Utilization Management Program Description

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3004 Utilization Management Program Description

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Policy

It is the policy of Vaya Health (Vaya) to develop and maintain a utilization management (UM) program for medical, physical health, behavioral health, intellectual/ developmental disabilities (I/DD), traumatic brain injury (TBI), long-term services and supports (LTSS), and pharmacy services that is based on nationally recognized, evidence-based Clinical Practice Guidelines and decision support methodologies. Vaya's UM program supports an integrated, holistic look at a person's physical health, pharmacy, behavioral health, I/DD, TBI, and LTSS needs, noting that alternative treatments or supports may be appropriate considering the individual's complete clinical and other support needs. Vaya's UM program includes processes to evaluate the medical necessity, clinical appropriateness, efficiency, and effectiveness of requests for authorization of State-funded Services against established service definitions.

Scope

This UM Program Description is considered Vaya's UM Program Policy and applies to all health benefit plans managed by Vaya pursuant to contracts with the NC Department of Health and Human Services (NCDHHS or Department), including the Behavioral Health and Intellectual/Development Disabilities (I/DD) Tailored Plan (Tailored Plan) and NC Medicaid Direct Prepaid Inpatient Health Plan (PIHP) (collectively, the "NCDHHS Contracts"). Vaya's comprehensive UM program is designed to support UM and prior authorization for all services covered under the NCDHHS Contracts, including both inpatient and outpatient services. [UM 2(A)(4)] [UM 1(A) (5-6)].

Prohibition on Financial Incentives in Service Reviews

Consistent with 42 C.F.R. § 438.210(e), Vaya ensures that compensation to individuals or entities that conduct UM activities is not structured to provide financial incentives for the individual or entity to deny, limit, or discontinue services to any member. Vaya does not establish or implement any procedures, quotas, or staff performance objectives that provide incentives for utilization reviewers to deny, limit or discontinue coverage or medically necessary services to any member including but not limited to establishing a number or percentage of authorizations that must be denied, reduced, or terminated. Vaya does not provide reimbursement, bonuses, incentives, rewards, or encouragement to staff or to contracted providers, monetary or otherwise, for withholding medically necessary services or for denying, reducing, or terminating member utilization of services.

NCDHHS UM Program Policy Submission and Publication Requirements

1. Vaya is required to document our UM program, including referral and prior authorization processes, in a written UM Program Policy submitted to the Department for review and approval. **This Utilization Management Program Description constitutes Vaya's UM Program Policy for purposes of meeting this requirement.**

2. Vaya shall revise this UM Program Policy based on changes requested by the Department or the National Committee for Quality Assurance (NCQA), or as recommended by Vaya's Chief Medical Officer (CMO) and/or Clinical Advisory Committee.
3. If Vaya revises this UM Program Policy, Vaya shall submit any changes to the Department in writing no less than sixty (60) Calendar Days before such changes go into effect.
4. Vaya shall post this UM Program Policy on our publicly available website for members and providers, or in other forms as requested by the provider or member, at no cost.
5. Vaya shall include a prominent reference to the web address of this UM Program Policy in our Provider Operations Manual, Member Handbook, Recipient Handbook, Innovations Handbook, and TBI Waiver Handbooks (if applicable).

The following sections contain definitions of terms that are used throughout this UM Program Policy. If any member, provider, or stakeholder has questions about this Policy, please call Vaya Member and Recipient Services at 1-800-962-9003 M-Sat between 7:00 a.m. and 6:00 p.m. or call the Provider Support Service Line at 1-866-990-9712 M-Sat between 7:00 a.m. and 6:00 p.m.

Definitions

Adverse Benefit Determination (ABD) applies to Medicaid only, means as defined at 42 CFR §438.400(b), and is limited to:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service, except that a denial, in whole or in part, of a payment solely because the claim does not meet the definition of a ''clean claim'' at 42 CFR §447.45(b) is not an Adverse Benefit Determination.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of Vaya to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- For a resident of a rural area with only one (1) MCO, the denial of an Enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.
- The denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

Adverse Decision means an Adverse Benefit Determination or Adverse State-Funded Decision as defined herein.

Adverse State-Funded Decision means the denial, in whole or in part, of a request for authorization of a State-funded service, or a reduction, suspension or termination of a previously authorized State-funded service, unless such adverse decision is based on lack of funding for the requested service. Unlike Medicaid services, State-funded services are not an entitlement.

Authorization: The approval of a request for a health care service funded by Vaya based on a determination that the request meets medical necessity criteria and all clinical and administrative requirements for the service (as

documented in the request). For non-Medicaid services, funding must be available for the service to be authorized. Outpatient pharmacy authorizations are determined based on specific NCDHHS clinical criteria.

Authorization Review: The process used to evaluate requested health care services and determine whether they are medically necessary or, in the case of outpatient pharmacy authorizations, meet NCDHHS clinical criteria.

Behavioral Health includes the emotions and behaviors that affect a person's overall well-being, such as mental (MH) conditions and substance use disorders (SUDs).

Behavioral Health Home Provider: A contracted MH or SU provider with overall responsibility for planning and monitoring services for a member, even if more than one provider is serving the member during the same time period. A member has only one Behavioral Health Home Provider at any time.

Care Plan is a written individualized person-centered plan of care for members with behavioral health needs that is developed using a collaborative approach led by the member/Legally Responsible Person (LRP), incorporates the results of the care management comprehensive assessment, and identifies the member's desired outcomes and the training, therapies, services, strategies, and formal and informal supports needed for the member to achieve those outcomes.

Clinical Peer Review: Clinical review conducted by an appropriately licensed health professional when a request for admission, procedure, medications, or service was not approved during initial clinical review. This process may also be referred to as "second level clinical review" and be conducted by either an internal or external party.

Clinical Practice Guidelines (CPGs) are statements that guide practitioner and patient decisions about appropriate health care for specific clinical presentations. CPGs are usually issued by professional organizations and/or peer-reviewed and define the role of certain diagnostic and treatment modalities for patient care. The statements contain recommendations that are based on evidence from a rigorous systematic review and synthesis of the published medical literature.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): the federal benefit program that requires Medicaid to provide all medically necessary health care services to Medicaid-eligible children. This means that children under age 21 who have Medicaid are entitled to medically necessary screening, diagnostic and treatment services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [Section 1905(a) of the Social Security Act] that are needed to "correct or ameliorate defects and physical and mental illnesses and conditions," regardless of whether the requested service is covered in the North Carolina Medicaid State Plan (State Plan). According to the Centers for Medicare and Medicaid Services (CMS), "ameliorate" means to improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Basic EPSDT criteria are that the service must be safe, effective, generally recognized as an accepted method of medical practice or treatment and cannot be experimental or investigational (which means that most clinical trials cannot be covered). The EPSDT benefit does not apply to adults 21 years of age or older or to children who are not Medicaid beneficiaries.

Evidence-based practices (EPBs) are specific treatment interventions that have been demonstrated to be effective with the individuals served and the problems being treated. In general, EBPs have:

- A sound theoretical basis;
- Clinical literature regarding efficacy;
- Acceptance in clinical practice;
- No evidence of substantial harm or risk;
- A manual sufficiently detailed to allow replication;
- Demonstrated efficacy based on at least two randomized, controlled trials; and
- The majority of outcome studies support efficacy.

Expedited Review: Authorization review for those cases in which adherence to the standard timeframe could seriously jeopardize a member or recipient's life, health, or ability to attain, maintain, or regain maximum function is expedited review. Expedited review may also be referred to as "urgent review."

Initial Clinical Review: A clinical review conducted by an appropriately licensed or certified health professional. Initial Clinical Review staff may approve requests for admissions, procedures, medications, and services, but must refer requests that do not appear to meet clinical review criteria to the Peer Clinical Review process for approval or denial. An initial clinical review may also be referred to as "first level clinical review."

Legally Responsible Person (LRP): as defined in N.C.G.S § 122C-3(20)

1. Incompetent Adults: When applied to an adult who has been adjudicated legally incompetent, an LRP is a guardian.
2. Incapable Adults: When applied to an adult who is incapable as defined in N.C.G.S. § 122C-72(4), but who has not been adjudicated legally incompetent, an LRP is a health care agent named in a valid health care power of attorney. When applied to an adult who is incapable as defined in N.C.G.S. §122C-72(4), but who has not been adjudicated legally incompetent and does not have a health care agent or guardian, one of the persons specified below (also specified in N.C.G.S. §90-21.13(c)(3)-(7), shall be selected based on the following priority:
    A. An agent, with the powers to make health care decisions for the adult, appointed by the adult, to the extent of the authority granted;
    B. The adult's spouse;
    C. A majority of the adult's reasonably available parents and children who are at least 18 years of age;
    D. A majority of the adult's reasonably available siblings who are at least 18 years of age;
    E. An individual who has an established relationship with the adult, who is acting in good faith on behalf of the adult, and who can reliably convey the adult's wishes;
3. Minors: When applied to a minor, an LRP is the minor's parent, guardian, person standing in loco parentis, or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment. For purposes of this policy, in loco parentis shall mean a person who is not the parent or guardian of a minor, but who has either legal custody or physical custody of a minor and is providing the majority of support and care for the minor, such as a relative who is caring for a child due to the death or absence of a parent but who has not yet been appointed as guardian. To ensure appropriate access to care, Vaya recognizes that a family member or other person acting in loco parentis in emergent situations may consent to treatment and

sign a minor's person-centered plan or other necessary treatment documents if the parent or LRP is unavailable.

Member includes the term "Enrollee" as referenced in 42 CFR Part 438 and also refers to the following: (a) a Medicaid beneficiary whose Medicaid eligibility arises from residence in a county located within the Region and who is enrolled in a Vaya Health Plan; (b) a State-funded Services recipient who is eligible for and enrolled in the Tailored Plan, including individuals who receive MH/SU/IDD/TBI services funded with state, county and/or federal block grant dollars; or (c) where applicable within the context of the terms of this policy, the Legally Responsible Person for a Member who is a minor or who has been adjudicated incompetent. *Both Members and Recipients (defined below) are collectively referred to as "members" in this policy.*

Peer-to-Peer Discussion: A conversation between a provider and a clinical peer reviewer to discuss an actual or potential Adverse Decision.

Person-Centered Plan: The treatment planning form that meets the requirements of the Division of MHDDSUS Records Management and Documentation Manual APSM 45-2, and is used for identification of a member/recipient's service needs and preferences, recommended services and treatment goals.

Pharmacy Benefit Manager (PBM) – An entity which contracts with pharmacies on behalf of Vaya and administers or manages prescription drug benefits by performing any of the following functions:

- Processing claims for prescription drugs or medical supplies.
- Providing retail network management for pharmacies or pharmacists.
- Paying pharmacies or pharmacists for prescription drug or medical supplies.
- Reviewing prior authorization (UM) requests, appeals, and grievances related to pharmacy benefits.

Pharmacy UM: The requirement to meet pre-specified criteria before coverage of a prescription medication is allowed. This includes prior authorization and override requests for quantity limits, cost exceeds maximum, age limits and step therapy edits. The pharmacy UM process is delegated to Vaya's PBM subcontractor.

Prospective Review: Authorization review for medical or behavioral health services conducted prior to the start date of a service authorization, including subsequent authorizations of the same service.

Prospective Drug Utilization Review (prospective DUR, aka concurrent DUR): Drug utilization review for medications that occurs during the dispensing and claim adjudication process for outpatient pharmacy claims.

Reduction: A reduction of the duration and/or the amount of service or service intensity in an existing authorization but not withdrawing authorization of services already delivered prior to notification of the Adverse Decision.

Recipient is a State-funded Services recipient who is eligible for and enrolled in the Tailored Plan, including individuals who receive MH/SU/IDD/TBI services funded with state, county and/or federal block grant dollars; or (c) where applicable within the context of the terms of this policy, the Legally Responsible Person for a Recipient who is a minor or who has been adjudicated incompetent. *Both Members (defined above) and Recipients are collectively referred to as "members" in this policy.*

Retrospective Drug Utilization Review (retro DUR): Utilization review for medications after they have been dispensed.

Retrospective Review: Authorization review for medical or behavioral health services conducted after services have been provided.

Reversal of Authorization: Withdrawal of an authorization previously made, including instances in which services have been delivered.

Routine Review: Authorization review of non-urgent services.

Service Authorization Request (SAR): The prior authorization request that contains all the elements required in the NCDHHS service request template.

Termination: Shortening an existing authorization timeframe to reflect an earlier end date but not withdrawing authorization of services already delivered prior to notification of the Adverse Decision.

UM Clinician: A licensed or certified clinician who conducts initial clinical reviews of plans of care and authorization requests.

Section I: Basis for Coverage Determinations and Coverage Criteria

1. Vaya's UM program coverage determinations are based on the requirements, benefit plan limitations, and criteria found in the following Coverage Criteria, as may be amended from time to time:
    A. North Carolina's 1115 Demonstration Waiver.
    B. North Carolina's 1915(c) Home and Community Based Services (HCBS) Waiver (NC Innovations).
    C. North Carolina State Plan for Medical Assistance, including but not limited to the North Carolina's 1915(i) State Plan Amendment (SPA).
    D. NCDHHS Division of Health Benefits (DHB) NC Medicaid Clinical Coverage Policies (CCPs).
    E. Vaya's Medicaid Clinical Coverage Policies, *In Lieu of* Service Definitions and Alternative Services Definitions approved by NCDHHS (collectively Vaya Coverage Policies).
    F. NC Division of Mental Health, Developmental Disabilities and Substance Use Services (Division of MHDDSUS) service definitions for State-funded Services, which are not an entitlement and are subject to available funding (DMHDDSUS Service Definitions).
    G. The NC definition of Medical Necessity, defined in 10A NCAC 25A.0201.
    H. The MCG (formerly Milliman Care Guidelines).
    I. CPGs adopted by the Vaya Clinical Advisory Committee (CAC) in accordance with Vaya's policy for the Development and Review of Clinical Guidelines, Treatment Modalities, and Pharmacy Procedures.
2. Vaya also uses Clinical Decision Support Tools, which include but may not be limited to the following:
    A. Child and Adolescent Needs and Strengths Survey (CANS);
    B. North Carolina Support Needs Assessment Profile (NC-SNAP);
    C. American Association on Intellectual and Developmental Disabilities (AAIDD) Supports Intensity Scale (SIS®);

D. American Society for Addiction Medicine (ASAM) Leveling Tool; and
E. Innovations Waiver Level of Care (LOC) assessment tool and processes.

