Government Business Division
Policies and Procedures

Section (Primary Department) Clinical Quality Management - Utilization Management		SUBJECT (Document Title) Utilization Management - Medicaid Delegation and Oversight	
Effective Date 09/01/2011	**Date of Last Review** 06/20/2019	**Date of Last Revision** 05/20/2020	**Dept. Approval Date** 05/20/2020
Department Approval/Signature :			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☐ Arkansas	☐ Indiana	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☐ California	☐ Iowa	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☒ Kentucky	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Louisiana	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Maryland	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Minnesota	☐ South Carolina	☐ West Virginia

POLICY:

The Company provides oversight of delegated Utilization Management (UM) arrangements for Medicaid, in which delegates are held responsible for implementation, operation, reporting and meeting health plan standards in accordance with the contractual terms of the delegation agreement. The objective is to promote adherence to nationally recognized and State specific delegation standards.

Delegates are granted authority to act on the behalf of the Company. The Company retains accountability for the delegated activities and maintains oversight for compliance, accreditation and regulatory standards. Delegates for UM are evaluated and selected according to the Delegate/Vendor Oversight & Management Committee (DVOMC) program requirements. (Reference Vendor Selection and Oversight Program Procedure)

DEFINITIONS:

Account Manager: The Company associate responsible for the day-to-day management of the delegate contract. This can be the Business Owner or Delegation Account Manager at the Corporate level or the Health Plan.

Auditor: Subject Matter Expert designated to perform specific audit review of delegated functions and activities as necessary for National Committee for Quality Assurance (NCQA), CMS, state and federal compliance.

Company: Corporate and all of its wholly owned subsidiaries.

Deficiency: When a delegate does not meet contractual, accreditation, state/federal regulations.

Delegate: An entity performing core administrative functions on behalf of the Company (e.g., credentialing, claims payment, provider contracting, UM, etc.)

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Delegated Activities: The day-to-day operations performed by the delegate as a component of the applicable delegated function.

Delegated Functions: Administrative functions the Company may choose to delegate such as: Utilization Management, Case Management, Disease Management, Credentialing and Re-credentialing, Claims Processing, Call Center Operations, Marketing, Network Maintenance and Development, Enrollment and Applications Processing, and /or Provider Appeals, Complaints and Grievances. The Company may also choose to delegate member appeals only in the cases of routine dental and/or vision care. Certain functions above may require the submission of the agreement to the state agency for approval prior to implementation.

Delegation: Granting of authority by the Company to an entity to perform one or more core functions that are otherwise part of Company's administrative responsibilities. By law and/or state specific contract, delegation of a function does not relieve the company of ultimate responsibility of the performance of such functions.

NCQA: National Committee for Quality Assurance. Utilization Management functions for delegation may include: Internal Quality Improvement Process, Agreement and Collaboration with Clients, Privacy and Confidentiality, UM Structure, Clinical Criteria for UM Decisions, Communication Services, Appropriate Professionals, Timelines of UM, Clinical Information, Denial Notices, Policies for Appeals, Appropriate Handling of Appeals, Satisfaction with the UM Process, Emergency Services, Triage and Referral for Behavioral Health Care, and Delegation/ Subdelegation of UM.

Required Corrective Action: Noted or identified deficiency or significant deficiency which must be addressed in writing within a specified timeframe.

Significant deficiency: When a delegate does not meet contractual, accreditation, State/Federal regulations, and places the Company at risk for penalties/sanctions, loss of accreditation, contract termination, legal ramifications or causes harm to the member/potential member.

DELEGATION OVERSIGHT:

Delegate/Vendor Oversight & Management Committee (DVOMC): DVOMC is the executive decision making body for the Company's delegation oversight processes. DVOMC oversight ensures compliance with state contractual requirements, state and federal regulatory requirements, NCQA, and any other applicable regulatory and accreditation standards. DVOMC reports to the Company Quality Improvement Committee. The DVOMC Committee Charter may be referenced for further detail.

