.
- Provide education related to MAHP managed care model to the members of the Committee.
- The CMO or Director of Quality and Health Care Services & the Managers of Health Care Services Departments will be responsible for revising the Utilization Management Program Description and Work Plan on an annual basis. Amendments and addendums will be submitted to the UMC, QIC, and Clinic Board of Directors for ratification.

MONITORING OF PRACTITIONER UTILIZATION
Under the direction of the Clinic Board of Directors, the monitoring of individual practitioner and specialty utilization is the responsibility of the Utilization Management Committee. The Committee identifies concerns in the areas of hospital, ambulatory care, prescription drug, out-of-area referral, and under-and over-utilization through a very critical analysis of comparative practitioner data including external data. Once outliers are identified, data will be shared with these practitioners
for the purpose of generating discussions regarding possible corrective actions. Corrective action plans will be forwarded to the QIC, and Clinic Board of Directors in the form of a recommendation. It will be the responsibility for the Clinic Board to implement the recommendation.

REVIEW OF HOSPITAL CLAIMS
As directed by the CMO, meetings will be held with specialty departments to review hospital medical records and hospital claims. The purpose of these meetings is to review and consider the elimination of costly services/equipment, yet not jeopardizing the quality of care of the patient. Any cost-saving measure identified, which could benefit practitioners in other specialties will be communicated by the CMO. The effects of the implemented changes in practitioner-practice will also be monitored.

TYPES OF CLINICAL INFORMATION TO DETERMINE COVERAGE
- Office and hospital records.
- A history of the presenting problem.
- A clinical exam.
- Diagnostic testing results.
- Treatment plans and progress notes.
- Patient psychosocial history.
- Information on consultations with the treating practitioner.
- Evaluations from other health care practitioners and providers.
- Diagnoses including the diagnosis codes
- Photographs.
- Operative and pathological reports.
- Rehabilitation evaluations.
- A printed copy of criteria related to the request.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from responsible family members

EVIDENCE BASED MEDICINE DECISION MAKING
MAHP utilizes evidence-based medicine in its decision-making process. HCS Utilization Management Review Policy is utilized in the determination of medically necessary services ensuring that the criteria are applied consistently and fairly to all patients.

Resources utilized by the Health Plans in determining medically necessary services include, but are not limited to:
- Nationally Developed Criteria (NCCN and Medical Necessity guidelines from MAHP’s current vendor)
- MAHP HCS Policies and Procedures
- Attending practitioner exam
- Recommended treatment plans
- Medical records (hospital and office)
- Board Certified practitioner who is a peer of the attending practitioner
- Subscriber contract (benefits/criteria related to the request)
- Practitioner contacts from tertiary care centers (consultations and/or information)
- Medical literature
- Clinical Criteria established by our current Pharmacy Benefits Manager

THE HOSPITAL ADMISSION REVIEW PROCESSES
MAHP utilizes a hospital pre-certification program as the system to ensure that the Plan’s resources are utilized to deliver care in the most appropriate setting. To achieve this goal, MAHP has adopted nationally developed criteria published by
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MAHP’s current vendor, and reviewed and approved by UMC, QIC, and Clinic Board of Directors for use during the authorization procedure. These criteria are reviewed and approved on an annual basis.

The MAHP Health Care Services Department will review requests for elective admissions from participating practitioner’s offices as indicated per facility and member contracts and provides authorization per HCS Authorization and Referral Management Policy and HCS Utilization Management Review Policy. Elective admissions requiring authorization should be communicated to the Health Care Services Department at least 14 days prior to admission. After authorization has been granted, discharge planning needs are assessed, and these arrangements can be coordinated by the Health Care Services Nursing staff.

DISCHARGE PLANNING AND CASE MANAGEMENT
Discharge planning begins upon receipt of information of the impending admission or upon the initial review of the patient’s medical record. Cases are reviewed utilizing HCS Authorization and Referral Management Policy, HCS Decision Timeframes and Determination Policy and HCS Utilization Management Review Policy. The Health Care Services nurse discusses the case with the attending practitioner/practitioner’s staff, appropriate hospital staff and the patient and patient’s family.

IN-PLAN REFERRAL PROCESS
Referrals made by a participating practitioner to other MAHP participating practitioners within the same provider network do not require an authorization approved by the CMO.

PRIOR AUTHORIZATION/PRE-CERTIFICATION
Requests made by Health Plans’ participating practitioners for services requiring authorization are authorized according to established Health Care Services Policies and Procedures, Authorization and Referral Management and Decision Timeframes and Determination. These guidelines are reviewed and approved annually by the CMO, Utilization Management Committee, Quality Improvement Committee, and Clinic Board of Directors. Prior authorization requirements may be initiated or removed as deemed necessary by MAHP. These processes apply to MAHP and Health Choices members and practitioners.

