Medica®

Quality Improvement Program Description 2023

February 2023

QUALITY IMPROVEMENT PROGRAM DESCRIPTION 2023
TABLE OF CONTENTS

© 2011-2023 Medica. Medica® is a registered service mark of Medica Health Plans. "Medica" refers to the family of health services companies that includes Medica Health Plans, Medica Community Health Plan, Medica Insurance Company, Medica Self-Insured, MMSI, Inc. d/b/a Medica Health Plan Solutions, Medica Health Management, LLC and the Medica Foundation.

© 2011-2023 Medica. Medica® is a registered service mark of Medica Health Plans. "Medica" refers to the family of health services companies that includes Medica Health Plans, Medica Community Health Plan, Medica Insurance Company, Medica Self-Insured, MMSI, Inc. d/b/a Medica Health Plan Solutions, Medica Health Management, LLC and the Medica Foundation.

INTRODUCTION

Medica Mission, Vision and Values

Mission
To be the trusted health plan of choice for customers, members, partners and our employees.

Vision
To be trusted in the community for our unwavering commitment to high-quality, affordable health care.

Values

- Customer focus
- Excellence
- Stewardship
- Integrity
- Diversity

Quality Program Purpose

The purpose of the Medica quality improvement (QI) program is to identify and implement activities that will:

- Improve member care, service, experience, access, equity and/or safety; and/or
- Improve service to practitioners, providers, employers, brokers and other customers and partners; and/or
- Improve Medica's internal operations related to care, service, experience, access and patient safety.

The QI Program Description defines the context in which Medica conducts its QI program. Medica also develops an annual QI work plan, consistent with the program description, to describe the priority improvement opportunities for each year.

Program Description Scope

The 2023 Quality Improvement Program Description includes content formerly found in the separate Care and Utilization Management Program Description, which has been retired. The Quality Improvement Program Description now encompasses activities addressing care and utilization management; health equity; population health; and quality improvement.

© 2011-2023 Medica

PROGRAM STRUCTURE

Populations Served

The Medica QI program serves all Medica legal entities and business segments.

Commercial Markets Division

- Medica Health Plans: HMO, POS
- Medica Insurance Company: PPO
- Medica Self-Insured: PPO
- MMSI, Inc. d/b/a Medica Health Plan Solutions (PPO)

Government Programs

- Medica Health Plans: HMO, POS, Medicare Supplement
- Medica Insurance Company: Medicare Cost

Individual and Family Business

- Medica Health Plans: Commercial POS, Marketplace POS
- Medica Insurance Company: Commercial EPO, Marketplace EPO (IA, KS, MN, MO, NE); Commercial PPO, Marketplace PPO (OK)
- Medica Community Health Plan: Commercial EPO, Marketplace EPO (WI, AZ)

QI Models

Medica teams use various QI and project management models to identify and implement QI strategies and activities, including:

- Plan-Do-Study-Act (PDSA)
- Four Disciplines of Execution (4dX)
- Agile/Scrum
- Lean Six Sigma

All models support a structured approach to project planning, priority-setting, timelines, progress tracking and outcome measurement.

© 2011-2023 Medica

Identifying Opportunities for Improvement

In identifying opportunities for clinical and service improvements, Medica focuses on high-risk, high-volume, and problem-prone areas that may expose members to potentially adverse clinical or service outcomes. Medica integrates clinical quality priority setting, department priority setting, and business segment planning into the identification process. Medica evaluates the full spectrum of clinical care: inpatient, outpatient, ambulatory, ancillary, pharmacy, emergency services, home health, and skilled nursing care.

Medica routinely monitors and analyzes data from a variety of sources, including:

- Claims (showing utilization rates, disease prevalence by population, potential over- and underutilization)
- Clinical studies/disease management self-reported data
- Clinical medical record data
- Customer Service Center performance statistics
- EBM Gaps in Care: data analytics showing gaps in members' health screenings and outcomes
- Health Assessment (for select populations)
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Internal audits of Medica's utilization review, case management and grievance and appeals processes
- Medicare Stars current and projected ratings
- Member complaints and appeals
- Member demographic data
- Member and practitioner satisfaction surveys, including Consumer Assessment of Health Plans Study (CAHPS)
- Social Determinants of Health (SDoH) data
- State and federal regulatory audit results, including but not limited to: Centers for Medicare and Medicaid Services (CMS); Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS)
- Utilization data from care management software applications

When a potential improvement opportunity emerges, Medica evaluates it to determine:

- The improvement's relevance to Medica's population
- Medica's ability to make an impact
- Integration potential with other programs
- Applicable laws and regulations
- Program costs and resource needs
- Availability of regional or national benchmarks for goal-setting

Measurable goals are set against current baseline measures. Periodic re-measurements assess the improvement's effectiveness.