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Delegation Operations Committee (DOC): DOC is comprised of representatives from the following areas: delegate/vendor Account Manager, Quality Management, Legal, Compliance, Plan Compliance Officer (PCO), EDOM Auditors, as needed; additional departments are included as needed.
DOC assesses oversight and compliance with contractual and applicable federal, state, and accreditation standards, monitors Corrective Action Plan(s) activity by ensuring remediation of identified deficiencies, including recommendations to DVOMC for escalation/additional actions; evaluates delegate/vendor performance through analysis of reports and provides recommendations to DVOMC, and reviews and makes recommendations to DVOMC regarding audit tools used by EDOM auditors to conduct oversight audits. DOC reports to DVOMC on a monthly basis.

Joint Operations Meetings (JOM): Are held for each delegate performing core administrative functions on behalf of the Company on a quarterly basis to assure appropriate oversight and communication occurs between Corporate, health plans and its delegates. The JOMs are chaired by the Organization Delegate Account Manager. Other participants include the delegate contact/Account Representative, the Health Plan Medical Director or designee, the Provider Relations lead or designee, the Quality Assurance Lead or designee, Plan Compliance Officer, Delegation Oversight lead or designee, if UM is delegated, and other associates are invited to attend as needed.

PROCEDURE:

1) UM Pre-delegation Evaluation
   The Company evaluates each delegate's capabilities prior to implementation and ratification of the contract. Evaluation consists of a written review of the delegate's understanding of the NCQA standards and delegated tasks, compliance with federal and state regulatory requirements, appropriate documents, staff capabilities, performance record, and a review of state licensing/certification requirements. Evaluation may include a site visit.

   Results of this evaluation are reported the DVOMC. The DVOMC is the executive decision making body for the delegation oversight processes.

2) Contract/UM Delegation Agreement
   An executable agreement and/or appropriate addendum or other binding communication are developed for the delegated functions that are in compliance with accreditation, regulatory, state and federal delegation standards. The written delegation document:
   a) Is mutually agreed upon and includes a written document that specifies responsibilities of the organization and its delegate.

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b) Describes the delegated activities and the responsibilities of the Company and the delegate as they relate to the delegated activities. The agreement specifies the UM activities:
   i) Performed by the delegate and relative to applicable NCQA standard categories in detailed language.
   ii) Not delegated, but retained by the organization
   iii) If the delegate sub-delegates an activity, the agreement must specify that the delegate is responsible for subdelegate oversight.
c) Requires at least quarterly reporting to the Company, and specifies
   i) Information reported by the delegate about delegated activities
   ii) How, and to whom, information is reported
   iii) Other reports as deemed necessary
d) Describes the process by which the Company evaluates the delegate's performance
e) Describes the remedies, including revocation of delegation, available to the Company if the delegate does not fulfill its obligations
f) Describes provisions that ensure that Protected Health Information (PHI) remains protected if the delegation arrangement includes the use of PHI. The document must include the following provisions:
   i) List of the allowed uses of PHI
   ii) Description of delegate safeguards to protect the information from inappropriate use or further disclosure
   iii) Stipulation that delegate ensures sub delegates have similar safeguards
   iv) Stipulation that delegate provides individuals with access to their PHI (as stipulated in the Business Associate Agreement). The delegation agreement includes procedures to receive, analyze and resolve members' requests for access to their PHI.
   v) Stipulation that delegate informs the Company if inappropriate use of the information occurs
   vi) Stipulation that delegate ensures that PHI is returned, destroyed or protected if the delegation agreement ends
g) Describes the requirement for annual submission and approval of Delegate UM Program.

3) Annual UM Audit:
   Designated auditors are required to perform an annual audit for delegation arrangements. An annual desktop and/or onsite UM audit is conducted by the Corporate Delegation Oversight Auditor or designee. The audit scope is dependent upon the type of services/functions delegated and is reviewed in accordance with NCQA UM standards (or other nationally recognized accrediting body as applicable) and state and federal regulatory requirements. At a minimum, it must involve an audit of the delegated entity's files, as applicable, and review of meeting minutes.