3. All UM decisions, enrollee education, coverage of services, and other decisions impacting member care will be consistent with the Coverage Criteria listed above.
4. All UM clinicians use the Coverage Criteria and Clinical Decision Support Tools listed above to evaluate and approve authorization of services [UM 4(A)(2)].
5. UM decision-making is objective and based only on clinical evidence, appropriateness of care and service and existence of coverage [UM 2(A)(1)].
6. If clinical criteria are specified in the CCPs, Vaya will base physical health coverage determinations on those criteria. If clinical criteria are not specified in the CCPs, Vaya will base physical health coverage determination on the MCG.
7. As described in Vaya's policy for the Development and Review of Clinical Guidelines, Treatment Modalities, and Pharmacy Procedures, if Vaya determines the need to develop proprietary clinical coverage policies, we include guidance from appropriate practitioners in the development, adoption and review of these criteria and implement these policies only after review and approval by NCDHHS.
8. When the Department updates CCPs, they also involve appropriate practitioners in this review and development, as well as seeking public comment prior to policy adoption. Vaya routinely involves clinical staff in reviewing and submitting public comment for CCPs.
9. Vaya shall:
    A. Cover all services in the North Carolina Medicaid State Plan except for services carved out of Medicaid Managed Care under N.C.G.S. § 108D-35; as specified in 42 CFR § 438.210; and as otherwise noted in the NCDHHS Contracts;
    B. Cover state-appropriated and block grant-funded non-Medicaid behavioral health, I/DD and TBI services subject to available resources, as determined by the Department;
    C. Use the NC definition of medical necessity, defined in 10A NCAC 25A.0201, in making coverage determinations;
    D. Consistent with 42 CFR § 438.210(a)(3)(ii), not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the member's diagnosis, type of illness or condition;
    E. Furnish covered benefits to Tailored Plan beneficiaries in an amount, duration, and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under NC Medicaid Direct per 42 CFR § 438.210(a)(2);
    F. Ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. 42 CFR § 438.210(a)(3)(i);
    G. Implement and adhere to all EPSDT policies and protocols for Medicaid members; and
    H. Ensure that our UM program aligns with the Department's requirements for Third Party (Subcontractor) Contractual Relationships, as set forth in the NCDHHS contracts.
    I. Specify what constitutes medically necessary covered services and administer the services in a manner that:
        i. Is no more restrictive than that used in the NC Medicaid Program, including quantitative and non-quantitative treatment limits (as indicated in North Carolina regulations, procedures, and administrative rules).
        ii. Takes into account and addresses the following:
            1. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability.

2. The ability for a member to achieve age-appropriate growth and development.
3. The ability for a member to attain, maintain, or regain functional capacity.

Section II: UM Program Responsibilities, Goals, and Strategic Components

1. The UM Program is responsible for accredited UM functions, including prospective, concurrent, and retrospective utilization review. Under the direction of Vaya's CMO, UM also provides clinical support to other Vaya departments and reviews service utilization and trend analyses to support organizational decision-making [UM 1(A) (1-2)].
2. As required by the NCDHHS Contracts, UM evaluates the medical necessity, appropriateness, and efficacy of requests for services against Coverage Criteria listed in Section I, above [UM 1(A)(5) [UM 2(A)(1)]. Decisions to deny (in whole or in part), reduce, terminate, or suspend a SAR based on medical necessity are made by appropriately licensed peer reviewers who meet the criteria outlined in this UM Policy.
3. **UM Goals**: Vaya's goals for its UM program include the following:
    A. Provide access to high quality, medically necessary healthcare services in the most appropriate setting.
    B. Ensure effective and efficient utilization of healthcare through appropriate allocation of resources and services.
    C. Document and evaluate patterns of resource utilization, including over- and under-utilization.
    D. Provide data and support to identify areas for improvement of clinical services, establish priorities, and support implementation of recognized best practices for optimal outcomes.
    E. Ensure medically necessary healthcare services are timely, coordinated, and effective.
    F. Ensure members with both psychiatric and medical illnesses receive appropriate treatment that integrates whole person concepts.
    G. Encourage the development and provision of high-quality, evidence-based, evidence-informed, or best practice services based on cultural humility, recovery, self-determination, and system of care principles and practices.
    H. Involve members and families to improve member satisfaction with services.
    I. Use data and quality improvement activities to improve service quality, efficiency, and member outcomes.
    J. Support the Department's five priority goals designed to advance our shared commitment to whole-person care and improve the health, safety and well-being of all North Carolinians, including advancing health equity and child and family wellbeing.
    K. Support the aims of the Department's Medicaid Managed Care Quality Strategy, including "Healthier People, Healthier Communities: Improve the health of North Carolinians through prevention, better treatment of chronic conditions and better behavioral health care, working collaboratively with community partners."
4. **Strategic Components**: Vaya's UM Program includes the following components to achieve the goals listed above [UM 1(A)(1)]:
    A. Use of standardized procedures to request, review, and approve authorizations for behavioral health, I/DD, physical health and certain medications that require prior authorization.
    B. Review of all documentation, records, and materials submitted by treating providers and consideration of clinical discussions with treating providers prior to making a making a coverage determination or a determination of medical necessity.
    C. Use of clinical criteria outlined in Section II, above, to evaluate medical necessity.

D. Monitoring use of CPGs and leveling tools by providers.
E. Ongoing use of clinical data to detect and manage over- and under-utilization and improve outcomes for high-risk, high-cost, and high-volume populations.
F. Ongoing collaboration with providers to ensure they meet contractual requirements and performance standards related to clinical outcomes that are set through value-based contracting.
G. Limitation of prior authorization requirements to services that are best managed through this type of oversight practice.
H. Implementation of processes for evaluation, approval, and revising the UM Program [UM 1(A)(5)(6))].

5. **Sites and Levels of Behavioral Healthcare**: Vaya offers 24/7 telephonic behavioral health triage through the Behavioral Health Crisis Line (1-800-849-6127) and in-person triage through Mobile Crisis Management services and comprehensive care centers. These centers also offer medication management and individual/group therapy. Vaya's network providers also deliver a comprehensive range of behavioral health care services including in-home services, residential care and inpatient psychiatric care. Vaya has developed a behavioral health network designed to meet the Department's adequacy and access requirements.
6. **Behavioral Health UM Program:** The scope of the behavioral health UM Program includes activities related to psychiatric and substance use inpatient, transitional, outpatient, and HCBS.
    A. Vaya's Behavioral Health UM Program collaborates with other programs to ensure effective care coordination, discharge planning, and case management to meet members' behavioral and physical healthcare needs; supports effective member education to promote measurable positive health outcomes; adopts an integrated medical management model based on the behavioral, physical, and social needs of members; and, in collaboration with Vaya's Care Management programs, facilitates the delivery of the most appropriate education, medically necessary care and services to eligible members in the most appropriate setting – **the right services, in the right amount, for the right duration, at the right time**.
    B. The Behavioral Health UM Program utilizes the Coverage Criteria, including the CPGs and Clinical Decision Support Tools listed in Section II of this Policy, above. These objective and evidence-based guidelines support clinical decision-making. When using clinical criteria to match level and intensity of care to a member's current condition, UM reviewers consider the severity of illness and co-morbidities, as well as episode-specific variables. Their goal is to view members' needs in a holistic manner to ensure they receive necessary support services within a safe environment optimal for their treatment and recovery.
7. **Committee Oversight for the UM Program [UM 1(A)(1)]**
    A. Quality Improvement Committee Charter: The CMO, the Assistant Vice President (AVP) of Clinical Solutions, the Pharmacy Director of North Carolina Medicaid Managed Care Program, and other medical and clinical leadership develop, review, and annually evaluate the UM Program, which is then presented to Vaya's Quality Improvement Committee (QIC) for approval. [UM1(A)(1)].
    B. The Clinical Advisory Committee Charter reports to Vaya's QIC. It is chaired by Vaya's CMO and includes licensed network providers and Consumer and Family Advisory Committee (CFAC) representatives. The purpose of the Clinical Advisory Committee is to:
        I. Provide advisory input to Vaya about Clinical Practice Guidelines (CPGs). CPGs are developed in consultation with and upon the recommendation of the Clinical Advisory Committee and are used by Vaya and its delegates in the authorization of services and by Vaya Network Providers in delivering services to enrollees.

II. Make recommendations regarding Evidence Based Practices (EBPs) or best practices that will be based on valid and reliable clinical evidence, consensus, or national practice standards established by professionals in the appropriate field or discipline.

C. The Network & Services Management Committee Charter (NSMC) monitors and manages budgets for service dollars and maintains responsibility for the oversight of Vaya benefit plans and provides ongoing analysis and evaluation to assure the coordination of funding and service delivery. NSMC is responsible for the monitoring and coordination of service funding and service delivery to ensure that needed services are delivered in an effective manner. NSMC strives to ensure alignment between the Network Access Plan and the Services Budget/ Clinical Plan. [UM 1(A)(3)]. This committee develops, disseminates, and provides education about in lieu of and alternative service definitions that align with organizational goals [UM 1(A)(1)(3)].

Section III: Oversight and Staffing

1. **Oversight**: Vaya's UM Program is directly overseen by the CMO, who is the designated senior clinical staff person for Vaya and oversees the medical and clinical aspects of all Vaya functions as outlined in Policy 2363 Senior Clinical Staff Responsibilities and Qualifications [UM 1(A)(2)]. The CMO and the Vice President (VP) of Clinical Strategies direct, support, and monitor utilization review activities. Vaya ensures that only appropriately licensed professionals supervise all medical necessity decisions.
2. The UM Program will have sufficient, qualified staff under the clinical supervision of the CMO.
3. UM Leadership includes the CMO, Deputy CMO, Vice President (VP) of Clinical Strategies, AVP of Clinical Solutions, I/DD and TBI Clinical Director of North Carolina Medicaid Managed Care Program and State-funded Services (I/DD Clinical Director), Behavioral Health UM Director, and the Physical Health UM Clinical Director. **These positions are available to UM Clinicians and other UM Staff on site or by phone for consultation and clinical support as needed**. Additionally, UM Clinicians and other licensed clinical staff are always available for consultation and support to Care Reviewers when they conduct pre-review screenings.
4. The AVP of Clinical Solutions, with support from the CMO, Deputy CMO, VP of Pharmacy Operations, and VP of Clinical Strategies, provides oversight of clinical decision-making and is actively involved in implementation, supervision, and evaluation of the Utilization Management Program Description [UM 1(A)(1)]. This occurs through regular meetings between the AVP of Clinical Solutions with UM leadership, UM clinical staff and peer reviewers, and the Pharmacy Director of North Carolina Medicaid Managed Care Program, as well as quarterly departmental meetings. This position oversees and/or delegates the presentation of reports concerning denial data and other relevant data points to the Quality Improvement Committee (QIC) and Regulatory Compliance & Quality Committee (RCQC) of the Vaya Health Board of Directors. They lead and direct the overall operation of Vaya's UM functions to ensure consistency of policies, procedures and workflows. They participate in and provide clinical input to the Network & Services Management Committee.
5. UM staff have specific job responsibilities, a scope of practice defined by their individual professional discipline(s) and assigned job description(s).
6. Only a doctoral-level psychologist or a physician may issue clinical denials [UM 4(A)(2)]. For services provided by a physician, and for physician-directed services (e.g., Inpatient Psychiatric Treatment Services, Acute Inpatient Care, etc.), only a physician may render a denial for medical necessity reasons. For services requested by a licensed or certified masters or doctoral degrees, non-physician provider, or by a provider that is not licensed or certified, a Licensed Psychologist or Licensed Physician may render a clinical denial.
7. **Accordingly, only the CMO, Deputy CMO, I/DD Clinical Director, Psychologist Peer Reviewer, and Physician Peer Reviewer are qualified to issue clinical denials:**

A. Chief Medical Officer: The CMO is a Board Certified, North Carolina licensed physician with extensive medical experience. As a psychiatrist, the CMO serves as the designated behavioral health practitioner in the implementation of the behavioral healthcare aspects of the UM program [UM 1(A)(3)(4)]. The CMO reports to Vaya's Area Director & Chief Executive Officer (CEO) and performs the following UM functions:
    I. Provides clinical oversight for implementation of this UM Program Description/ UM Program Policy.
    II. Supervises the Deputy CMO, VP of Pharmacy Operations, and VP of Quality Management.
    III. Provides clinical oversight and clinical supervision for the VP of Clinical Strategies, VP of Care Management, VP of Transition and Housing, VP of Member and Recipient Services, Quality Director of North Carolina Medicaid Managed Care, and other licensed clinical staff.
    IV. Provides clinical oversight, clinical supervision, consultation, and training for all UM staff.
    V. In collaboration with other clinical leaders, develops, approves and reviews annually all clinical decision tools used by UM staff.
B. Deputy Chief Medical Officer: The Deputy CMO oversees and is responsible for organizational clinical oversight including but not limited to the proper provision of covered services to members, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management. As a primary care/ family practice physician, this position is responsible for the Physical Health component of the Utilization Management program, and for supporting the CMO in ensuring the organization has an integrated approach to the physical and behavioral health of members, including those with I/DD and TBI needs. The Deputy CMO also provides Peer Clinical Reviews for the UM Program.
C. I/DD and TBI Clinical Director: The I/DD and TBI Clinical Director is a doctoral-level clinical psychologist qualified to perform clinical oversight for the services managed by the behavioral health UM team. The I/DD and TBI Clinical Director is responsible for the following functions:
    I. Oversees and is responsible for all I/DD and TBI clinical activities, including but not limited to the proper provision of covered Medicaid, State-funded, and Innovations and TBI waiver services to members, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management of I/DD and TBI benefits and integration of I/DD and TBI benefits with physical health and behavioral health benefits.
    II. Contributes to the development and implementation of UM policies and procedures.
    III. Provides clinical oversight for behavioral health UM staff.
    IV. Performs Peer Clinical Reviews.
    V. Supervises the Psychologist Peer Reviewers, the Innovations Access Coordinators, the Innovations Monitoring Specialists, and the UM Program Assistant.
    VI. Oversees any behavioral health, IDD, or TBI peer reviews performed by a delegated subcontractor.
    VII. In collaboration with other clinical leaders, develops, approves and reviews annually all clinical decision tools used by UM staff.
    VIII. Monitors UM performance indicators and implements necessary corrective measures.
D. Psychologist and Physician Peer Reviewers [UM 4(A)(2)2)]:
    I. Psychologist Peer Reviewer Qualifications: The Psychologist Peer Reviewer has a doctoral

degree in psychology from a regionally accredited educational institution, at least three years' experience in delivering psychological services and holds a current, unrestricted North Carolina license as a Health Services Provider Psychologist.