© 2011-2023 Medica

Customer-Driven Quality Strategy

An understanding of customer perceptions and expectations is critical to integrated strategic and quality planning. Medica learns about its members and other important stakeholders through monitoring and analysis of:

Satisfaction surveys and related data

- CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey data
- Physician advisory groups
- Aggregate complaint, grievance and appeal data (members and providers)
- Market research data
- Member enrollment and disenrollment surveys
- Member forums and advisory groups
- Member satisfaction surveys: care coordination, case management, Customer Service

Health outcome data

- Health outcomes from utilization management and case management programs
- HEDIS (Healthcare Effectiveness Data Information Set) data
- Clinical studies
- Medical record data
- Medicare Health Outcomes Survey
- Pharmacy claims data

Social Determinants of Health

- Member demographic and claims data, analyzed and categorized to identify socio-economic risk factors

Utilization management data

- Over- and underutilization measures

Progress toward QI work plan goals

- Quarterly work plan updates

© 2011-2023 Medica

Data and Information Systems

Medica collects, manages and integrates data from a variety of sources and systems for its quality improvement programs. Medica uses both purchased and internally-developed software products to meet its quality goals. Examples include, but are not limited to:

- **CIAO (Clinical Indicators Assessments and Observations)**: Internally-developed software for documenting and analyzing data collected through medical record review.
- **Compliance360**: Supports regulatory and accreditation compliance.
- **Cotiviti Quality Compass**: Supports HEDIS data processing and analysis.
- **Guiding Care**: Clinical system for care management: UM, appeals/grievances, care coordination products, disease management and provider portal.
- **Johns Hopkins ACG Case-Mix System**: Risk assessment software that processes medical, behavioral and pharmacy claims to identify potential Health and Wellness Coaching and case management participants, as well as Special Needs Plans (SNP) members at high risk for hospitalization.
- **QCS**: Internally-developed secure software application for managing quality of care investigations.
- **Symfact**: Used to manage credentialing and recredentialing data.
- **Symmetry EBM Connect**: Claims analysis algorithm that identifies potential gaps in members' disease management, medication adherence, care patterns and safety.

Through its vendor contract with United HealthCare (UHC), Medica also uses a number of UHC systems and applications for enrollment, claims processing and customer service.

Medica's data systems have standard and customized reporting capability. Medica can generate reports on medical record and claims data sorted by multiple variables, including patient, provider, diagnosis and procedure. Other report types include program activity, history and performance trends.

Medica has mechanisms to ensure that information received from service providers is accurate, complete and readily available to the health plan or to regulators when needed. Data accuracy is monitored through activities including claim and coding audits, quality studies and fraud/abuse investigations.

© 2011-2023 Medica

Regulatory and Accreditation Compliance

The Medica QI program is designed and administered according to applicable state and federal regulatory standards. Medica is accountable to state-level regulatory agencies in each state in which it operates. These include:

- **Arizona:** Department of Insurance
- **Iowa**: Insurance Division
- **Kansas**: Insurance Department
- **Minnesota**: Department of Health, Department of Human Services, Department of Commerce
- **Missouri**: Department of Insurance
- **Nebraska**: Department of Insurance
- **North Dakota**: Insurance Department
- **Oklahoma**: Insurance Department
- **South Dakota**: Division of Insurance
- **Wisconsin**: Office of the Commissioner of Insurance

Federal agencies that regulate Medica's business include the Center for Medicare and Medicaid Services, the Department of Health and Human Services and the Department of Labor.

Medica's quality program may be audited by any of these regulators on a scheduled or ad hoc basis. If any quality program audit results in the need for corrective action, a project lead will be designated to convene a cross-functional work team, which will develop and execute a corrective action plan. The project lead will monitor and document all corrective actions, communicate with the appropriate regulators, and report progress to Medica leaders.

Medica provides timely reporting on quality and outcome measures to regulators on a scheduled and ad hoc basis.