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Findings are presented to the DVOMC as per the DVOMC program requirements. Applicable findings below or outside of NCQA standards/requirements are addressed with the delegate through a formal corrective action plan developed by the auditor. The UM audit is conducted utilizing comprehensive delegation tools for audit and file review, and evaluates the following components as applicable:

A. The delegate's UM Program description includes the following:
   1. A written description of the program structure
   2. Involvement of designated licensed senior-level physician/practitioner in UM program implementation.
   3. Program scope and process used to determine benefit coverage and medical necessity.
   4. The delegate annually evaluates and updates the UM Program, as necessary.
B. Annual evaluation of UM Program which includes the review and evaluation of:
   1. The program structure
   2. The program scope, processes, information sources used to determine benefit coverage and medical necessity.
   3. The level of involvement of the senior-level physician in the UM program.
C. State utilization licensure and accreditation status, if applicable
D. Clinical criteria for UM decisions:
   1. Written objective evidence based UM determination criteria that have been designated by the Company, as applicable
   2. Involvement of appropriate practitioners in developing, adopting and reviewing objective, evidence-based criteria/algorithms, with appropriate committee approval by the Company, as applicable.
   3. Written policies for applying criteria based on individual needs and assessment of the local delivery system, and for practitioner and member access to criteria.
   4. Process for annual review and approval of criteria and procedures for applying criteria, and for updating criteria when appropriate.
   5. Delegate evaluates consistency of application of criteria in UM decision-making (Inter-Rater Reliability) at least annually, and acts on opportunities for improvement, as applicable.
E. Delegate provides communication services for members and providers seeking information about the UM process and authorization of care.
F. Appropriately licensed qualified professionals supervise all medical necessity decisions. Written procedures/processes specify:
   1. A licensed physician or other health care professional as appropriate reviews an nonbehavioral healthcare denial based on medical necessity
   2. Job description for practitioners who review for medical necessity requires current unrestricted licensure and education or professional experience in medical or clinical practice
   3. The type of personnel responsible for each level of UM decision-making

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4. Procedures for use of board-certified consultants in appropriate circumstances
5. Distribution of affirmative statement to practitioners, providers and employees that make UM decisions.

G. UM decision-making and notifications adherent to NCQA-compliant timeframes/federal/state contract standards if more stringent.
   1. Delegate monitors and tracks in NCQA-required reports the timeliness of decision making and of notification of UM decisions resulting from medical necessity review, whether they are approvals or denials.

H. Written description identifies the clinical information needed and the delegate obtains relevant clinical information to support UM decision-making.

I. Delegate notifies practitioners of availability of appropriate practitioner reviewer to discuss any UM denial decision and how to contact the reviewer.

J. Delegate uses approved denial notice templates supplied by health plans that have been approved through the Collateral Materials Approval Process (CMAP) and approved by the State, if required, and clearly documents and communicates decisions and appeal rights to members and to treating practitioners in denial notices that are compliant with applicable accreditation standards and regulatory requirements. NCQA-compliant notices to members and practitioners include:
   1. Specific reasons for the denial in easily understandable language
   2. Reference to the benefit provision/criterion/ protocol on which the denial decision was based
   3. Notification that member, upon request, can obtain a copy of the benefit provision/ criterion/protocol on which the denial decision was based.
   4. Description of appeal rights, which includes the right to submit written comments or other information relevant to the appeal
   5. Explanation of the appeal process, which includes the member's right to representation, the timeframe for the member to file an appeal and the timeframe for the organization to make a decision on the appeal, including the different timeframes for expedited appeals.
   6. Notification of the member's right to the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman, if the State provides this service
   7. Description of an expedited appeal process for urgent pre-service or urgent concurrent denials

K. Policies/procedures for appropriate handling of appeals, as applicable,
   1. Where member appeals are handled by the Company, the delegate has written policies and procedures that explain how it handles appeals and under what circumstances they are forwarded to the Company.
   2. Where provider appeals are handled by the Company, the delegate has written policies and procedures that explain how it handles appeals and under what circumstances they are forwarded to the Company.