II. Physician Peer Reviewer Qualifications: The Physician Peer Reviewer holds an MD or DO from a regionally accredited educational institution and holds a current, unrestricted license.

III. Roles and Responsibilities: The Psychologist and Physician Peer Reviewers conduct clinical peer reviews of service authorization requests (SARs) that UM Clinicians are unable to approve for medical necessity reasons, and for which they are qualified to review. Additionally, the Psychologist and Physician Peer Reviewers conduct clinical reviews for first level appeals and participate in mediations and second-level appeals at the Office of Administrative Hearings (OAH) or the Division of Mental Health, Developmental Disabilities, and Substance Use Services (MHDDSUS).

8. **The following UM Clinicians are qualified to issue approvals but may not render clinical denial decisions:**

A. AVP of Clinical Solutions: The AVP of Clinical Solutions supervises the Behavioral Health UM Director, I/DD and TBI Clinical Director, and the Physical Health (PH) UM Clinical Director. The AVP of Clinical Solutions is a Registered Nurse (RN) and is responsible for the implementation, supervision, oversight and annual evaluation of the UM program, and updates the UM program, as necessary [UM 1(A)(1)]. This position ensures that UM responds to the needs of members by delivering and rendering sound clinical decisions and by ensuring compliance with applicable regulatory, accreditation and ethical standards. This position ensures the review, update and needed modifications of criteria used to make determinations occur as needed but no less than annually [UM 1(A)(3)].

B. Behavioral Health UM Director: The BH UM Director has a master's degree in a behavioral health discipline and holds a current unrestricted license in North Carolina in counseling, psychology, social work, nursing, or a related discipline. The BH UM Director:

I. Oversees and is responsible for all BH, TBI and IDD UM operational functions.

II. Contributes to the development and implementation of UM policies and procedures.

III. Provides day-to-day supervision and consultation and trains BH, TBI and I/DD UM staff.

IV. In collaboration with other clinical leaders, develops, approves and reviews annually all clinical decision tools used by UM staff.

V. Monitors for consistent application of UM criteria for each level and type of UM decision.

VI. Monitors documentation for adequacy.

VII. Monitors UM performance indicators and implements necessary corrective measures.

C. Physical Health UM Clinical Director: The PH UM Clinical Director holds a bachelor's degree, is licensed as a Registered Nurse in the state of North Carolina, has at least five years' experience providing direct patient care, and at least five years' experience in a management/leadership role. The PH UM Director:

I. Contributes to the development and implementation of UM policies and procedures.

II. Provides day-to-day supervision of the PH UM Registered Nurse Clinicians making non-behavioral health decisions.

III. Supervises, consults, and trains PH UM staff.

IV. Oversees PH peer reviews performed by a delegated subcontractor.

V. In collaboration with other clinical leaders, develops, approves and reviews annually all

clinical decision tools used by UM staff.

VI. Ensures the fidelity of PH UM clinical decision tools and accuracy of PH UM documentation.

VII. Monitors for consistent application of UM criteria for each level and type of UM decision.

VIII. Monitors documentation for adequacy.

IX. Monitors UM performance indicators and implements necessary corrective measures.

D. Behavioral Health UM Manager: The BH UM Manager has a bachelor's degree and meets NC standards as a Qualified Professional (QP) as defined in 10A NCAC 27G.0104. The Behavioral Health UM Manager provides day-to-day supervision of MHSU and IDD UM Clinicians and Care Reviewers. The Behavioral Health UM Manager:

I. Recruits, selects, and trains UM staff, and ensures that the team develops and follows departmental policies and procedures to ensure plan members can access appropriate, high-quality care.

II. Sets team direction, resolves problems, provides guidance to members of the team and communicates critical issues to the Behavioral Health UM Director.

III. Ensures the team meets established performance metrics and that Care Reviewers work within the appropriate scope of their position and do not engage in the evaluation or interpretation of clinical information.

IV. Oversees team reviews of plans of care and SARs.

V. Ensures that whole person care principles are incorporated into team procedures and training.

VI. Monitors for consistent application of UM criteria for each level and type of UM decision.

VII. Monitors documentation for adequacy.

VIII. Monitors UM performance indicators and implements necessary corrective measures.

E. UM Clinicians [UM 4(A)(2)]] (Behavioral Health and Non-Behavioral Health): UM Clinicians have a master's or doctoral degree in a behavioral health discipline from a regionally accredited educational institution, or a four-year bachelor's degree in Nursing (BSN), hold a current, unrestricted North Carolina license and have at least two years field experience as well as two years post degree experience providing services related to the services that they review. UM Clinicians:

I. Conduct initial clinical review of SARS.

II. May approve requests for admissions, procedures and services that meet clinical review criteria and may render "unable to process" and "administrative denial" decisions where insufficient information is provided to process the request.

III. Have access to consultation with an MD or DO, a licensed health professional in the same licensure category as the requesting provider, or with a health professional with the same clinical education as the requesting provider in clinical specialties where licensure is not issued.

IV. May engage in case discussions with any requesting provider, regardless of the provider's qualifications or credentials, to clarify authorization requests and to discuss concerns about cases. In doing so, UM clinicians shall never request a provider to withdraw a request or otherwise discourage the provider from proceeding with the request.

9. All UM clinicians are qualified by the CMO and the AVP of Clinical Solutions to render a clinical opinion about the medical condition, procedures, and treatment under review, but may not issue clinical denials. If a UM Clinician cannot approve an authorization request for medical necessity reasons, they must refer the request

to clinical peer reviewers for a medical necessity determination.

10. **The UM Department includes the following additional staff, who engage in UM activities for which no clinical judgment is required:**
    A. Care Reviewers: Care Reviewers are Qualified Professionals (QPs) as defined in 10A NCAC 27G.0104 for the disability group(s) for which they review care. Care Reviewers may not render clinical denial decisions; decisions to deny (in whole or in part), terminate, suspend, or reduce covered services are not based on initial screening. Care Reviewers:
        I. Screen SARs for completeness.
        II. Approve requests based on a review of checklist templates and refer valid requests that do not meet checklist requirements to UM Clinicians for review.
        III. Render "unable to process" decisions where insufficient information is provided to process the request.
        IV. May gather or prepare clinical information for staffing and consultation with UM Clinicians and then may enter UM Clinicians' decisions into the administrative health record (AHR) but do not evaluate or interpret clinical information.
    B. UM Program Assistants: UM program assistants perform a variety of support functions that facilitate efficient processing of SARs and other clinical processes, which include, but are not limited to:
        I. Data entry of SARs not submitted by providers electronically in Vaya's AHR.
        II. Supporting departmental meetings and cross-functional teams.
        III. Preparing files for clinical review.
    C. Innovations UM Monitoring Specialist: The UM Monitoring Specialist provides data monitoring and coordination support for the UM team with a primary focus on Innovations Waiver services. This occurs in three primary areas:
        I. Innovations claims monitoring through monthly data reports and analysis of Innovations members' budgets, authorizations, and claims to identify areas of over/under utilization. They review claims submitted by the provider to ensure that the individual is receiving services as outlined in the plan and/or to identify potential service deviations. Any potential service deviations identified via review of claims require follow-up/further research by the member's tailored care manager or care coordinator. The UM Monitoring Specialist coordinates documentation of identified concerns, care management or care coordination referral, and resolution.
        II. Resource Allocation administrative support.
        III. Annual Innovations Waiver allocation: Administrative support to the I/DD Clinical Director in the annual notification of Innovations Waiver slot allocations, beginning at the start of the Innovations waiver year.
    D. Consultants [UM 4(F)]: The Vaya Medical Team consists of licensed behavioral healthcare specialists with relevant training and credentials in all aspects of behavioral health and I/DD. This includes Adult Psychiatry, Child Psychiatry, Addiction Medicine, Psychopharmacology and Family Medicine. If Vaya subcontracts with external consultants to help make recommendations for medical necessity determinations, those consultants must meet the Peer Clinical Reviewer Standards listed immediately below. Vaya maintains a list of the specialties of all board-certified consultants with contact information for the external entity. The list is available to UM staff as a reference.
11. Peer Clinical Reviewer Standards [UM 4(A)(2)]. Physicians and psychologists who conduct peer clinical reviews are clinical peers who:

A. Hold an active, unrestricted license or certification to practice medicine or psychology in North Carolina.
B. Are residents in a state or territory of the United States when conducting a peer clinical review.
C. Are qualified, as determined by the CMO or the AVP of Clinical Solutions, to render a clinical opinion about the services under review.
D. Hold a current and valid license in the same licensure category as the ordering provider OR as a Doctor of Medicine or Doctor of Osteopathic Medicine.
E. Additionally, Peer Clinical Reviewers who conduct appeal considerations are clinical peers who:
    I. Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate.
    II. Are neither the individual who made the original non-certification, nor the subordinate of such an individual.
    III. Are board-certified (if applicable) by a specialty board approved by the *American Board of Medical Specialties* (Doctor of Medicine) OR the *Advisory Board of Osteopathic Specialists* from the major areas of clinical services (Doctor of Osteopathic Medicine).
F. Furthermore, for each appeal case that they accept, reviewers attest to:
    I. Having a scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review; and
    II. Current, relevant experience and/or knowledge to render a determination for the case under review.

12. A summary of which UM staff can perform specific UM activities is listed below in **Figure 1.1**.

Figure 1.1 UM Activities

Activity	Administrative Review	Clinical Review Issuing Clinical Approvals	Issuing Clinical Denials Clinical Appeal Review
Minimum licensure level required	UM Care Reviewers (Meet NC requirements for Qualified Professional)	UM Clinicians (Licensed Master's Level or RN)	• *Physicians, all types:* Medical, behavioral, pharmaceutical, chiropractic, vision • *Doctoral-level clinical psychologists:* Behavioral • *Pharmacists:* Pharmaceutical • *Chiropractors:* Chiropractic • *Physical therapists:* Physical therapy • *Doctoral-level board-certified behavioral analysts:* Applied behavioral analysis
Job Titles That Can Perform the Activity	• UM Care Reviewers • UM Clinicians • BH UM Manager • BH UM Director • I/DD Clinical Director • PH UM Clinical Director • AVP of Clinical	• UM Clinicians • BH UM Manager • BH UM Director • I/DD Clinical Director • PH UM Clinical Director • AVP of Clinical Solutions • Psychologist Peer	• I/DD Clinical Director • Psychologist Peer Reviewer • Deputy CMO • CMO • Physician Peer Reviewer (delegated contractors)

Activity	Administrative Review	Clinical Review Issuing Clinical Approvals	Issuing Clinical Denials Clinical Appeal Review
	Solutions • Psychologist Peer Reviewer • Deputy CMO • CMO	Reviewer • Deputy CMO • CMO	

13. Availability of UM Program Staff: Vaya provides access to its medical and behavioral health UM review staff by a toll- free telephone line from 8:30 a.m. to 5:00 p.m. each business day, and its pharmacy UM staff Monday through Saturday 7:00a.m. to 6:00 p.m. in each time zone where Vaya conducts at least two percent of its review activities. For Vaya, most review activities are conducted within the U.S. Eastern Standard Time Zone. We maintain processes to:
    A. Receive communications from providers and members during the business day and after business hours.
    B. Respond to communications within one business day; and
    C. Conduct outgoing UM communications during providers' reasonable and normal business hours, unless otherwise mutually agreed.
14. Complaint Monitoring: The Human Resources (HR) Department notifies the appropriate supervisor of all complaints against UM staff. When any complaint is made against a UM staff member, the individual's supervisor for gathers all available information from the complainant, the clinician, and any other relevant sources and assists the Grievance Resolution and Incidents Team (GRIT) in responding to and resolving the complaint to the greatest extent possible. The respective supervisor follows up directly with the UM staff to provide support, education, and training if needed.