Medica is currently accredited by the National Committee for Quality Assurance (NCQA) for Commercial, Individual and Family Business and Medicaid health plan products. Medica also holds NCQA's Multicultural Healthcare Distinction for its Medicaid product line.

Medica applies NCQA standards and guidelines to its entire book of business where appropriate. The Quality Improvement department coordinates preparation for NCQA accreditation surveys and monitors ongoing compliance with standards.

When regulatory and NCQA requirements differ for any element, Medica adopts the most stringent standard applicable.

© 2011-2023 Medica

Quality Improvement Policies

Medica maintains a number of company-wide policies that affect the quality program, and/or assure service quality and affirm compliance with regulatory and accreditation standards. These include:

- **Confidentiality**: Corporate and departmental policies govern use, disclosure and security of personally-identifiable health information (PHI). Medica staff, consultants and vendors have access to PHI only as needed for specific quality improvement activities. Only de-identified or aggregated patient information may be used in peer review committee presentations or reports of quality measurement studies, surveys or audits.

- **Conflict of Interest:** No provider may participate in the evaluation and approval of any issue in which he/she has been professionally involved, or in which relationships with the parties involved may compromise the reviewer's judgment. All provider member of Medica's board-level and advisory committees sign a conflict of interest statement annually. In addition, all Medica employees must annually sign a conflict of interest statement, and must immediately report any potential conflicts to the Medica Law department.

- **Financial Incentives**: Medica does not offer, and employees may not accept, any financial incentives to deny or limit authorizations or to make clinical decisions that result in underutilization. All consultants, delegates and vendors must also comply with this standard.

Each Medica business unit maintains internal operational policies and procedures, and is responsible for ensuring that policies comply with all applicable regulations.

Communication of Program Activity

Medica communicates the results of its QI activities to internal and external audiences. Internal communication occurs through committees, work groups and management meetings. External communication vehicles include member, provider, and employer/broker newsletters and the Medica Web site. Medica's providers also receive program information through practitioner guidelines and quality study results.

© 2011-2023 Medica

PROGRAM STAFF AND GOVERNANCE

Staff Involved in Quality Improvement Activities

Chief Clinical and Provider Strategy Officer (CCPSO)
A licensed physician, the CCPSO leads the strategic direction of Medica's clinical programs and provider relationships. The Health Services, Pharmacy and Physician Services business units report to the CCPSO.

Vice President, Health Services Operations
Reporting to the CCPSO, this position provides strategic leadership to the quality program, as well as leading provider connectivity efforts across the organization. The Senior Director for Quality and Clinical Advancement reports to this VP.

Senior Medical Director, Quality Improvement
A licensed physician, the Senior Medical Director for Quality Improvement is ultimately responsible for quality program development, implementation and oversight. The Senior Medical Director provides primary clinical leadership to the Quality Review Oversight Committee, staffs the Credentialing Subcommittee and represents the Subcommittee to the Medical Committee of the Medica Board of Directors.

Vice President, Health Services
Leads care management functions including complex case management, disease management and population health strategies. Leads utilization management functions: prior authorization, clinical appeals and utilization review.

Vice President, Physician Services
A licensed physician, the Vice President of Physician Services oversees the medical directors and Physician Services leaders who support Clinical Services quality, care management and utilization management teams. This position also provides oversight to the clinical value efforts and development of ACO partnership initiatives.

Senior Director, Quality and Clinical Advancement
Leads quality improvement activities in Health Services. Responsible for ongoing oversight and evaluation of QI program activities, including medical record review and site surveys; Medicare Stars clinical improvements; accreditation compliance; patient safety; quality improvement data collection and dissemination; and quality committees, including Quality Subcommittee and Credentialing Subcommittee.

Departments and staff throughout Medica participate in quality improvement activities. Key staff with QI program accountabilities include:

© 2011-2023 Medica

Senior Medical Director, Utilization Management
A licensed physician, the Senior Medical Director for Utilization Management provides clinical leadership for care and utilization management programs and for medical policy development and implementation.

Director, Quality Analytics and Improvement
Provides organization-wide leadership and oversight related to the Medicare quality program, including Star ratings; HEDIS data collection and improvement; medical record review; and claims validation.

Director, Quality Operations
Leads quality evaluation and support activities including accreditation preparation; quality committee management; quality program documentation; and compliance with Qualified Health Plan quality program requirements. Facilitates Credentialing Subcommittee.