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L. Handling of new technologies as applicable
M. Annual assessment of member/provider satisfaction (as applicable per contractual requirements)
N. Policy/procedure with a process for Health Plan provisions of member data to its delegates when requested:
Member experience data, if applicable
Clinical performance data.
O. For any sub-delegation of UM activities, the delegate has requested permission prior to sub-delegation, per contractual requirement. If sub-delegation of UM activities has been approved, the delegate performs delegated oversight according to NCQA/regulatory standards and annually provides documentation of oversight of the sub-delegated entity.
P. For delegation agreements in effect for more than twelve (12) months, there has been identification and follow up on opportunities for improvement, at least once in each of the past two (2) years.
Q. For non-par authorizations, delegate uses written OIG/SAM screening process using the OIG LEIE and SAM (System for Award Management, formerly called GSA EPLS) sites, prior to services being performed, with a method for consistent documentation of the verification that the practitioners/providers were not under sanction or excluded at the time the authorization was requested.

4) Auditors are responsible for:
   A. Completing any and all necessary pre-delegation audits and annual audits for any new or existing delegates in accordance with DVOMC program requirements.
   B. Completing the Vendor Audit Tool, including outlining any deficiencies, and uploading the pre-delegation or annual audit supporting documentation in the DVOMC shared folder.
   C. Identification and communication of any deficiencies, and necessary Action Plan(s) to DVOMC and the delegate.
   D. Follow up with the delegate on any required delegate Action Plan(s) and updating the database at a minimum of every 30 days until the Auditor deems the Action Plan(s) has been completed.
   E. Notify manager/ DVOMC Coordinator and Account Manager immediately of significant compliance failures and/or repeated deficiency findings.

5) Delegation Oversight
   DVOMC oversight ensures compliance with state, federal, NCQA, and other applicable regulatory requirements and accreditation standards. DVOMC functions include:
   A. Review and approval of entities for capitation/delegation
   B. Review and approval of annual and/or semiannual audit findings
   C. Review quarterly/semiannual reporting requirements

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D. Assess financial solvency requirements
E. Determination when termination and/or de-delegation are appropriate courses of corrective action

The DVOMC is responsible for delegation oversight activities such as pre-delegation evaluations, annual and semiannual audit analysis, and ongoing oversight to include analysis of quarterly reports through the JOM. The DVOMC makes appropriate determinations regarding continued delegation or other determinations regarding additional oversight of delegates that do not meet regulatory or accreditation standards.

Each health plan is responsible to ensure that any delegate performing delegated functions/activities in their market is monitored, at a minimum on a quarterly basis, or more frequently as needed, through the review of relevant reports or other identified delegate data. Review is performed by designated Subject Matter Expert(s) (SME) at the health plan, and is noted at the Quarterly JOM. If the SME identifies any deficiencies, the SME is responsible for notifying the Account Manager who will work with the delegate to resolve. If the delegate is unable or unwilling to correct the deficiency, the Account Manager will report such finding and any associated corrective action plan to the health plan and DVOMC.

JOMs are held on a quarterly basis to assure that appropriate oversight and communication occurs between Corporate, health plans and its delegates. JOM policy suggested agenda items include Corporate and health plan updates, Delegate updates, Delegated function report overview, market-specific issues and collaborative project reports, annual audit results, corrective action plans, identification and follow up on opportunities for improvement, review sampling of denial and appeal letters (as applicable), and outreach efforts (where outreach is a vendor responsibility). The Account Manager is responsible for ensuring that the proceedings as well as any significant deficiencies identified are reported to the Delegate/Vendor Oversight & Management Committee and available for regulatory, accreditation and internal audits.

Pharmacy vendors are not reviewed under the DVOMC process; they are handled through the P&T Committee.