NON-CERTIFICATIONS
Denials in the utilization management program are known as non-certifications. The Health Care Services Staff utilizes HCS Decision Timeframes and Determination Policy when making a non-certification for a requested medical service.

BEHAVIORAL HEALTH CARE
MAHP has established policies and procedures to ensure access to medical care for members needing behavioral health care and to establish standards for access. Requests are triaged through the Health Care Services Department. A Behavioral Health Practitioner is available to review treatment plans as indicated. A Behavioral Health Practitioner is a member of the Quality Improvement (QIC) and Utilization Management Committees. QIC focuses on improving Behavioral Health care through monitoring of HEDIS measures and discussing results, interventions and follow-up. As a member of UMC, the behavioral health practitioner is involved in the implementation of the behavioral health care aspects of the MAHP UM program including review of behavioral health policies and procedures. Network and levels of care for Behavioral Healthcare Services is evaluated annually by the Credentialing Coordinator at MAHP. See Operations Policy #12 Network Adequacy Testing.

MENTAL HEALTH/CHEMICAL DEPENDENCY TRIAGE
MAHP has an established policy, HCS Mental Health /Chemical Dependency Access Standards Policy, to assure access to medical care for members needing behavioral health care and to establish standards for access to behavioral health care. All MAHP members have open access to Medical Associates Clinic Behavioral Health Department and all contracted providers for behavioral health services.

COMPLEX CASE MANAGEMENT
Medical Associates Health Plans (MAHP) Complex Case Management (CCM) program focuses on supporting the
Practitioner – patient relationship and helping members access needed resources, services and coordinated care. The CCM processes are documented and available in the Complex Case Manager Program Description.

ADVANCING MEDICAL TECHNOLOGIES
MAHP has established a process to assure that coverage for medically necessary services and advancing medical technologies is evaluated and applied consistently and fairly to all its members. This process is outlined in the HCS Policy titled, Determining Coverage of Advancing Medical Technology.

POST SERVICE/RETROSPECTIVE REVIEW FOR COVERAGE
MAHP has established a process to facilitate post service/retrospective review when a request for coverage is made after care/service has been received and a determination of coverage is required. This process is outlined in HCS Policy and Procedure, Decision Timeframes and Determination.

DELEGATION OF UM ACTIVITIES
Medical Associates Health Plans is responsible for the oversight of all Utilization Management Activities, even if there is a delegation of these functions.

PROVIDER/MEMBER EDUCATION
MAHP is dedicated to the promotion of health and wellness through a well-developed education program. This program focuses on patients as well as the providers of health care. This approach involves continually evaluating the type of health education available to patients and health care providers through an organized approach. Past claims experience is utilized to identify the most frequent diagnoses experienced. These diagnoses become the target for health promotion and wellness activities. The goals of the education program are to improve the overall health status and quality of life of patients and decrease overall utilization of health care services.

MAGELLAN PHARMACY AND THERAPEUTICS COMMITTEE
MAHP contracts with Magellan Rx as their Pharmacy Benefit Management vendor and utilizes the Magellan Precision Formulary. A Magellan Pharmacist located at MAHP will attend quarterly P&T Committee meetings and provide review and update of significant formulary changes that impact the MAHP member population. For full description of Magellan Pharmacy and Therapeutics Committee activity see Magellan P&T Committee Charter.

PROGRAM EVALUATION

EVALUATION OF THE UTILIZATION MANAGEMENT PROGRAM
A. The participating UMC members, consisting of: the senior-level physician, designated Behavioral Health physician or practitioner, other specialty and/or primary care physicians and Clinic and MAHP staff, will annually reassess, amend, and approve the Utilization Management Program Description and Work Plan. Criteria used in decision-making will be reviewed on an annual basis. Health Care Services Policies will be reviewed annually by the UMC.
B. Participating practitioners and staff will be requested to provide annual comments and suggestions relative to the Utilization Management program in the first quarter of every year. These suggestions will be taken into consideration by the UMC in its annual assessment of the program.
C. The UMC will review a summary of the utilization management activities for the year. The summary will list the problem areas identified, the assessment techniques used, the results or impact on patient care and clinical performance and time frames for continued monitoring. This problem list including action plans can be amended as needed throughout the year.
D. Through analysis of this information, any deficiencies or inadequacies will be identified and addressed.
E. Changes in policies, authority, and communication techniques will be made as deemed appropriate.

Results of this evaluation, as well as the plan of action for the upcoming year developed by the Committee Chairperson, will be summarized and reported to the QIC, MAHP Board of Directors, and Clinic Board of Directors.
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