Director, Risk Adjustment and HEDIS Operations
Accountable for the direction and coordination of analytical activities supporting customized reporting, health management programs and evaluations, regulatory reporting of clinical and quality data, provider risk-sharing arrangements, and medical expense management.

Director, Behavioral Health
Provides organization-wide leadership, strategy and consultation related to behavioral health programs and initiatives, including clinical leadership and oversight of behavioral health vendor.

Director, Care and Utilization Management Optimization
Provides leadership and oversight of the programs, systems, vendors and business analytics supporting care and utilization management.

Director, Case Management
Leads complex case management program development and operations.

Director, Utilization Management
Leads prior authorization, utilization review and clinical appeals program development and operations.

Manager, Quality and Accreditation
Responsible for daily and strategic activities of the Quality and Accreditation team. Program responsibilities include health plan accreditation, delegated credentialing oversight and behavioral health quality program management.

Manager, Clinical Data Collection and Improvement
Leads clinical quality activities including HEDIS data collection; medical record review and site surveys; claims validation; and efforts to improve HEDIS and Star ratings.

Quality Improvement Clinical Program Manager
Responsible for network quality activities. Leads investigation of clinical quality complaints; manages skilled nursing facility quality review program.

© 2011-2023 Medica

Credentialing staff
Responsible for credentialing and recredentialing data collection, verification and processing, and for preparing information for the Credentialing Subcommittee to review.

Health Care Economics staff
Responsible for data infrastructure, collection, reporting and analysis. Conduct surveys and assist with design, interpretation and evaluation of QI studies and programs. Develop performance monitoring tools and provide technical and statistical consultation to Health Services and other Medica staff.

Quality Improvement staff
Responsible for executing quality improvement activities and initiatives including, but not limited to: clinical data collection and improvement; Medicare Stars and HEDIS analysis and improvement; quality improvement infrastructure, including accreditation compliance; and network quality activities including clinical and service quality investigations.

Corporate Compliance staff
Leads delegation oversight functions and regulatory compliance, including internal and external compliance auditing.

Staff Involved in Care and Utilization Management Activities

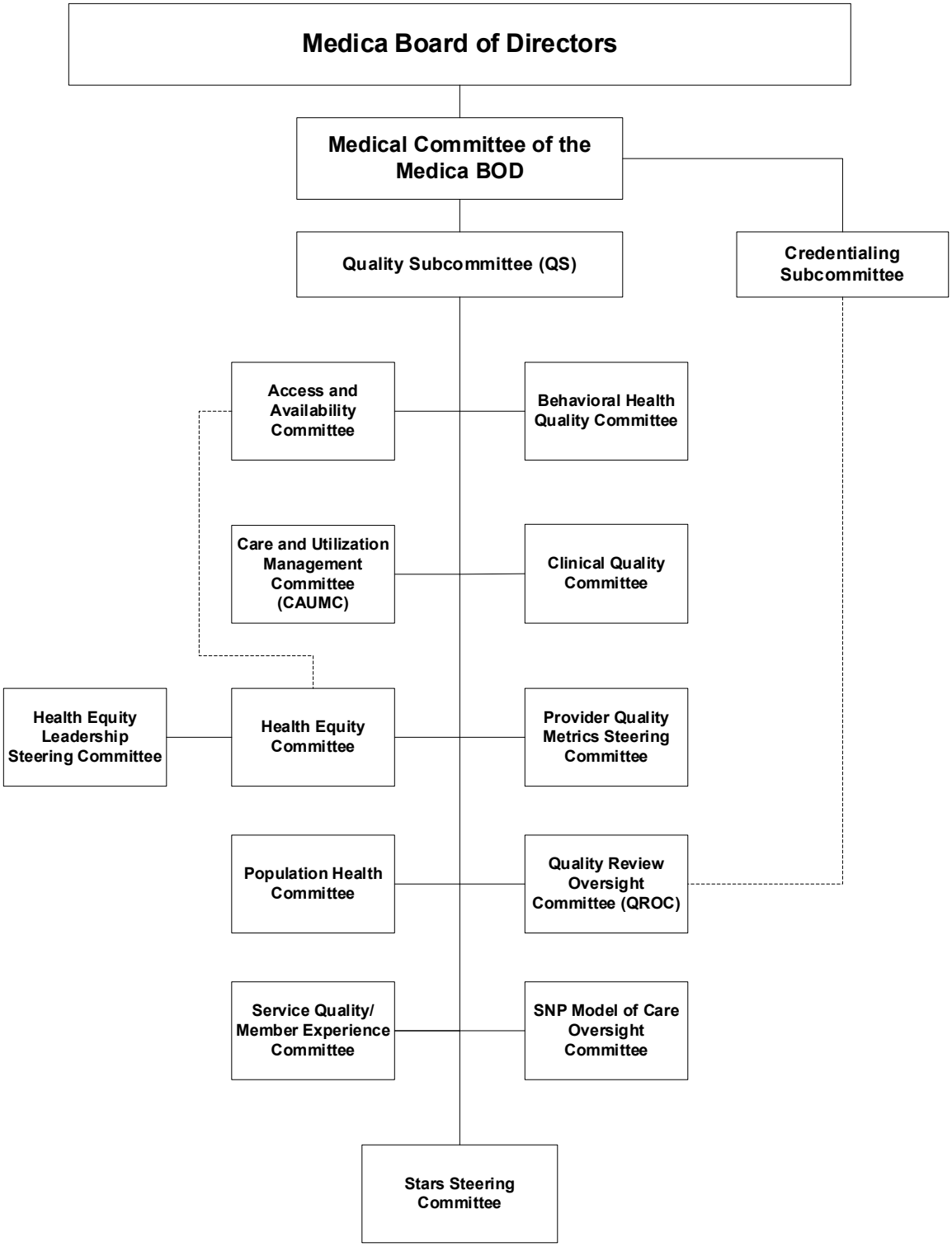
Physician Leadership and Staffing
The Medical Committee delegates overall accountability for the administration of the Care and Utilization Management programs to the Chief Clinical and Provider Strategy Officer, the Senior Medical Director for Utilization Management and the VP of Health Services. These leaders, in partnership with the Director of Behavioral Health, Director of Clinical Pharmacy and Senior Director of Quality and Clinical Advancement, are responsible for ensuring that strategic planning and goal setting processes for care and utilization management programs align with business needs.