Section IV: UM Staff Training

1. The CMO and the VP of Clinical Strategies establish initial and ongoing training protocols for UM staff. UM staff participate in regular clinical supervision, training, and ongoing consultation.
2. Vaya ensures that UM Clinicians are trained in, and knowledgeable about, applicable laws, rules, and regulations, the Coverage Criteria listed in Section II of this Policy, Clinical Decision Support Tools, EPSDT, and other guidelines or policies that describe the requirements for the Medicaid and State-funded Services managed by Vaya.
3. Training topics include new procedures and protocols and a review of medical necessity criteria for a particular service:
    A. New Hire Training (NHT) in accordance with the specific UM Training Matrix that applies to the respective job description: NHT extends for approximately four weeks from the date the new employee completes new employee orientation (NEO).
    B. Ongoing training [UM 2(C)(2)]: UM staff participate in ongoing training and consultation no less than annually to ensure consistency in application of UM criteria and to maintain professional competency. UM leadership includes training topics in staff meetings and clinical case staffings. With input from the CMO, UM leadership schedules topic specific training(s) for the UM quarterly meeting. In addition, periodic, focused training sessions are scheduled to address the application of specific UM guidelines as needed.
    C. Clinical decision-making tools: This training occurs as a component of the NHT. Additionally, the

proper use of these tools is reviewed in multiple settings including the following: regular staff meetings, individual and group supervision, and ongoing clinical consultation. Training involves education and review of skills needed to ensure the consistent application of these tools.

D. UM policies and procedures: This training occurs as necessary to provide in-depth training on new policies, amended policies, and annually reviewed policies to ensure their consistent application. All staff are required to read all current, revised and amended policies through the policy management platform and compliance is monitored via this platform.

E. No less than annually, Vaya's General Counsel and Chief Compliance Officer or designee conducts training on due process and EPSDT as required by Vaya's contract with NC Medicaid. All new staff are required to review the approved Due Process/ EPSDT training slides within two weeks of hire.

4. Vaya may use pre- and post-testing to ensure that staff have adequate understanding of training topics. UM Clinicians and Care Reviewers are expected to score above 90% individually and above 80% as a team on the post-test.
    A. If individual UM Clinicians and Care Reviewers score below 90%, this indicates the need for further topic review, training, and retesting on the topic.
    B. If the team scores below 80%, this indicates that further review and retesting on the topic is needed for the entire team.
5. Continuing Education Training Opportunities – UM staff have opportunities to attend continuing education training relevant to specific treatment populations, best practice interventions, general clinical skill building, and other topics to enhance UM skills. Staff who attend external training are expected to provide information and training to their respective teams.

Section V: Service Authorization

This section describes Vaya's processes for prior and concurrent authorization of services, including the process used to authorize services, and criteria used to support authorization of services.

1. Medical and Behavioral Health UM: UM review determines the medical necessity of requested healthcare services (for Tailored Plan Medicaid members only), medical, behavioral, I/DD and TBI services. The UM process provides clear and timely responses to members' and providers' requests for service authorization [UM 1(A)(1)].
2. All services reimbursed by Vaya must be medically necessary. Vaya adheres to the definition of Medically Necessary Treatment Services or Supplies found in the DHB Contract: "According to N.C.G.S. § 58-3-200, medically necessary services and supplies are those covered services or supplies that are: (1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under N.C.G.S. § 58-3-255, not for experimental, investigational, or cosmetic purposes; (2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms; (3) Within generally accepted standards of medical care in the community; and (4) Not solely for the convenience of the insured, the insured's family, or the provider.")]
3. All services reimbursed by Vaya must be:
    A. Furnished by or under the supervision of a practitioner licensed (as relevant) under NC state law in the specialty for which they are providing service and in accordance with federal and state laws, rules, and regulations, the Coverage Criteria listed in Section II of this Policy, and other applicable federal and state directives.
    B. Individualized, specific, and consistent with symptoms or confirmed diagnosis of the condition under treatment, and not in excess of the member's needs.

C. Able to be safely furnished, with no equally effective and more conservative/less costly treatment available.
D. Sufficient in amount, duration, and scope to reasonably achieve their purpose.

4. UM adheres to the following utilization management guidelines when conducting Expedited, Routine, Prospective or Retrospective Reviews [UM 1(A)(1)]:
   A. Accepts information from any reasonably reliable source that assists in the certification process;
   B. Considers individual needs such as age, comorbidities, complications, progress of treatment, psychological situation, and home environment (when applicable) in applying criteria [UM 2(A)(2)];
   C. Considers available services in the local delivery system and their ability to meet the member's specific health care needs in applying criteria [UM 2(A)(3)];
   D. Collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services using standardized SAR templates and supporting documentation (e.g., service plan and assessment information);
   E. Does not routinely require hospitals, physicians, or other providers to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available;
   F. Does not routinely request copies of all medical records for members reviewed;
   G. Requires only the portion(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency, or duration of service; and
   H. Makes all clinical and demographic information about individual members maintained in electronic or paper format available to all Vaya departments requiring such information to avoid duplicate requests for such information from providers.
5. To effectively manage the care of health plan members, Vaya establishes and maintains a referral and prior authorization process that is centered on the member's primary care provider (PCP).
6. Vaya conducts prior authorization reviews using current clinical documentation and considers the comprehensive range of the member's physical health, pharmacy, behavioral health, I/DD, TBI, and LTSS needs, noting that alternative treatments or supports may be appropriate considering the individual's complete clinical and other support needs.
7. Vaya may require a referral for any medical services not provided by the PCP except where specifically prohibited in the NCDHHS Contracts and in federal and state laws, rules, and regulations.
8. Vaya may require a referral for any behavioral health or I/DD services except where specifically prohibited in the NCDHHS Contracts and in federal or state laws, rules, or regulations.
9. Vaya does not require the submission of an Individualized Education Program (IEP) plan as a condition of receiving a prior authorization nor shall evidence of an IEP be grounds for a prior authorization request denial for services that are not required to be provided by the Local Education Agency (LEA).
10. Vaya does not retract a service authorization after the services, supplies, or other items have been provided, except as provided in N.C.G.S. § 58-3-200(c) or for emergency services after the services have been provided, except as provided in N.C.G.S. § 58-3-190(c).
11. As more fully described in Policy 3059 PHP Transition of Care, Vaya will honor prior authorization approvals from the member's prior plan for members transitioning between North Carolina Medicaid Direct, Standard Plans, Tailored Plans, or the Eastern Band of Cherokee Indians (EBCI) Tribal Option until the approval expiration date.
12. Any decision to deny a SAR or to authorize a service in an amount, duration, or scope that is less than requested must be made by an individual who has appropriate expertise in addressing the member's

medical, behavioral health, I/DD, TBI, or LTSS needs. 42 CFR § 438.210(b)(3).

13. Consistent with 42 CFR § 438.206, Vaya does not require referral or prior authorization on any of the following Medicaid services, and includes information on services that do not require a referral or prior authorization in its Member Handbook:
    A. Emergency services
        I. In accordance with 42 CFR § 438.114, Vaya does not require members to obtain a referral or prior authorization before receiving emergency services.
        II. Vaya does not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms.
        III. Vaya does not refuse to cover emergency services, including ambulance services, based on the provider of such services, the hospital, or the fiscal agent notifying Vaya or the member's PCP of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.
        IV. Vaya covers and pays for emergency services regardless of whether the provider that furnishes the services is in the Vaya Network.
        V. Vaya does not hold a member with an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
        VI. Vaya does not deny payment for treatment obtained due to an emergency medical condition or because of the member having been instructed by a representative of Vaya to seek emergency services.
    B. Family planning services
        I. Vaya does not require members to obtain a referral or prior authorization for family planning services and supplies and reproductive health services and supplies. 42 CFR § 438.206(b)(3).
        II. Vaya does not restrict the member's free choice of family planning services and supplies providers. 42 CFR § 431.51(b)(2).
        III. Vaya does not hold members liable for payment for family planning services or supplies that are not in the Vaya network.
        IV. Vaya does not require members to obtain referrals for services provided by women's health specialists in accordance with 42 CFR § 438.206(b)(2) and N.C.G.S. § 58-51-38.
        V. Vaya does not require female members to obtain a referral or prior authorization to women's health specialists within the network for covered care necessary to provide women's routine and preventive health care services.
        VI. Vaya does not require providers to obtain prior approval for any obstetrical ultrasound.
        VII. Women's routine and preventive health care services may include but are not limited to initial and follow-up visits for services unique to women such as mammograms, pap smears, prenatal and maternity care, and for services to treat genitourinary conditions such as vaginal and urinary tract infections and sexually transmitted infections.
    C. Medications included in the Physician Administered Drug Program Drug (PADP) Catalogue when being used within the PADP guidelines
    D. Vaya does not require members to obtain a referral or prior authorization for children's screening services.
    E. Vaya does not require members to obtain a referral or prior authorization for Local Health

Department (LHD) services.

F. Vaya does not require members to obtain a referral or prior authorization for primary care services or for services rendered at school-based clinics.

14. Service Authorization Request Criteria
    A. Services requiring authorization as set forth in the applicable benefit plan(s) must be authorized prior to the provision of services. Vaya does not require prior authorization of emergency services or other specific services listed as “no authorization required” in the applicable Vaya benefit plan.
    B. Providers are required to notify Vaya of physical health acute inpatient admissions within 48 hours of admission.
    C. When an authorization is required, the provider must complete and electronically submit a SAR along with other required documentation to establish the need for medical necessity and/or to satisfy service authorization criteria. In documented instances where electronic transmittal is not possible, Vaya may accept transmittal via facsimile, U.S. mail or hand delivery. It is the responsibility of the provider to maintain documentation verifying the date the request was submitted.
    D. A SAR must be submitted for each service requiring authorization.
    E. For non-Innovations Waiver services, each service provider must submit a separate SAR. Behavioral Health Home providers generate and submit the care plan for all services for a given member but may request authorization only for those services they provide.
    F. SARs for Innovations Waiver services must be submitted by the assigned Care Manager or Complex Care Coordinator following development of the Care Plan.
    G. The SAR must be complete and include all information necessary to certify medical necessity. A complete request contains the minimum requirements specified in the applicable clinical decision tools and NC Medicaid CCPs including any specifically required documentation or clinical information, such as a Person-Centered Plan. It is the responsibility of the requesting provider to document medical necessity.
    H. UM may offer technical assistance and flexible authorization procedures, possibly including retrospective authorization review, for providers that are new to the network and to address unanticipated software malfunctions that may prevent entry of a request. UM staff provide education on instances in which retrospective review is permitted. UM documents any technical assistance offered in the AHR.
15. Administrative Review Process
    A. UM Clinicians or Care Reviewers complete administrative review of the SAR and any associated documents to determine if the request is valid and complete. Licensed UM Clinicians are always available to non-licensed UM staff while completing this review to provide guidance and to address any questions raised in the administrative review process [UM 1(A)(1)].
    B. Unable to Process Determinations: SARs that lack information necessary for Vaya to identify and process the request are returned to the provider as Unable to Process. An Unable to Process determination is not an Adverse Decision. Circumstances that prevent processing of SARs may include but are not limited to any of the following:
        I. Missing or incorrect member name, address, date of birth, identification number.
        II. Missing or incorrect identification of provider who is to perform the service.
        III. Missing or incorrect identification of service or procedure code requested.
        IV. Missing or incorrectly requested service effective dates.
        V. Duplicate request (from the same or a different provider).

VI. Member not enrolled or registered.
VII. Diagnosis or service not covered by applicable benefit plan.
VIII. Funding is not available for a non-Medicaid service.
IX. Requests for services that require a comprehensive clinical assessment (CCA) submitted more than 30 days prior to the requested service start date.
X. Requests for NC Innovations Waiver services submitted more than 45 days prior to the requested service start date.
XI. Provider certifies in request that service is not medically necessary.
XII. Service does not require prior authorization.

C. Administrative Denial: SARs that can be processed but lack required signatures or clinical information required by the NC State Plan for Medical Assistance, the 1115 Waiver, applicable CCP, or DMHDDSUS Service Definition to render a medical necessity decision will be denied administratively.
    I. Missing behavioral health information that may result in an administrative denial includes but is not limited to the following (as applicable):
        a. ASAM or CANS score.
        b. NC-SNAP or SIS® assessment.
        c. Care Plan signatures, certifications, or attestations.
        d. Attestation for child and family team involvement in the Care Plan.
    II. Missing physical health information that may result in an administrative denial includes but is not limited to the following (as applicable):
        a. Provider is neither in Vaya's network nor approved by Vaya as an out-of-network provider for the services requested.
        b. Provider is excluded from a federal or NC public health program or otherwise listed on an exclusion list.
        c. Vaya requested that the provider submit more information to approve the SAR, but the provider failed to submit the information.
        d. NC Medicaid does not cover the requested service in the State Medicaid Plan.
        e. Records submitted unequivocally do not meet the specific prior authorization/ eligibility criteria set forth in Sections 3 through 5 of the applicable CCP.
D. UM works with providers, Tailored Care Managers, and Complex Care Coordinators ("requestors") to correct administrative deficiencies within the timeframe available and to render a determination according to the level of urgency (routine or expedited) of the SAR. If time is available before a decision must be rendered, UM staff may telephonically or electronically request missing information necessary for UM to conduct a medical necessity review. In such cases, the requestor will be allowed up to three business days from the date of the notification to submit the requested information:
    I. UM staff document all communication with requestors about missing information.
    II. When leaving a message for a requestor regarding missing information, UM staff must provide the deadline by which the information must be received and document this date and time.
    III. If the requestor does not submit the missing information within the specified time frame, the UM Clinician issues an administrative denial of the SAR.

