V. Utilization Management (UM) Program

Overview

Better Health Network's Utilization Management (UM) Program is designed to provide quality, cost-effective and medically necessary services while meeting the requirements of HFS as a health plan for Medicaid eligible persons in the State of Illinois. Apex Healthcare, Inc. is Better Health Network's delegated entity responsible for Utilization Management.

The focus of the UM program is to:

- Evaluate requests for services by determining the medical necessity, efficiency and appropriateness consistent with the Member's diagnosis and level of care required
- Provide access to medically appropriate, cost effective health care services in a culturally sensitive manner
- Facilitate timely communication of clinical information among Providers
- Reduce overall expenditures by developing and implementing programs that encourage preventive health care behaviors and active Member participation in their health and wellbeing
- Encourage and facilitate communication and collaboration among members, families, Providers, delegated entities, social service providers and Better Health Network in an effort to enhance cooperation and appropriate utilization of health care services
- Incorporate the principles of care coordination into the delivery of medical services for members at risk for complex case management services
- Integrate behavioral and medical services to enhance the coordination of care and minimizing barriers in the delivery services

Better Health Network's UM program includes components of referrals, prior authorization/certification, and concurrent review activities.

Medically Necessary Services

In accordance with 42 CFR 440.230, each medically necessary service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The determination of whether a covered benefit or service is medically necessary complies with the requirements established by HFS in accordance with the Code of Federal Regulations Title 42, Part 438.210, and National Committee for Quality Assurance (NCQA®) accreditation standards. **Please refer to the HFS Provider Manual to review guidelines for Medical Necessary Services. The HFS Provider Manual can be accessed on HFS' website at www.hfs.gov.**

Apex Healthcare Inc. will use Apollo Medical Review Criteria and Guidelines to evaluate medical necessity. Apex will also take into consideration other sources of information including, but not limited to, the following when making coverage determinations:

- Better Health Network Clinical Coverage Guidelines
- Medical necessity
- HFS Contract for Accountable Care Entities (ACEs)

V. Utilization Management (UM) Program (continued)

The **Utilization Management Process** is comprehensive and includes the following review processes:

- **Notifications**
- **Referrals**
- **Prior Authorizations**
- **Concurrent Review**

Forms for the submission of notifications and authorization requests can be accessed through the Provider Portal on Better Health Network's website at **www.betterhealthchicago.org**.

Notification

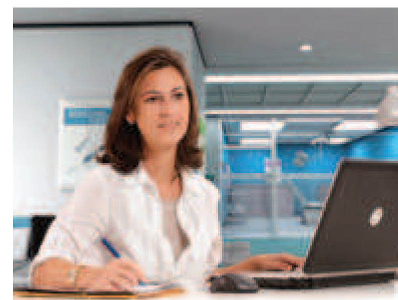
Notifications are communications to Better Health Network with information related to a service rendered to a Member or a Member's admission to a facility. Notification is required for:

- Prenatal Services

This enables Better Health Network to identify pregnant Members for inclusion into the Care Coordination Program. OB providers are required to notify Better Health Network's Care Coordination delegated entity, Family Health Network (FHN) of pregnancies via fax using the OB Notification Form located on the Better Health Network Website Provider Portal within 2 business days after the initial visit. This process will expedite case management services.

- Scheduled Admission to a Hospital

Notifying Better Health Network through Apex Healthcare, Inc. of a Member's scheduled admission to the hospital enables Better Health Network to log the hospital admission and follow-up with the facility on the following business day to receive clinical information. The notification should be received by fax or telephone by the following business day and include member demographics, facility name, admitting diagnosis, and clinical information that includes the severity of the illness, intensity of services, and illustrates medical necessity.



- Behavioral Health Services

In evaluating the physical and mental health of a Member if it is determined that the Member may benefit from Behavioral Health Services, the PCP is requested to send a notification to Better Health Network's delegated entity for behavioral health services, PsycHealth, Ltd. This notification form is located on Better Health Network's website at **www.betterhealthchicago.org**. Notification should be sent within 2 business days after the initial visit to expedite case management services.

V. Utilization Management (UM) Program (continued)

Referrals

Referrals are a key component for Primary Care Physicians (PCPs) in coordinating care and ensuring members receive medically necessary services to address their health problems and improve their overall health. An effective referral system ensures a close relationship between all levels of providers and helps to ensure members receive the best possible care. Referral forms may be found on the Provider Portal on Better Health Network's website at **www.betterhealthchicago.org**. Referrals are valid for 30 days. The Policy and Procedure Section of this manual has a copy of the Referral Process adopted by Better Health Network.