REFERENCES:

42 C.F.R. § 438.6(h)
42 C.F.R. § 422.208
42 C.F.R. § 422.210
Indiana Hoosier Healthwise, Ex. 1.C, Section 6.3.2; Indiana Healthy Indiana Plan, Ex. 2.C, Section 9.3.2; and Indiana Hoosier Care Connect, Ex. 1.G, Section 7.3.1

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Iowa Health Link Contract § 11.1.4
Kentucky Medicaid Managed Care Contract Section 21.2
Kentucky Revised Statute 304.17A.607
NCQA Accreditation Standards and Guidelines
Virginia Commonwealth Coordinated Care Plus Contract, Section 6.0
Virginia Medallion 4.0 Contract, Section 8.1.D

Related Materials
DVOMC Committee Charter
Health Plan Utilization Management Program Description
Utilization Management Audit Tool

Related Policies and Procedures
Delegate Account Management Responsibilities
Delegate/Vendor Oversight and Management Program Quality Management Program Oversight
Utilization Management - Medicaid Delegation and Oversight - DC
Utilization Management - Medicaid Delegation and Oversight - LA

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management - Utilization Management

Secondary Department(s):
Corporate Clinical Quality Management - Delegate/Vendor Oversight & Management Committee
Health Plan Provider Relations

EXCEPTIONS:

The health plan does not delegate member medical necessity appeals except for dental and vision delegates.

Kentucky:
Decisions to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, must be made by a physician who is of the same specialty and subspecialty, when possible, as the ordering provider, has appropriate clinical expertise in treating the Member's condition or disease and is consistent with state and federal regulations and state contracts.

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REVISION HISTORY:

Review Date	Changes
10/14/13	• Rebranded for VA Medicaid Migration. Remove company specific references. Remove OH exception due to market departure.
01/01/14	• Added Kentucky health plan.
03/17/14	• Updates to Louisiana exception.
04/01/14	• Added Wisconsin as applicable health plan and removed New Mexico
04/23/15	• Annual Review
06/04/15	• Remove LA as applicable market. Remove LA exceptions.
12/03/15	• Off-cycle edit to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016.
04/28/16	• Annual review by PPOC and MOC • Added definitions for Company & NCQA • Revised content related to Delegation Oversight, Contract/UM Delegation Agreement, UM Audit and auditor responsibilities • Revised references and responsible departments sections • Added KS exception language
12/01/16	• Off-cycle edits to add New York – Western as an applicable market and add NY – Western exception language.
04/27/17	• Annual review • Updated VSOC name • Inserted Delegation Operations Committee information • Added Regulatory Requirements to UM Pre-delegation Evaluation and Annual UM audit sections • Updated References and Related PorPs • Added IA Exceptions • Removed KS Exceptions
10/26/17	• Off-cycle edit to add definition of NCQA UM Standards
11/08/17	• Off-cycle edit to add IN as an applicable market.
01/03/18	• Off-cycle edit to IA Exception language
06/07/18	• FL Only – 2/1/18 - Off-cycle review prior to Simply Utilization Management Committee vote to adopt in FL • Updated Plan name to Simply/Amerigroup/Clear Health Alliance to reflect legal rebranding of Simply, Better and Amerigroup to Simply and separate branding for Clear Health Alliance as Simply Healthcare Plans, Inc. dba Clear Health Alliance • No changes were made to the policy language
06/28/18	• Annual review

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	• Revised References
08/10/18	• Off-cycle edit to add MN as an applicable market. Exception added to notate market go-live of 10/1/18.
10/25/18	• Off-cycle modifications required for AHCA Contract No. FP068 signed 08/01/2018 that becomes effective 12/01/2018 • Adopted/rebranded for all FL Simply Healthcare Medicaid Plans
01/25/19	• Off-cycle edit to add AR as an applicable market. No content edits.
02/18/19	• Off-cycle adoption for Simply FL Medicare and Simply Florida Healthy Kids plans. Added DC as an applicable market.
06/20/19	• Annual Review • Updates to policy, definition, procedure, references • Added KY exception language • Added CA, LA, SC, WV as applicable markets
05/20/20	• Off-Cycle Review • Revised KY exceptions section • Updated KY references

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