Section VI: Consistency and Monitoring

This section describes Vaya's mechanisms to ensure consistent application of review criteria, inter-rater reliability, and when appropriate, consultation with the requesting provider; evaluation of the consistency with which UM criteria are applied to SARs; and monitoring procedures

1. **Peer Review Concordance** is a measure of the level of agreement between recommendations made by UM Clinicians and decisions rendered by Peer Clinical Reviewers. Overall peer review concordance for initial decisions must be 80% or above. Because new information is received and reviewed for most appeals, the first and second reviewers evaluate different information and concordance for appeal reviews is not routinely assessed.
    A. Peer review concordance is measured monthly and quarterly by the AVP of Clinical Solutions and reported to the QIC. If the minimum 80% concordance rate is not achieved for the quarter, the global rate is broken into smaller increments (e.g., service, UM Clinician, peer reviewer) to determine where lower agreement has occurred and to identify the need for corrective actions.
    B. Corrective actions to improve concordance may include individual consultation with specific peer clinical reviewers or clinicians who need additional training on medical necessity criteria or additional training for groups of clinicians and/or peer reviewers on targeted topics.
2. **Inter-Rater Reliability (IRR) [UM 2(C)].:** On an annual basis, UM team leadership will create at least 3 or more hypothetical UM test cases per UM team to reflect the service authorization requests that both physician and non-physician staff frequently review. For each hypothetical UM test case, the VP of Clinical Strategies will select an internal peer reviewer to make the decision, and that peer reviewer's decision will serve as the result against which the other UM staff members' responses are evaluated. Each UM staff member (e.g., clinicians, nurses, care reviewers, managers) will be assigned the appropriate hypothetical test cases to complete. Each Peer Reviewer must also complete these hypothetical test cases based on their specialty to ensure consistency in applying UM criteria between physicians and psychologists.
    A. Each UM Clinician, Care Reviewer, and Nurse must achieve an average rating of 85% or higher.
    B. Reviewers that do not receive an average of 85% will be required to attend training on services and UM processes. This may include increased supervision from their direct supervisor. They will be retested within 3 months of the completed training.
    C. If each UM team (Behavioral Health and Physical Health) as whole does not average at least 85% or greater, UM leadership will conduct further trainings with all staff and increase the frequency of IRR assessments to Quarterly.
3. **Supervision and Plans of Correction/ Improvement:** Vaya UM leadership, in consultation with the CMO, conduct ongoing, regular supervision of their respective UM Clinicians as described below.
    A. Group Supervision at least monthly during UM Team Meetings - Group discussions and training during team meetings provide opportunities for routine group supervision, as well as for identifying the need for individual supervision.
    B. Individual Supervision – Vaya UM leadership utilize information from IRR reviews for regular staff supervision. The monitoring process allows the respective supervisors the opportunity to give individualized, direct feedback and training to UM staff and to further tailor individualized supervision as needed.
    C. Daily/As Needed – Vaya UM leadership can provide immediate supervision of their respective staff daily. Individual, specialized supervision may result when any performance indicator standard is not met, or as the result of substantiated complaints against individual UM staff.
4. **UM Team Satisfaction Survey Process:** No less than annually, the Performance Reporting Team shall collect

information on provider satisfaction with UM processes and staff and communicate such information to the CMO. The information from this survey may be utilized to improve or amend departmental processes, to reinforce accomplishments, and may result in modifications to UM monitoring and supervision processes.

5. **Inter-Departmental Coordination:** The UM team interfaces with other Vaya Departments in a manner that promotes best practices, improves member safety and quality of care, and complies with Vaya's standards for excellent customer service.
    A. Care Management department: UM staff have access to review Care Management documentation in the member's AHR during any review of a member's clinical needs. UM staff can contact CM leadership or individual Care Managers to ask any specific questions about a member's clinical needs to support authorization decisions.
    B. Quality Department: The UM team regularly participates in meetings of the Quality Improvement Committee (QIC), which are chaired by the CMO [UM 1(A)(1)]. The UM team, in collaboration with Vaya's Appeals team, tracks and trends denials, reconsiderations and appeals and reports findings quarterly to the QIC [UM 1(A)(1)]. QIC reports are presented to Vaya's Executive Leadership Team (ELT) and the Regulatory Compliance & Quality Committee of the Board of Directors. The UM team improves member experience and outcomes through review and consideration of member and practitioner experience data with support of the Performance Reporting Team for collection and analyzing data and reporting to the QIC.
    C. Member and Recipient Services (MRS) Department: UM staff are available during regular business hours to assist MRS in answering questions received via the Member and Recipient Services Line or the Behavioral Health Crisis Line, including but not limited to help with triage and referral questions. MRS also manages the waitlist for 1915(c) Innovations Waiver services for individuals with IDD, also known as the Innovations Waiver Waitlist and coordinates with UM for Innovations Waiver Waitlist eligibility reviews.
    D. Provider Network Operations (PNO) department: If a medically necessary service is not available for a particular Medicaid enrollee within the Vaya Provider Network, Vaya's policy is to enter an Out-of-Network (OON) Agreement. In such cases, UM will authorize services to OON providers when the requested service is covered by the Vaya benefit plan and is medically necessary, but not available or accessible from a Vaya Network Provider. UM staff who identify potential gaps in services or need for additional network providers complete the PN Service GAP Referral Form and send to provider.info@vayahealth.com within three (3) business days of such identification. UM staff participate in the annual Network Adequacy and Accessibility Analysis performed by the PNO department in accordance with NCDHHS requirements, which informs Vaya's Network Access Plan, identifies service gaps, and identifies potential need for additional providers.
    E. Compliance Department: In accordance with the annual Compliance Work Plan, the Regulatory Compliance Team (RCT) may audit designated UM functions or documentation. The RCT will report any findings to the CMO, Chief Operating Officer, and UM leadership, and any non-compliance findings must be addressed in a written plan of correction. The UM team conducts ongoing self-evaluations related to decision turnaround time, educational notices, calls and clinical consultations, medical necessity, and peer review referrals, and reports these self-evaluation results to the Regulatory Compliance Committee [UM 5(C)]
6. **Specialty Needs Staffing:** When a member presents with complex or specialty needs, the UM team participates in a cross-functional, interdisciplinary discussion and collaboration to ensure appropriate services are being provided in the least restrictive environment.

7. **Peer-to-Peer Discussion After Decision is Rendered:** It is preferable for the clinical peer reviewer to have a Peer-to-Peer Discussion with the requesting provider prior to rendering an Adverse Decision based on lack of medical necessity. However, the clinical peer reviewer who conducted the review (or another equivalently qualified clinical peer reviewer if the first peer reviewer is unavailable) shall be available for a Peer-to-Peer Discussion with the attending physician or requesting provider within three (3) business days after rendering the Adverse Decision [UM 7(A)(D)(G)]. A Peer-to-Peer Discussion that occurs after a decision is rendered is not an appeal. If a Peer-to-Peer Discussion is requested after the decision is rendered, the following shall apply:
    A. Within one (1) business day of a request by the attending physician or requesting provider, an opportunity is made available for a Peer-to-Peer Discussion with the peer reviewer.
    B. The Peer-to-Peer Discussion may be face-to-face, by telephonic or electronic means.
    C. If the clinical peer reviewer who rendered the initial decision is unavailable, a clinical peer reviewer with equivalent qualifications shall be made available to discuss the decision within one (1) business day. The goal of the Peer-to-Peer Discussion is to allow the treating provider and the clinical peer reviewer a chance to discuss the clinical determination before initiation of the reconsideration/appeal process.

Section VII: Ensuring Appropriate Levels of Care

This section describes Vaya's mechanisms to assess whether members are receiving the appropriate level of care corresponding to their clinical information.

1. As part of its standard UM responsibilities, Vaya assesses whether members are receiving the appropriate level of care corresponding to their clinical information.
2. Innovations Claims Monitoring: The I/DD Utilization Monitoring Specialist is responsible for the monthly data reports and analysis of Innovations members' budgets, authorizations, and claims to identify areas of over/under utilization. This employee will review claims submitted by the provider to ensure that the individual is receiving services as outlined in the plan and/or to identify potential service deviations. Any potential service deviations identified via review of claims require follow-up/further research by the member's Care Manager to identify if a service deviation occurred and, if so, the reason for the deviation. This employee will coordinate documentation of identified concerns, Care Management referral, and resolution.
3. Initial Clinical Review: If the SAR includes sufficient information to render a decision based on medical necessity, appropriately qualified UM staff conduct an Initial Clinical Review [UM 1(A)(1)]:
    A. UM Clinicians make decisions based on the individual representations of each request, consistency with the care plan, and the publicly available Coverage Criteria, CPGs, and Clinical Decision Support Tools listed in Section II of this Policy, above, which allow case-by-case exceptions to service limitations in specific individualized circumstances with respect to non-Medicaid services.
    B. UM non-licensed staff may also obtain structured clinical data using review tools/criteria developed from CPGs. These review tools do not require evaluation or interpretation of clinical information.
    C. UM Clinicians consider all relevant information that is submitted in addition to the information that is provided on required forms, regardless of whether the additional information is included on a particular form.
    D. For Prospective Reviews, UM Clinicians base review determinations solely on the medical/psychological information presented to Vaya at the time of the review determination.
    E. For Retrospective Reviews, UM Clinicians base review determinations solely on the

medical/psychological information available to the attending physician or ordering provider at the time the care/treatment was provided.

F. UM staff conducting Initial Clinical Review have access to consultations with the following:
    I. CMO, who is a licensed psychiatrist;
    II. Deputy CMO;
    III. Pharmacist;
    IV. Licensed health professionals in the same licensure category as the ordering provider;
    V. Health professionals with the same clinical education as the ordering provider in clinical specialties where licensure is not issued.
G. UM Clinicians authorize outpatient services for the anticipated length of the service and may be reviewed for a requested extension of the service [UM 1(A)(5)].
H. All requests for services for a Medicaid beneficiary under age 21 must be evaluated against EPSDT criteria. All EPSDT criteria must be met to authorize a request under EPSDT.
I. If an educational discussion with the requestor results in a different understanding of the member's needs and/or submission of a modified service request, and if the UM Clinician determines that the service request can be approved, the UM Clinician approves the SAR.
J. Documentation of review must include references to each source of data used to make the decision (PCP, assessment, type of clinical decision support information, etc.) for both approval and denial of services.
K. Vaya does not issue non-certifications based on Initial Clinical Review. Clinical Peer Reviews are conducted for all cases where a certification or full approval is not issued through initial clinical review or initial screening. Adverse Decisions based on the absence of medical necessity are only made by an appropriate clinical peer reviewer.

4. Requests Above the Policy Limit are generally reviewed as follows:
    A. A Care Reviewer first confirms the requestor submitted all required documentation and information.
    B. The Care Reviewer refers the request to a UM Clinician to review for medical necessity and clinical appropriateness.
    C. UM Clinicians can approve services up to their maximum policy limits and issue an administrative denial for services requested above the maximum policy limits (unless EPSDT applies). If the UM Clinician does not approve the services up the maximum policy limits, they refer the SAR for Clinical Peer Review.
    D. If the request is for a Medicaid beneficiary under age 21, it must be evaluated against EPSDT criteria. If UM determines that the request does not meet EPSDT criteria, UM issues an Adverse Decision Notice that includes appeal rights.
    E. If the request is for an adult Medicaid beneficiary aged 21 or older and UM determines the policy maximum is medically necessary, Vaya authorizes the maximum amount. There are no appeal rights in this case, but UM sends an educational notice to the provider reminding them about the policy limit. If a Clinical Peer Review determines the policy maximum exceeds the amount found to be medically necessary, UM issues an Adverse Decision Notice that includes appeal rights.
    F. UM reviews Requests Above the Policy limit for Innovations Waiver services as follows:
        I. If the request is to exceed the Waiver Appendix B $184,000 annual budget/ cost limit, (other than for members qualifying for Supported Living Level 3), it may not be approved. Vaya will authorize up to the annual budget limit and issue an Adverse Notice Decision that includes

appeal rights.

II. If the request is to exceed the Waiver Appendix C/CCP 8-P Attachment D Limits on Sets of Services and UM determines that services are medically necessary up to these limits, UM authorizes up to these limits and issues an Adverse Decision Notice that includes appeal rights. If UM makes a clinical determination that the request is not medically necessary up to these limits, Vaya issues an Adverse Decision Notice that includes appeal rights.

III. If the request is to exceed the individual service limit-dollar amount (e.g., $50,000 limit on ATES and home modifications) and UM determines the policy maximum is medically necessary, UM will authorize the maximum amount. There are no appeal rights in this case, but UM sends an educational notice to the provider reminding them about the policy limit and the member's grievance rights. If a Clinical Peer Review determines the policy maximum exceeds the medically necessary amount, UM issues an Adverse Decision Notice that includes appeal rights.

5. Subsequent Prospective Authorization Reviews ("continued stay"): UM staff conduct continued stay reviews prior to re-authorizing a service the member is currently authorized to receive:
    A. Vaya adheres to Coverage Criteria to determine length of authorization. If UM determines that lengthening a Medicaid authorization period for a specific service best serves a member's needs, it may extend the authorization period beyond the limits in the applicable CCP. Vaya has the authority to both lengthen and shorten authorization timeframes for non-Medicaid services based on population needs and to have adequate time to review member response to the service, progress made, and the necessity of continuation of the service.
    B. Vaya does not require prior authorization for the first seven (7) days of psychiatric inpatient care for Medicaid benefit plan members. For State Benefit Plan members, Vaya does not require prior authorization for the first three (3) days of inpatient psychiatric care. Timeframes for subsequent prospective reviews are based on the member's clinical needs. UM staff document the rationale for the next review date in each continued stay review.
6. Medical and behavioral health requests: Vaya does not issue non-certifications (referred to as Adverse Benefit Determinations (ABD) in Medicaid managed care regulations) based on initial clinical review. Vaya conducts Clinical Peer Reviews for all cases where a certification is not issued through initial clinical review or initial screening.
    A. Appropriately licensed peer reviewers who meet criteria outlined in NCDHHS contracts make decisions to deny (in whole or in part), reduce, terminate, or suspend a SAR based on inadequate documentation evidencing medical necessity. [UM 4(B)(C)), UM 1(A)(1)].
    B. If the UM Clinician is unable to approve a SAR, in whole or in part, the UM Clinician refers the request for Clinical Peer Review.
    C. The clinical peer reviewer has access to and reviews all relevant information Vaya has received regarding the SAR.
    D. The clinical peer reviewer may attempt to contact the requesting provider to conduct a Peer-to-Peer Discussion of the case before rendering a determination.
        I. If the Peer-to-Peer Discussion occurs before the decision is rendered, the clinical peer reviewer shall not engage in discouragement of any kind, including a request to withdraw or modify a SAR.
        II. During or after the Peer-to-Peer Discussion, the clinical peer reviewer shall render a determination to authorize, deny, partially approve, reduce, or terminate the requested

service.