Prior Certification/Authorization

Pre-Certification of medical services is necessary to ensure quality of care. It is performed to ensure that the proposed hospital admission, procedure or service is rendered in the appropriate setting, is medically necessary and is appropriate to the member's medical co ndition, meeting professional recognized standards of care, through the evaluation of available medical information. Pre-Certification is an integral part of Better Health Network's standards of care.

Except in medical emergencies, it is the policy of Better Health Network that all Medicaid covered medical services must be provided, initiated and approved by the Enrollee's Primary Care Physician (PCP). All procedures/services must be referred to a contracted BHN Provider or facility or pre-certified by Better Health Network's Medical Director if out of network. This pre-certification process includes the determination of medically necessity and the appropriateness of the propose site where services will be performed.

The following services require precertification from Better Health Network:

- Referrals to Providers not participating in Better Health Network
- Elective inpatient medical, surgical and 23 hour observation stays (including scheduling, following outpatient procedures, and deliveries)
- Outpatient surgical procedures
- Outpatient services performed in other than a physician's office

This may include, but not be limited to the following services:

  - Skilled nursing placements
  - Physical therapy, occupational therapy, speech therapy
  - Home Health Care
  - Dialysis
  - Durable Medical Equipment
- Invasive cardiac testing (i.e. cardiac catheterization)
- Invasive pulmonary testing
- Rehabilitation including inpatient, intensive outpatient (day program) and cardiac rehab
- Any case requiring an inpatient or outpatient surgical suite and/or the use of recovery room
- High Cost Injectable Drug

Apex Healthcare, Inc. as the delegated entity for Better Health Network is responsible for utilization management and reviewing Pre-certification referrals. Apex will work with Better Health Network's Medical Director regarding Pre-certification referrals.

V. Utilization Management (UM) Program (continued)

Concurrent Review

Concurrent review activities involve the evaluation of a continued hospital, long-term acute care (LTAC) hospital, skilled nursing facility or acute rehabilitation stay. The review entails evaluation for medical appropriateness and utilizing appropriate criteria to determine if continued stay is medically necessary.

Apex Healthcare, Inc. will be conducting Concurrent Review on behalf of Better Health Network. Apex's nurse will follow the clinical status of the Member through telephonic or onsite chart review and communication with the attending Provider, hospital utilization manager, Case Management staff, or hospital clinical staff involved in the Member's care.

Concurrent review is initiated as soon as Better Health Network is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the Member, complexity, treatment plan and discharge planning activity.

Apex Healthcare Inc. will:

- Ensure that services are provided in a timely and efficient manner
- Ensure that established standards of quality care are met
- Implement timely and efficient transfer to lower level of care when clinically indicated and appropriate
- Complete timely and effective discharge planning
- Identify cases appropriate for case management

The concurrent review process incorporates the use of Apollo criteria to assess quality and appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of Apex Healthcare, Inc. Apex will notify Better Health Network on a daily basis of Members receiving Concurrent Review.

Second Opinion

Obtaining a second opinion from a physician outside of the person's primary care physician is a person's right. Second opinions can also be viewed as checks and balances regarding a diagnosis and course of treatment that the person may not accept. Better Health Network (BHN) believes Members have the right to obtain a second opinion for a health condition, a specific diagnosis or a recommended course of treatment.

The objective of obtaining a second opinion affords the Member the privilege of requesting an examination or evaluation of a health condition by a second physician to either verify or challenge the diagnosis or treatment plan recommended by the first physician.

A Member of Better Health Network may seek a second opinion from another BHN in-network Provider according to procedures used by the Illinois Department of Healthcare and Family Services (HFS). The Member's PCP may make a recommendation regarding a physician qualified to render a second opinion regarding the Member's health, diagnosis and course of treatment. If the Member would like to receive a referral for a second opinion from a physician not recommended by their PCP, they may review BHN's Provider List and select a specialist. A referral can be obtained from Better Health Network's Medical Director.

If there is substantive disagreement between the first and second opinion, the PCP may consult with BHN's Medical Director to obtain a third opinion. BHN's Medical Director may make a recommendation as to the physician to provide the third opinion.