III. If the clinical peer reviewer renders a decision during the Peer-to-Peer Discussion, they inform the requesting provider of the decision and discuss it with the provider during the Peer-to-Peer Discussion.

E. The clinical peer reviewer makes an authorization determination based on the review of all available relevant information regarding the SAR.
   I. If the clinical peer reviewer determines that the requested service is medically necessary, they document the determination and authorize the request.
   II. If the clinical peer reviewer determines that the requested service is not medically necessary, or that only a portion of the requested service is medically necessary, they document the decision and Vaya sends an Adverse Decision Notice to the member.

F. The clinical peer reviewer documents the principal reasons and the clinical rationale for any medical necessity decision.
   I. The principal reason(s) for the action explains in simple language, understood by an average layperson, why the requested service is not necessary [UM 7(B)(1)].
   II. The full clinical rationale provides additional explanation of the action that references medical necessity criteria and clinical basis for the decision that may not be understood by an average layperson [UM 7(B)].

G. Vaya does not reduce, terminate, or suspend an authorization decision unless one of the following applies:
   I. Vaya receives new, relevant information that was not available at the time of the original authorization; or
   II. Vaya becomes aware that the original authorization was based on false or misleading information; or
   III. Vaya becomes aware that other first or third-party coverage for the authorized service or an equivalent service that is primary to Medicaid or Non-Medicaid coverage was in effect at the time of authorization or came into effect during the authorization period; or
   IV. Vaya becomes aware that the member terminated services with the provider to whom authorization of the service was made; or
   V. New information indicates that the member's condition has changed, and UM determines that the service type, duration, amount, or intensity previously authorized is no longer appropriate or medically necessary for the member; or
   VI. There is a change in the availability of funding for non-Medicaid services (e.g., funding is withdrawn, reduced or exhausted) and Vaya can no longer fund the service; or
   VII. Vaya determines that continued provision of services is inconsistent with federal and state laws, rules, and regulations applicable to the delivery of publicly funded healthcare services and/or the Coverage Criteria listed in Section II of this Policy, above (e.g., member/ LRP refusal to comply with Innovations Waiver requirements); or
   VIII. Vaya determines that continued provision of services may seriously compromise the health, safety or welfare of the member receiving such services.

H. Vaya avoids changing existing authorizations whenever possible to minimize disruption of services. If it is necessary to make a change to suspend, reduce or terminate an existing authorization, Vaya gives at least a ten (10) day notice in writing to the member and provider to allow for planning.

I. Notification of suspension, reduction, or termination of services is not required with ten (10) days

notice in the following circumstances:

I. The agency has factual information confirming the death of a member.
II. The agency receives a clear written statement signed by the member that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.
III. The member has been admitted to an institution where he/she is ineligible under the plan for further services.
IV. The member's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address.
V. The agency establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
VI. A change in the level of medical care is prescribed by the member's physician.
VII. The notice is regarding an adverse determination that involves preadmission screening requirements.

J. If probable member fraud has been verified, Vaya gives notice five (5) calendar days before the date of action.
K. Vaya does not reverse a certification determination unless it receives new information that is relevant to the certification that was not available at the time of the original certification. Vaya maintains a formal process to consider appeals of non-certifications that includes:
    I. The availability of standard appeal for non-urgent cases and expedited appeal for cases involving urgent care; and
    II. Written appeal policies and procedures that:
        a. Clearly describe the appeal process, including the right to appeal of the member, provider, or facility rendering service.
        b. Include instructions for issuing notices of Adverse Benefit Determinations (NABDs) as required by NCDHHS Contracts and accrediting organizations;
        c. Provide explicit time frames for each stage of the appeal resolution process; and
        d. Are available, upon request, to any member or provider, including facilities.
    II. Vaya delegates first-level appeals for the pharmacy benefit to Vaya's PBM. For these, physicians with clinical expertise in treating the member's condition or disease who were not involved in making the initial denial perform the review. These physicians are employees of a subcontractor to Vaya's PBM.
    III. Vaya provides the opportunity for a Peer-to-Peer discussion for a limited time after we issue a denial. This discussion occurs between the provider and the reviewer who issued the denial decision or an equally qualified reviewer. Following the Peer-to-Peer discussion, Vaya may change the denial decision if the provider offers clinical information that demonstrates the service is medically necessary. This is not considered an appeal. [UM 1(A)(1)]

Section VII: Authorization of State Plan LTSS

This section describes Vaya's process for authorizing State Plan LTSS based on a member's current needs assessment and consistent with the person-centered service plan.

1. UM reviews all Care Plans submitted in conjunction with a SAR.
2. Care Plan Development and Submission:

A. Providers, Care Managers, and Complex Care Coordinators develop and submit Care Plans.
B. Service provider(s) must collaborate to develop the Care Plan.
C. Care Plans must include all services, paid and unpaid (including natural supports).
D. All Person-Centered Plans must meet the requirements of the Division of MHDDSUS Person-Centered Planning Instruction Manual and the RMDM, APSM 45-2, and must be submitted to Vaya at the following times:
    I. Upon development of the initial plan following the initial assessment.
    II. Annually.
    III. Upon significant changes in the member's situation and/or plan of care, including all changes to recommended services for the member; and
    IV. When required by applicable Coverage Criteria, an updated Person-Centered Plan must be included when submitting a SAR.
E. The Care Plan for Innovations participants includes all elements of the ISP and must be submitted to Vaya at the following times:
    I. Initial care plans must be developed at the time an individual is admitted to the Innovations Waiver, and services must be implemented within 45 days of care plan approval.
    II. Annual care plans, to be implemented on the first day of the month following the member's birth month, are developed on an annual basis, and submitted by the first day of the individual's birth month.
    III. Care Plan revisions or updates, to be implemented on the effective date identified in the update, are developed on an as needed basis whenever the member's life circumstances change, the cost of a service changes, or if the member's provider changes or needs change and requires services to be added, increased, decreased, or terminated.
F. For LTSS services that require review of a Care Plan for the approval of services, the reviewing clinician ensures the following:
    V. The Care Plan is present and has the required signatures.
    VI. The Care Plan reflects the needs of the member as indicated within the applicable assessments.
    VII. The Care Plan includes all the requested units of services and types of services requested.
    VIII. The Care Plan is individualized and was developed in conjunction with the provider and the member.

Section VIII: Timeframes for SAR Decision Making

1. UM staff review and render decisions for SARs according to the timeframes and requirements set forth in applicable laws, rules, regulations, and accreditation, including time frames specified in 42 C.F.R. § 438.210(d) and as outlined in the NCDHHS Contracts. Types of reviews include:
    A. Initial Prospective Review: Providers (or assigned Tailored Care Managers or Complex Care Coordinators for Innovations services only) must submit SARs at least 14 days prior to the requested start date of service, except for inpatient, facility-based crisis, or other expedited requests.
    B. Subsequent Prospective Review: Provider must submit SARs for routine services at least 14 days prior to the end of the previous authorization to avoid a gap in authorization, except for inpatient, facility-based crisis, or other expedited requests.
    C. Expedited Review: In cases in which a provider indicates, or Vaya determines, that the 14-day standard timeframe could seriously jeopardize the member's life or health or ability to attain,

maintain, or regain maximum function, Vaya reviews the request and makes an expedited authorization decision within 72 hours after receipt of the request, unless the member requests an extension or Vaya justifies (to DHB upon request) a need for additional information and how the extension in the member's best interest. A provider indicates a request for expedited review by attesting that the criteria for expedited review are met and by clearly indicating that the request is for an expedited, not routine, review. An incomplete or invalid expedited request by a provider or member will not be accepted as an expedited review, will be treated as a routine request, and will be reviewed as a routine initial or subsequent prospective review.

D. Retrospective Review: Providers may submit a SAR after a service is delivered in cases of retroactive Medicaid eligibility. In this circumstance, the provider must submit the SAR and all associated documentation no later than 90 days from the date the provider knew, or should have known, of such eligibility determination. Any authorization information from a different vendor or health plan that may have been applicable during the period of services to be reviewed should be included with the request. If Medicaid eligibility is approved after the service was provided, authorization should not exceed six (6) months prior to the date of eligibility determination.
E. Provider Transfer Review: Under exceptional circumstances, such as those associated with immediate health and safety concerns, UM may complete concurrent authorization of services to transfer a member to a different service provider without individual review of member information. Following this initial transfer, standard review procedures apply.
F. Out-of-Network (OON) Review: UM reviews requests for prior authorization of non-emergency services to be delivered by OON providers. Vaya does not require prior authorization for emergency services delivered by OON providers.
G. EPSDT Review: UM reviews request for Medicaid beneficiaries under the age of 21 when the request exceeds limitations or exclusions as delineated in the applicable Coverage Criteria, including but not limited to unit or age restrictions, or when the requested service is not in the applicable Medicaid benefit plan.
H. Criterion 5 Reviews: If the criteria for continued acute stay in an inpatient psychiatric facility as specified in 10A NCAC 25C. 0302 are not met for a Medicaid beneficiary through the age of 17, Vaya may authorize continued stay in an inpatient psychiatric facility at a post-acute level of care to be paid at an established residential rate if the facility and program services are appropriate for the member's treatment needs and if all of the Criterion 5 conditions are met. Vaya approves Criterion 5 when the member has a history of sudden de-compensation or measurable regression, and experiences weakness in their environmental support system that is likely to trigger a de-compensation or regression.
I. Psychiatric Treatment on a Medical Floor Review: UM reviews requests for psychiatric treatment provided on a medical floor against the criteria found in NC Medicaid Clinical Coverage Policy 8-B and may be approve these requests under the following circumstances:
    I. Inpatient psychiatric treatment is medically necessary and no inpatient psychiatric bed (at the same facility or in a facility that can be reasonably accessed) is available.
    II. Inpatient psychiatric treatment is medically necessary, but the member is too medically compromised to be safely treated on a psychiatric unit or
    III. The member is admitted to a medical bed and then determined to have a psychiatric disorder as the principal diagnosis [UM 1(A)(3)].

2. Review and notification timeframes begin at the time Vaya receives the SAR and end when Vaya sends

decision notification to the requesting provider. Vaya notifies members and providers of all decisions within the decision review timeframes.

A. Routine Prospective and Retrospective Service Reviews: UM must issue a decision and provide notice to approve or deny non-urgent SARs within 14 calendar days of receipt of the request for services [UM 5(A)(5)(6), UM 5(B)(5)(6)].
B. Expedited Inpatient Hospitalization Reviews: UM must make an authorization decision and provide notice no more than 72 hours following receipt of the request [UM 5(A)(3), UM 5(B)(3)].
C. Expedited Service Reviews: UM issues a decision to approve or deny a service within 72 hours after it accepts an expedited request for services. For requests to extend a current course of treatment that involves urgent (e.g., inpatient, facility-based crisis) care, UM issues a decision within 24 hours of receipt of the request provided the request was received at least 24 hours before the expiration of the current authorization. UM issues a decision within 72 hours of the request if the request was received less than 24 hours before the expiration of the current authorization [UM 5(A)(2), UM 5(B)(2)].
D. For Reductions or Terminations as defined herein, the determination must be issued early enough to allow the member/ LRP to request a review and receive a decision before the reduction or termination occurs.
E. Deadlines may be extended up to 14 additional calendar days if the member/LRP requests an extension, the provider requests an extension, or UM justifies (to NCDHHS upon request) the need for additional information and how the extension is in the member's interest.
F. In such cases, Vaya must send a written notice to the member/ LRP and provider, prior to the expiration of the initial review timeframe, explaining the circumstances requiring the extension and the date when Vaya expects to decide and informing the member/LRP of the right to file a grievance if they disagree with that decision.
G. If the member/LRP or provider fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information and the member/LRP must be given at least 45 calendar days from receipt of the notice to respond to the request for more information.

3. The UM team interfaces with the Member and Recipient Appeals Team in the Legal department to produce reports, track Clinical Peer Reviews, and coordinate denial notifications.

Section IX: Non-Discouragement Protection

This section describes how Vaya protects members from discouragement, coercion, or misinformation about the amounts of services that they may request in their plans of care or their right to Appeal the denial or reduction or termination of a service.

1. Prior to issuing a decision, contacts with the requestor are limited to those needed to obtain more information about the service request, to provide education about services or to conduct a Peer-to-Peer Discussion. Vaya staff never engage in discouragement, coercion, or misinformation about the amounts of services and are trained annually on due process, EPSDT and non-discouragement principles.
2. Providers, Care Managers, and members/ LRPs are never asked to withdraw or modify the request for prior approval of services to accept a lesser number of hours, or less intensive type of service, or to modify a SNAP (Supports Needs Assessment Profile) or SIS® score or other clinical assessment discussions.
3. Material misinformation to or intimidation of providers or members that has the foreseeable effect of significantly discouraging request for covered services, continuation of covered services, or the filing or prosecution of OAH Appeals is prohibited. The care management process is not to be used to improperly

influence, change, or prevent a request for prior approval.