Emergency Care

There are no prior certification/authorizations requirements for emergency services. Better Health Network has put into place an ADT live feed notification system to Apex Healthcare, Inc. in its four primary owner hospitals: **St. Bernard Hospital, Loretto Hospital, Roseland Community Hospital and South Shore Hospital.**

Once Apex has received this live ADT feed, it will contact the Provider to inform him or her that their patient is in the Emergency Room. The Provider will be given all the pertinent information to contact the attending emergency room Provider. If Apex has information that the Member is in Care Coordination it will also contact the Care Coordinator. The attending emergency room Provider, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer to a BHN Hospital or be discharged.

Discharge Planning

Discharge planning begins upon admission and is designed to identify medical and/or psychosocial issues that will need post-hospital intervention early. Apex Healthcare, Inc. is responsible for discharge planning. Apex's Concurrent Care Coordinator will work with the attending provider, hospital discharge planner, ancillary providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the Member to the appropriate level of care.

Apex's Care Coordinator will also coordinate care with BHN's Care Coordinator assigned to the Member, if the Member is in care coordination. Once the Member has been discharged back to the Member's home, BHN Care Coordination will resume. If the Member is transferred to another facility, Apex will follow the case until the Member is discharged to his or her place of residence.

Continuity of Care

When a Member of Better Health Network is being treated by another doctor who is not a part of Better Health Network's Provider Network, they can ask to keep seeing that doctor for up to 90 days after becoming a member as long as the following conditions apply:

- They must keep seeing the same doctor regularly for the care of their specific medical condition.
- They are a pregnant woman in the seventh, eighth or ninth month of the pregnancy, until after the baby is born and follow up care is completed
- Doctor agrees to follow the Better Health Network's policies and payment plan

After the 90-day period, the Member will be asked to transition to a Better Health Network doctor.

If the Member's care can be transferred safely to a Better Health Network Provider, this will be done as soon as possible, depending on their treatment plan. Please allow a reasonable amount of time to complete the transition.

Transitions of Care

Better Health Network (BHN) believes that better care means better health for its Members. This includes providing seamless transitions of care for Members when the level of care necessary changes as well as changes in the provider of this new care. Transition of Care utilizes structured interventions to ensure coordination and continuity of health care as Members transfer between different locations or different levels of care.

The purpose is to minimize disruption of care, avoid adverse clinical outcomes and provide appropriate care expectations for the Member as well as the Provider of care.

Utilization Managers, Care Coordinators, and Behavioral Health care coordinators will coordinate and provide transition of care services to Members. They will follow Better Health Network's policies on Transition of Care listed in the Policies and Procedure Section of this Provider Manual.

Better Health Network will coordinate the following transitions of care between Providers, levels of care and care settings:

- Transitions between PCP and Behavioral Health Providers, PCPs and Specialists
- Transition from Outpatient to Inpatient Care
- Transition from Emergency Departments (ED) to PCP
- Coordination with Nursing Facilities
- Transition from Inpatient to Outpatient Care
- Transition from Inpatient to Inpatient
- Coordination with HCBS Waiver Services

V. Utilization Management (UM) Program (continued)

CARE COORDINATION

Overview

Better Health Networks primary goal is to improve health outcomes for its Members. Care Coordination is an integral part of the comprehensive services used to facilitate a Member's health assessment and follow-up to care, contributing to the process of achieving better health.

BHN 's Care Coordinators are Registered Nurses (RN) or Licensed Clinical Social Workers (LCSWs) who perform a comprehensive assessment of the Member's clinical status, develop an individualized care plan, establish goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan. Care Coordinators work collaboratively with Members, their designated representatives, PCPs and specialists to coordinate care and expedite access to needed services.

Better Health Network's Care Coordinators assist Providers in developing care plans and actively link the Member to specialists, behavioral health services, and other social services, as needed. A Provider may request care coordination services for any Better Health Network Member by calling **1-844-410-CARE (2273)**.

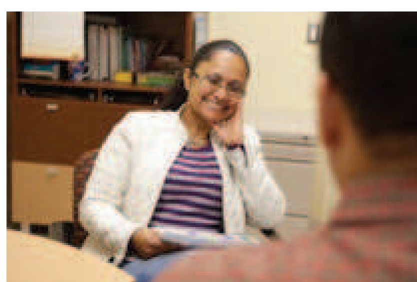
Members may be identified for Care Coordination by:

- Referral from a member's PCP or other specialist
- Self-referral
- Referral from a family member
- Referral after a hospital discharge
- After completing a Health Risk Assessment (HRA)
- Data mining for Members with high utilization rates through Risk Stratification Programs and other analytic tools in reviewing HFS claims data

Members commonly identified Case Management Program include:

- **Multiple Chronic Conditions –** multiple co-morbidities such as diabetes, chronic obstructive pulmonary disease (COPD), and hypertension, or multiple intricate barriers to quality health care.
- **Transplantation –** organ failure, donor matching, post-transplant follow-up;
- **Complex Discharge Needs –** Members discharged home from acute inpatient or skilled nursing facility (SNF) with multiple service and coordination
- **Special Health Care Needs –** Children or adults who have serious medical or chronic conditions with severe chronic illnesses, physical, mental, and developmental disabilities
- **Catastrophic Illness or Injury-** Traumatic injuries such as amputations, blunt trauma, spinal cord injuries, head injuries, burns, and multiple traumas and/or terminal illness

BHN's Complex Case Management and Disease Management Policy and Procedures are located in Appendix A.



V. Utilization Management (UM) Program (continued)

Disease Management Program

Disease management is a population-based strategy that involves providing care across the continuum for Members with certain diseases. Elements of the program include educating the Member about the particular disease and self-management techniques, monitoring the Member's adherence to the care plan, and the consistent use of validated, industry-recognized evidence-based Clinical Practice Guidelines.

The Disease Management Program targets the following conditions:

- Adult and Child Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Hypertension
- Pre-natal-postpartum care
- Smoking Cessation
- Alcohol and Drug Abuse
- Autism
- Cholesterol Screening
- Coronary Artery Disease
- Depression and Mental Illinois
- Obesity
- Behavioral Health Medical Management

The purpose of Better Health Network's Disease Management Program is to educate Members and their caregivers regarding the standards of care for chronic conditions. This includes identifying and avoiding triggers, learning appropriate medication management and incorporating diet and exercise, if needed into the Member's daily life.

The program also focuses on educating the Provider regarding the standards of specific disease states and current treatment recommendations. Intervention and education can improve the quality of life of Members, improve health outcomes and decrease medical costs.

For Members identified as needing disease management services, intervention depends on risk stratification level and needs. Medium and High Risk Members receive a comprehensive assessment, disease-specific educational materials, identification of a care plan and goals, with follow-up assessments to monitor adherence to the care plan. Low risk stratified members receive periodic health information and regular reminder to make annual appointments with their PCP.

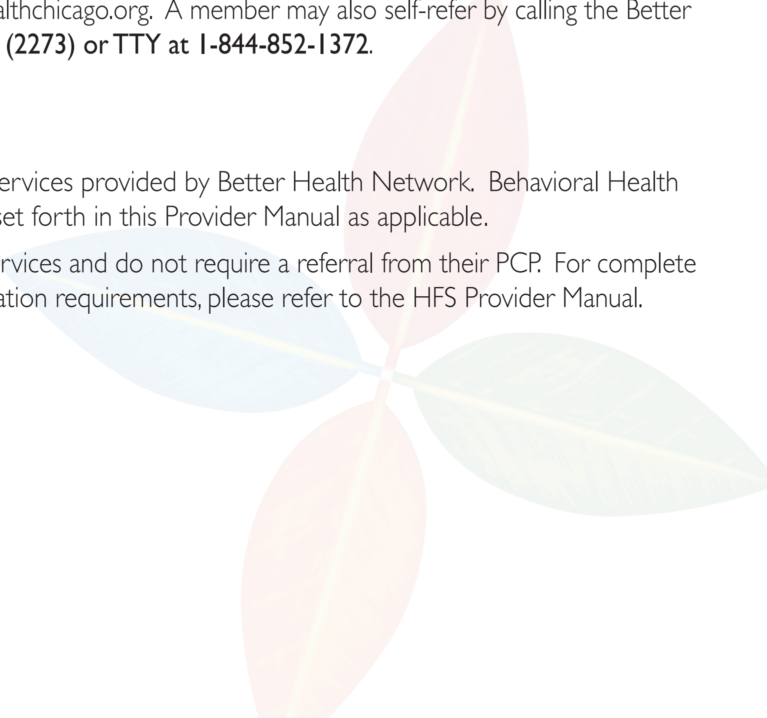
Providers who would like more information or to refer a member to Better Health Network's Care Coordination/Disease Management programs, please call **1-844-410-CARE (2273)** or complete the Care Coordination Referral Form located on the Provider Portal of BHN's web site at www.betterhealthchicago.org. A member may also self-refer by calling the Better Health Network's toll free number of **1-844-410-CARE (2273) or TTY at 1-844-852-1372**.