4. Vaya provides Members and Recipients with the opportunity to appeal any Adverse Decision issued by Vaya, including but not limited to a decision to deny (in whole or in part), reduce, terminate or suspend a Medicaid-covered service, in accordance with 42 CFR Part 438, Subpart F and N.C.G.S. Chapter 108D, or a decision based on medical necessity to deny (in whole or in part), reduce or terminate a State-funded service, in accordance with 10A NCAC 27G .7004 and Policy 2384 Member and Recipient Appeals of Adverse Decisions. Vaya does not retaliate against any member, LRP or Personal Representative (including a provider) who files an appeal, or against any provider who requests an expedited resolution or supports a member's appeal of an Adverse Benefit Determination. Vaya will handle and resolve all appeals in a manner that allows members to freely exercise their appeal rights and does not discourage Members or Recipients from exercising their right to appeal Adverse Decisions. [UM 1(A)(1)]
5. Notifications: All Notices referenced in this Section IX must meet health literacy requirements and utilize Department-issued templates. Notices include the basis for decisions rendered.
    A. Educational Notice: UM staff may issue an Educational Notice if a SAR cannot be processed, notification of prior approval when request exceeds policy maximum, and notice asking for additional information. Types of Educational Notices include:
        I. Unable to Process Notice: This notice is electronically transmitted or sent in writing to the provider when a SAR is received that lacks required information necessary for Vaya to recognize and process it as a valid request.
        II. Notice of Prior Approval when Request Exceeds Policy Maximum: This notice is electronically transmitted to the provider for those specific requests described in Section VI, C., 5. or when a request that exceeds policy limits has been received for a non-Medicaid member of any age and approved at the policy limit based on medical necessity. The notice educates the provider about the policy limit, reminds the provider that all requests must be submitted in accordance with policy requirements, and includes a member's grievance rights.
        III. Notice Asking for Additional Information: This notice is electronically transmitted to the provider requesting new or additional information because, even though the request included all required elements, at the discretion of Vaya, the UM staff needs more information to decide on the request. If the provider fails to respond, a decision will be made based on the information available.
    B. Notice of Approval of Service Request: This notice is electronically uploaded to the provider when Vaya has approved a covered service for a member.
        I. Service authorization notifications must be sent via secure electronic notification to contracted providers that have requested such notification upon approval and upon the request of the member/ LRP, attending physician or other ordering provider or facility rendering the service.
        II. Service authorization notifications must contain provider and member identification, tracking numbers for reference (authorization #), and the name and total number of units of the service authorized.
        III. Notification of authorization for continued services must include the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved in the current episode of care, and the date of admission or onset of services.

IV. Notification regarding the next anticipated review point for periodic services – if continued authorization is requested, the request and supporting documentation must be submitted to Vaya 14 calendar days prior to the lapse of the current authorization;
V. Notification regarding the next anticipated review point for Inpatient and Facility Based Crisis authorizations – if continued authorization is requested, the request and supporting documentation must be submitted to Vaya 24 hours prior to the lapse of the current authorization, unless the renewal date falls on a weekend or holiday when the request may be submitted the next business day for retrospective review.
VI. UM notifies the members/LRPs of approval(s)/ certification decision(s) upon request.

C. Benefit Exhaustion [QI 3(E)]: When a member's benefits for services are exhausted, Vaya notifies the member/ LRP in writing of the benefit limit and exhaustion and how to obtain alternative services. The Benefit Exhaustion Notice encourages members to seek alternative services as needed and encourages them to discuss their service needs and available alternative services with their service provider. The Notice also offers help from Vaya's Member and Recipient Services Department to members in identifying alternative services and providers.
   I. Vaya identifies services for which a defined limit of the number of sessions or monetary amount is allowed for a period of time. Such benefit limits may be based on a rolling 12-month period, an individual member's plan year, the life of a waiver, or other time period.
   II. A claims-based Benefit Exhaustion Report identifies members who have or who are about to reach such benefit limits.
   III. UM staff run the Benefit Exhaustion Report monthly to identify members who have reached or who are about to reach their benefit limits.
   IV. UM Team staff then mail Benefit Exhaustion Notices to members informing them of the benefit limit and their exhaustion or near exhaustion of that benefit for the specified time.
D. If any Notice is returned as undeliverable for any reason, the Appeals Coordinator or designee researches and verifies the address and mails a new notice with a new date if the delivery failure was the result of an error or omission by Vaya staff. If the address used in the original notice of adverse benefit determination was correct, the Appeals Coordinator notifies the applicable county Department of Social Services (for Medicaid members) or provider (for non-Medicaid services) that the mail was returned.
E. Annual Review of Notices: No less than annually, the UM Director or designee reviews, trends, and analyzes the reasons listed in Administrative Denials and Unable to Process notices. As applicable, these results are used to make improvements in the authorization processes. Interventions may include:
   I. Education of Vaya UM staff reviewing authorization requests;
   II. Education of providers regarding authorization requirements and procedures;
   III. Changes in the Vaya authorization procedures; or
   IV. Corrective Action Plans required of providers that demonstrate continued failure to follow Vaya authorization procedures and requirements, including repeated failure to develop and submit appropriate Person-Centered Plans or other service plans.

Section X: Mechanisms for Detecting and Addressing Over-, Under, and Misutilization

1. On a monthly basis, an internal Vaya workgroup consisting of UM, Finance, PNO and ISD staff compare claims paid against budgeted service groups, and compare authorizations made with projected utilization

rates against budgeted service groups. These utilization measures inform interventions related to potential over- and under- utilization of services. Authorization rates provide a projection of future service utilization and expenditure, while claims paid provide a measurement of past service utilization. [UM 1(A)(3)].

2. If data analyses identify any patterns that suggest question provider billing or utilization practices, UM may submit a referral to the Investigation Oversight Committee. Although questionable billing or utilization patterns could be a function of the provider's case mix severity, it could also indicate potential billing problems, fraud, waste or abuse, or other issues that need to be resolved through a post-payment review or other investigation.
3. Pharmacy claims adjudication technology and consistent standards allow enhanced monitoring of over- and under-utilization, in addition to monitoring for other fraud/waste/abuse or clinical medication-related problems.
4. Drug Utilization Review (DUR) edits deployed at the point of dispensing provide a prospective review of medication therapy at the time a new prescription is filled (prospective DUR). This involves comprehensive screening of the prescription for issues including but not limited to:
    A. Overutilization, such as therapeutic duplication and refill-too-soon screening.
    B. Underutilization, such as refill compliance (adherence) screening.
    C. Other issues such as drug-drug interactions, drug-age precautions, drug-gender precautions, drug-pregnancy precautions, drug-disease contraindication, inappropriate dose, or duration of therapy.
    D. Possible abuse or misuse of medications.
5. Vaya's PBM ensures that licensed pharmacists at network pharmacies counsel patients as appropriate in response to prospective DUR alerts by requiring entry of Professional Service or Result of Service codes before a claim with a DUR alert will adjudicate as covered.
6. DUR is also performed on a retrospective basis by Vaya, Vaya's PBM, and NCDHHS. Over- and under-utilization are detected through member-specific medication claim analysis that use medication-specific query logic that identifies member utilization over or under thresholds for appropriate use. Pharmacists are expected to respond to interventions triggered by these reviews. Vaya, through its PBM, also conducts retrospective DUR analyses that address issues similar to those addressed by prospective DUR as well as various measures of therapeutic appropriateness, inappropriate use of antipsychotics and psychotropic polypharmacy in children in youth and children, and appropriate use of generics. These retrospective DUR analyses include an educational component such as reports of patient- or medication-specific utilization accompanied by recommendations for improving prescribing or dispensing practices.
7. Members experiencing polypharmacy and/or low adherence may be referred to Care Management if not already engaged.
8. On at least a quarterly basis, Vaya evaluates medication utilization trends in the context of medical services. In addition to highlighting trends, this information is used to help detect fraud, waste/unnecessary or overuse or abuse of medications on the part of prescribers, pharmacists, and members. Data are examined to identify outlying prescribers and pharmacies, who are then targeted for face-to-face discussions about the areas of concern along with focused monitoring in the upcoming months.
9. Areas given particular attention by Vaya in prospective and retrospective DUR include misuse of opioids and off-label/inappropriate use of antipsychotic medications.
10. DUR related to opioid use is consistent with goals and activities expressed in Vaya's Opioid Misuse Prevention and Treatment Program, as well as other clinical best practices.
11. Vaya ensures adherence to the NC Medicaid CCP Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 and NC Medicaid CCP Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and

Older as follows:

A. For all members, the pharmacy claims adjudication system is configured to identify all prescriptions for an antipsychotic. In addition, the system detects whether the new prescription results in concomitant use of more than one antipsychotic medication for more than 60 days (polypharmacy).
    I. For Beneficiaries Through Age 17, the claim will reject and require safety monitoring documentation per NCDHHS Policy.
    II. Prescriptions for certain antipsychotic medications are exempt from this process if prescribed for a member who is at least 18 years old and does not result in antipsychotic polypharmacy.
B. If safety documentation is required:
    I. The prescriber is responsible for documenting safety monitoring through Vaya's PBM's UM process.
    II. For members at least 18 years of age, the dispensing pharmacist can override the prior authorization edit if the prescriber writes, in their own handwriting, "Meets PA criteria" on the prescription or includes that language in the comment block on an e-prescription.
C. The edits and process for administering the Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 are consistent with requirements of the A+KIDS program.

12. On an annual basis, and at any time at the request of NCDHHS, Vaya provides to NCDHHS a detailed description of its DUR activities over the past year. In addition, Vaya provides DUR data to NCDHHS on an annual basis, 90 days prior to the CMS submission date. This data is provided in a format consistent with the required NCDHHS reporting format.

Section XI: UM Functions Delegated to Other Entities, including Accountability and Reporting

1. Vaya delegates certain UM functions for specific medical service lines. UM delegates must execute contracts with Vaya that require them to adhere to all applicable NCDHHS Contracts requirements and to submit monthly reporting to Vaya.
2. Vaya has a standing Delegation Oversight Committee, as well as vendor-specific governance committees, and conducts oversight meetings with delegates no less than quarterly.
3. Delegated services lines include the following:
    A. First and second level clinical review and first level appeals for the following service categories: Durable Medical Equipment, Specialized Outpatient Therapy, Cardiology, and Imaging.
    B. First and second level clinical review for EPSDT, physical health acute inpatient concurrent review, Home Health Services and CAR-T Cell Therapy.
    C. Second level clinical review for medical services not included in A and B above.
    D. Second level clinical review and first level appeals review for behavioral health services when volume exceeds internal review capacity.
    E. Pharmacy.
4. In accordance with Section 1903(i) of the Social Security Act, Vaya adheres to standards for organ transplants that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to members.
    A. Vaya does not require prior authorization for organ transplant services.
    B. Vaya subcontracts with a delegated vendor for a network of providers that deliver transplant services; however, members are not required to use these facilities or providers.

Section XII: Pharmacy

1. Initial pharmacy reviews and first level appeals are delegated to Vaya's PBM, Navitus Health Solutions, LLC. Vaya, in conjunction with its PBM, also administers the following CCPs and programs as required by NCDHHS:
    A. Outpatient Pharmacy.
    B. Over-the-counter products.
    C. Off-label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17.
    D. Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older.
    E. Opioid Misuse Prevention and Treatment Program.
    F. Physician Administered Drug Program.
2. Pharmacy UM – General
    A. PBM physicians with clinical expertise in treating the member's condition or disease perform medication-related appeals.
    B. Pharmacy UM staff review and render decisions for pharmacy requests according to the timeframes and requirements set forth in applicable regulatory, statutory, and accreditation laws and standards. NC Medicaid CCPs are the only criteria used in the pharmacy UM process.
    C. Specially trained, licensed clinical pharmacists make denial decisions for pharmacy requests.
    D. NCDHHS designates medications that require prior authorization as well as the criteria used to review pharmacy requests. Lists of these medications and review criteria are available on Vaya's website and websites maintained by NCDHHS.
    E. Providers submit pharmacy requests through Vaya's electronic portal and review system and may also submit these via phone (1-800-540-6083), fax (TBD), or USPS. Vaya deems a request to have been received once the request has reached any Vaya or PBM department, or the mail room if delivered by the postal service.
    F. For requests submitted electronically, the system automatically assesses historical pharmacy claims data and member diagnoses to establish a determination. If the system is not able to render a determination, Vaya handles the request using the process described below.
    G. If a pharmacy enters a prescription claim that does not have an existing authorization or enough information in the member's medical or pharmacy claims history to support approval, the network pharmacy will notify the provider that prior authorization is required.
    H. The PBM's prior authorization system contains all relevant information used in making the determination.
    I. Vaya will consider pharmacy requests from prescribers or long-term care pharmacists for retroactive prior authorization when the date of services is less than or equal to one (1) year prior.
    J. In addition, although Pharmacy UM determinations are generally based solely on criteria published by NCDHHS, Vaya considers medical necessity in EPSDT reviews.
    K. Vaya, through its PBM subcontractor, identifies and notifies members and prescribers affected by a class II recall or voluntary drug withdrawals from the market for safety reasons within thirty calendar days of the FDA notification. The PBM notifies members and prescribing providers of class I recalls within ten (10) business days [UM 11(C)(1-2)].
3. Vaya's PBM processes pharmacy requests as follows:
    A. Except for requests reviewed under EPSDT program, determinations for pharmacy requests are based strictly on criteria generated and maintained by NCDHHS. For cases falling under the EPSDT program, medical necessity is also a consideration.