BEHAVIORAL HEALTH

Overview

Behavioral Health is a core component of the health services provided by Better Health Network. Behavioral Health Providers are required to comply with the provisions set forth in this Provider Manual as applicable.

Members may refer themselves for behavioral health services and do not require a referral from their PCP. For complete information regarding benefits, exclusions and authorization requirements, please refer to the HFS Provider Manual.



V. Utilization Management (UM) Program (continued)

RESPONSIBILITIES OF BEHAVIORAL HEALTH PROVIDERS

The following are the responsibilities of Behavioral Health Providers.

1. Provide the following documentation to Better Health Network
   - National Provider Identifier (NPI), if applicable
   - Medicaid Provider Number, if applicable
   - Be a member of Illinois Health Connect, if applicable
   - Board Certification, if applicable
   - Current license to practice psychiatry in Illinois, if applicable
   - Current credentials if not a psychiatrist
   - Current policies regarding professional liability/malpractice insurance; insurances related to the work place; general liability; workmen's compensation, etc.

2. Contact and Billing Information
   - Full name of Provider
   - Group name or affiliation;
   - Address, city, state, zip code for each office location
   - Documented disability accessibility for each location
   - Telephone or fax number; pager number
   - After hours telephone, if different from main number
   - Hospital affiliations:
   - Tax Identification Number (Tax ID or TIN) or Entity Affiliation (W-9 required);
   - Panel of services; and/or Directory listing
   - Mailing address for 1099s

3. Behavioral Health Access Standards

The table below is for Behavioral Health Access Standards

Type of Appointment	Access Standard
Behavioral Health Provider - Emergent	Available 24 hours per day with a wait time of no longer than one hour
Behavioral Health Provider - Urgent	Less than 24 hours
Behavioral Health Provider - Post inpatient discharge	Less than 7 days
Behavioral Health Provider - Routine	Less than 10 days
Behavioral Health Provider - Non-life threatening	Less than 6 hours

Behavioral Health Providers are required to meet the following Member Travel Time Standards and Access to Provider Locations:

Member Travel Time Standards:

- Members will not be required to travel more than 30 minutes or thirty miles to receive a primary health care appointment with a Better Health Network Provider.
- The Member has the choice to travel beyond these distance and time standards in selecting a Behavioral Health Specialist from Better Health Network's Provider Network.
- The choice of the Member to select Behavioral Specialist beyond the required travel standards will not adversely affect Better Health Network's reporting to HFS.

V. Utilization Management (UM) Program (continued)

Access to Provider Locations

- Provider locations must be accessible for Members with disabilities. Providers must document this accessibility in their contact information.
- Documentation of accessibility must comply with the Americans with Disabilities Act.
- Provider location shall be ADA compliant.
- Provider will document any accommodation unique to the Member's needs.

Delivery of Care

- Coordinate, monitor and supervise the delivery of behavioral health services to each Member
- Not exceed scheduled appointments made for per hour
- See Member for an initial office visit and assessment according to Behavioral Health access standards
- Coordinate, monitor and supervise the delivery of behavioral health services necessary as well as preventive care services to Member
- Provide health and wellness information to Members with behavioral health issues
- Provide information and resources to pregnant Members regarding behavioral health in relation to prenatal care and post-natal care, and other relevant behavioral health information pertinent to the behavioral health status of the pregnant Member
- Provide access to Better Health Network or its authorized representative to examine the primary care offices, books, records and operations of any related organization or entity as defines as an organization or entity having influence, ownership or control and either a financial relationship or a relationship for rendering services to the primary care office
- Submit an encounter for each visit
- Ensure members utilize network providers. If unable to locate a BHN participating provider for services required, contact Better Health Network for assistance.
- Comply with and participate in BHN's Quality Assurance/Quality Improvement policies, procedure and plans
- Comply with Better Health Network's Grievance and Appeals policies and procedures

CONTINUITY AND COORDINATION OF CARE BETWEEN MEDICAL AND BEHAVIORAL HEALTH PROVIDERS

Better Health Network encourages open communication between PCPs and behavioral health providers. If a Member's medical or behavioral condition changes, Better Health Network expects that both PCPs and behavioral health Providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between Providers.

Communication between Behavioral Health Care Providers and Medical Care Providers is critical to maintain continuity of care, patient safety and member well-being. This is particularly important for Members with co-morbidities receiving pharmacological therapy. Fostering a culture of collaboration and cooperation will help sustain a seamless continuum of care between medical and behavioral health and positively impact Member outcomes.