B. If the prescriber certifies that a member has tried a prerequisite medication or that a prerequisite medication is inappropriate, the PBM does not require proof or evidence. The PBM cannot void contracts or refuse contract renewal when this occurs.
C. Licensed pharmacy technicians, who are authorized to approve requests if criteria are met, perform Initial clinical review. If a request cannot be approved after this review, the licensed pharmacy technician refers the request to a licensed clinical pharmacist, who may approve or deny the request. Vaya approves pharmacy requests when published NCDHHS criteria are met.
D. The PBM compensates all utilization and peer review staff through salaries or hourly wages; no incentives are provided for denying coverage.
E. The PBM processes pharmacy requests and notifies prescribers and members of the determinations, within 24 hours after receipt of the urgent concurrent and urgent/nonurgent preservice request; except for requests for which the review cannot be completed due to insufficient information [UM 5(C)(2)(4)(7)]. In these cases:
    I. The PBM pends the request and requests the needed information within 24 hours of receipt of the request.
    II. The PBM completes its review within 24 hours after receiving additional information.
F. **The PBM processes post-service requests and notifies members and practitioners of decisions within 30 calendars days of the request [UM 5(C)(8)].**
G. The PBM sends decisions notifications to the prescriber via fax and to the member via USPS within 24 hours after receiving all information needed to review the request. The PBM uses an NCDHHS-designed and maintained template for notification. When the PBM denies coverage of the requested medication in its entirety or approves an amount or duration less than requested, notification includes:
    I. An indication of which coverage criteria for the medication were and were not met.
    II. The member's right to request and receive, free of charge, access to and/or copies of all information and documentation used in making the coverage determination.
    III. The member's rights to, and process for, filing an appeal or grievance. This includes the member's right for continuation of coverage while an appeal is being resolved, information about requesting an expedited appeal, and a copy of the Appeal Request form.
H. Vaya and its delegated PBM comply with all requirements to inform members of the amount and type of services available to them and do nothing to discourage them from availing themselves of these services.
I. Vaya allows coverage for a 72-hour supply of medication in emergency situations where the medication could not otherwise be dispensed due to a prior authorization requirement. Vaya does not require a pharmacy to dispense this 72-hour supply if the dispensing pharmacist believes that the prescription presents a risk to the member, and if the pharmacist has made good faith efforts to contact the prescriber about it. Vaya covers consecutive 72-hour supplies if the pharmacist has not been able to contact the prescriber to complete the requested review.

Section XIII: Dissemination of Guidelines to Providers, Members and Potential Members;

1. Providers receive accurate and timely information about UM requirements through the Vaya Provider Advisory Council (PAC), Vaya website and the Vaya Provider Operations Manual. Providers are notified of updates and changes to these requirements in periodic provider meetings and through Vaya Provider Communication Bulletins. UM Clinicians, Compliance Department, and Quality Department staff employ

these requirements in reviewing providers' services.

2. Providers are educated about medications requiring prior authorization and their criteria for coverage through Vaya's Provider Operations Manual and through Vaya's website. The website is accessible to both members and providers and has up-to-date listings of both the prior authorization medication list and the coverage criteria. The Vaya website also provides access to standardized prior authorization request forms developed from NCDHHS templates. A hard copy of the list of medications and criteria are available upon request by prescribers, members, or potential members.
3. Vaya shall provide training and education to providers, including prescribers, on changes to the UM Program prior to the effective date of the change as part of the Provider Training Plan.
4. UM authorization criteria/guidelines for each benefit plan and disability type and the application of these guidelines are routinely reviewed (no less than annually) and updated and are available to providers upon request and posted on the Vaya website. Information on how to obtain authorization guidelines is included in the Provider Manual. Providers are notified that the guidelines are available on the website at least annually through the provider communication bulletin. Providers may request the guidelines by contacting Vaya (phone or email) and Vaya will mail them if providers do not have email or internet access. The guidelines outline the services available to members in each benefit plan and requirements for any prior and continued authorization [UM 2(A)(5)] [UM 2(B) (1-2)].
5. Vaya updates our list of approved CPGs, EBPs and best practices as necessary or at least annually and makes the list available on the Vaya website. Vaya disseminates these materials to providers and, upon request, to enrollees [UM 2(B) (1-2)].

Section XIV: IMD and DSOHF Services

1. Under North Carolina's 1115 waiver authority, Vaya shall provide coverage for SUD services for members aged twenty-one (21) through sixty-four (64) in an Institute for Mental Disease (IMD), as well as any other State Plan services for which they may be eligible during their stay in the IMD.
2. Vaya complies with the authorization and admission requirements for state psychiatric hospitals, Alcohol and Drug Abuse Treatment Centers (ADATCs) and developmental centers in accordance with N.C. Gen. Stat. § 122C-261(f)(4).
3. Vaya authorizes benefits provided by DSOH facilities in accordance with the relevant Coverage Criteria listed in Section II of this Policy, above.
4. Psychiatric Hospitals and ADATCs:
    A. Vaya and/or its designated community providers (behavioral health community provider or hospital/emergency department) complete and submit a Regional Referral Form (RARF) or initiates referral using the North Carolina Behavioral Health Crisis Referral System (BH-CRSys) to the DSOHF facility.
    B. Vaya reviews the admission based on review of the information provided in the RARF and BH-CRSYs.
    C. When a member presents directly to a psychiatric hospital or ADATC for admission, Vaya complies with applicable provisions of the Emergency Medical Treatment & Labor Act (EMTALA) and Section 1867(a) of the Social Security Act related to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care provided to an individual who is determined to be stable by a medical screening examination.
    D. Vaya ensures that a Vaya staff member is available twenty-four (24) hours a day, three hundred sixty-five (365) days a year for discussions with the DSOHF facility's staff regarding admissions, prior to the issuance of the referral and throughout the admission.

E. For members subject to involuntary commitment proceedings, Vaya provides information or a representative who can assist the district court in determining if the member requires continued services. If Vaya elects to send a representative to appear in court, the representative may be a community provider or other designated provider.
F. Prior to authorizing or making a referral for the admission to a state psychiatric hospital, Vaya makes every effort to identify an appropriate alternative treatment location, including referral to community inpatient psychiatric units or other locations providing the necessary level of care. This effort may also include specialized or wraparound services for special populations such as individuals with I/DD, TBI or dementia.
G. Prior to referral or authorization of any member known or reasonably believed to have an intellectual disability for admission to a state psychiatric hospital, Vaya verifies that the referral is in accordance with the requirements of N.C. Gen. Stat. § 122C-261 and any other applicable North Carolina law governing the admission of members with intellectual disabilities to a state psychiatric hospital.
H. For members who have multiple disorders and medical fragility or have multiple disorders and deafness, Vaya serves as the Department's designee to determine whether members have a high level of disability such that alternative care is inappropriate, consistent with N.C. Gen. Stat. § 122C-261(e)(4).
I. In determining whether members are eligible for referral and/or authorization for admission to a state psychiatric hospital, Vaya utilizes and completes the I/DD diversion process and tools established and approved by the Department for this purpose to determine that any less restrictive and less costly options in the community have been exhausted.
J. Authorization of Emergency Services:
    I. Vaya covers emergency medical services provided by the DSOHF facility without regard to prior authorization. Vaya does not refuse to cover emergency services based upon the DSOHF facility failing to notify the member's primary care provider (PCP) or failing to notify Vaya of the individual's screening and treatment following presentation for emergency services.
    II. For members who present directly to the psychiatric hospital or ADATC as an emergency commitment or as a self-referral, the DSOHF facility submits a completed SAR the next business day following the admission to request admission authorization.
    III. Upon receipt of the SAR, Vaya authorizes ongoing emergency medical services in accordance with applicable clinical coverage policies and consistent with the prudent layperson standard, as defined in EMTALA (Section 1867(a) of the Social Security Act).
K. Authorization of Inpatient Services:
    I. Vaya issues a decision to approve or deny the inpatient service within seventy-two (72) hours after it receives the SAR, provided that the deadline may be extended for one additional business day if the individual or DSOHF facility requests the extension and Vaya justifies to the DSOHF facility a need for additional information and how the extension is in the member's interest.
    II. Vaya authorizes an admission authorization for a minimum of seven (7) days for inpatient psychiatric services and ADATC services.
    III. Following initial admission authorization, Vaya reviews and evaluates for possible re-authorization at an interval of every fifteen (15) days for inpatient psychiatric and every

seven (7) days for ADATC services.

IV. To request re-authorization, the psychiatric hospital or ADATC must submit a SAR for continued stay request to Vaya no later than the last covered day of the existing authorization, or the previous business day if the last covered day occurs on a weekend or holiday.

V. Vaya issues an authorization decision and notifies the psychiatric hospital or ADATC within seventy-two (72) hours after receipt of the SAR for continued stay.

L. Assessment and Stabilization:

I. Vaya is responsible for payment to the psychiatric hospital or ADATC for assessment and stabilization of members who are admitted and treated pursuant to the involuntary commitment statutes in Chapter 122C of the North Carolina General Statutes, or who present at the facility directly for emergency medical services and are admitted for stabilization subject to requirements of EMTALA (Section 1867(a) of the Social Security Act).

II. Vaya identifies an appropriate discharge plan for all such members beginning at admission.

5. State Developmental Centers (SDCs): Vaya exhausts all options for community care and supports before it refers a member or recipient to a State Developmental Center. On the rare occasion that Vaya refers a member to an SDC, Vaya will:
    a. Submit an application packet, inclusive of a letter of endorsement, to the SDC Admission/Discharge Coordinator
    b. Comply with all DSOHF admission criteria and protocols.
    B. Ensure timely execution of a Memorandum of Agreement (MOA) with the member's LRP regarding the member's discharge plan.
    C. Complete the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) level of care determination form prior to admission and obtain the required physician signature before sending a copy to the facility's reimbursement office to complete the authorization to bill Medicaid. If the facility does not receive this form by the time of admission, Vaya will provide retrospective authorization after the facility sends a SAR to Vaya's UM Team along with the completed level of care determination form.
6. Re-Authorization to State Developmental Centers: To reauthorize services in a State Developmental Center, the facility must send a completed level of care determination form, Person Centered Plan (if it has been updated since the previous authorization), and psychological evaluation to Vaya prior to the expiration of the initial authorization. Upon receipt of the request and the required documentation, Vaya makes a decision within the standard timeframes for prior authorization requests. Authorization shall be for at least 180 days from the date of the physician signature on the level of care determination form.
7. Vaya issues prior authorization for Respite - Facility Based services provided at a State Developmental Center for Innovations waiver participants prior to the member's admission.

Section XV: UM Policy for 1915(i) Services

1. Vaya shall use a Department-designated tool to conduct the independent evaluation to determine eligibility for 1915(i) services in alignment with requirements at 42 CFR § 441.715(d). Vaya complies with any additional guidance released by the Department on the process for conducting the independent evaluation.
2. Vaya utilizes an NC Medicaid-approved template to notify members of the results of any new independent assessments for 1915(i) services and to inform members in writing of the opportunity and process for filing a grievance regarding independent assessment evaluations and results.

3. The failure to request a grievance shall not waive the member's ability to argue that the results of the independent assessment for 1915(i) services are incorrect in requesting of services, or during reconsideration review or the State Fair Hearing.
4. Vaya ensures that the independent assessment is used to guide the development of the Care Plan/ISP, and that the results of the independent assessment are not the sole basis for limiting the services requested or approved. Vaya may use the independent assessment in conjunction with other information to reduce or deny requested services.
5. Vaya ensures that any request for authorization of 1915(i) services is consistent with and incorporates the desires of the member and that such desires are reflected in the member's Care Plan as required by 42 CFR § 441.725(b). Review of requests for authorization services are made in accordance with 42 CFR § 438.210(d).
    A. The member's care manager based at Vaya, an Advanced Medical Home Plus (AMH+) or care management agency (CMA) shall discuss with the member the duration of the services expected by the member.
    B. The member's care manager based at Vaya, an AMH+ or CMA shall assist the member in developing a Care Plan/ISP and shall explain options regarding 1915(i) services available to the member.
6. Vaya informs members that they may make a new request for 1915(i) services at any time by requesting an updated Care Plan.
7. Care managers based at Vaya, an AMH+, or CMA may not exercise prior authorization authority over the Care Plan.
8. Vaya issues prior authorizations for all behavioral health, I/DD and TBI services covered under the 1915(i) SPA according to the requirements set forth in the service definitions that will be established by the Department.

Section XVI: Healthy Opportunities Pilot (HOP) Program to Address Unmet Health-Related Resource Needs

1. As part of its role in the HOP, Vaya implements policies and procedures for authorizing HOP services that provide for:
    A. Validation that no identified other service, resource, or program, including those managed by Vaya, would meet the member's HOP service needs is available to the member at the time of HOP service authorization, consistent with Department guidance.
    B. Validation that the member's HOP service needs cannot be fully addressed through an identified, available federal, State, or local program (e.g., the Supplemental Nutrition Assistance Program), consistent with Department guidance, at the time of HOP service authorization.
    C. If a federal, State, or local program is available that could address the member's HOP service needs in full or in part, the authorization process ensures that Tailored Care Management requirements that require connecting the member with those services, including in some cases through comprehensive application assistance, have been fulfilled.
    D. HOP service authorization process includes verification of connection to and/or the provision of comprehensive application assistance to relevant available programs, where applicable.
    E. Vaya does not authorize HOP services once the member is receiving services from another federal, state, or local program, if that program fully meets the member's HOP service need.
    F. Specific training for staff conducting HOP service authorization designed to prevent duplication and displacement of Vaya-managed and other available services, resources, and programs with HOP services.

G. Regular, monthly audits of HOP service authorization procedures and outcomes to prevent duplication or displacement of Vaya-managed and other available services, resources, and programs.

2. Vaya makes HOP service authorization policies and procedures available to the Department upon request and retains documentation of member-level HOP service authorization determinations, including validation that no identified duplicative or displaceable service, resource, or program, including those managed by Vaya, that could meet the member's HOP service need was available to the member at the time of HOP service authorization. Vaya makes member-level HOP service authorization documentation available to the Department upon request, including for monitoring and audits.

Related Documents (All Hyperlinked)
Document Library: PN Service GAP Referral Form
PT Documents: Development and Review of Clinical Guidelines, Treatment Modalities, and Pharmacy Procedures; Quality Improvement Committee Charter; Senior Clinical Staff Responsibilities and Qualifications; Senior Clinical Staff Responsibilities and Qualifications; PHP Transition of Care; Member and Recipient Appeals of Adverse Decisions
Other: Division of MHDDSUS Records Management and Documentation Manual; Clinical Coverage Policy 8-B

Oversight References
Contracts: BH/IDD Tailored Plan
Statutory/ Regulatory Citations:
NCQA: UM 1(A), UM 11(C), UM 2(A), UM 2(B), UM 4(A), UM 4(F), UM 5(A), UM 5(B), UM 5(C)
Supersedes: v.6 Utilization Management Program Description