The Chief Clinical and Provider Strategy Officer and the Senior Medical Director for Utilization Management are physicians who, in partnership with the VP of Health Services, are accountable for administration of the Care Management and Utilization Management programs described in this document. Day-to-day operations for care management and utilization management programs are administered by leaders and individual contributors, including many licensed clinicians in director, manager, supervisor, and member support roles.

Health Improvement Program Leadership
Accountability for vendor health improvement programs, initiated and managed within each Medica business segment, is delegated to each respective business segment leader. These senior leaders, in partnership with Health Services Clinical and Optimization leaders, are responsible for oversight and management of their respective health improvement programs.

© 2011-2023 Medica

Quality Committee Reporting Structure 2023



© 2011-2023 Medica

Medical Committee/Medica Board of Directors

The Medica Board of Directors has designated its Medical Committee as the company's "quality assurance entity." The Medical Committee reports quality improvement activities to the full Medica Board of Directors on a quarterly basis. Reporting to the Medical Committee are the Credentialing Subcommittee and the Quality Subcommittee (QS).

Both the Medical Committee and the Board of Directors review Medica's quality improvement program, with the Board of Directors retaining final approval authority. The Medical Committee and the Board of Directors review and approve the Quality Improvement Program Description, Work Plan and Program Evaluation on an annual basis. (See the "Approvals and Signatures" section of this document for the most recent approval dates.)

Quality Subcommittee

The Quality Subcommittee (QS) directs, oversees and evaluates the Medica quality improvement program, with the goal of promoting and continually improving clinical quality, service quality, provider quality, patient safety and health equity. The Subcommittee's role is to:

- Evaluate and recommend action on program and committee reports, performance data and other inputs.
- Review subgroups' analysis of clinical quality, service quality, provider quality, patient safety and health equity activities and results.
- Recommend policy decisions targeted toward highest-quality, equitable clinical care and service delivery; identify priorities for action; follow up on progress.
- Review and approve program reports and documents, including annual Quality Improvement Program Description, Program Evaluation and Work Plan.
- Review and approve quality improvement program policies.
- Send a designated Subcommittee officer member to the Medical Committee of the Medica Health Plans Board of Directors at least quarterly to report on subcommittee activities and to secure approval of the subcommittee's reports and actions.
- Send a designated Subcommittee officer member to the Medical Committee, and to the Medica Health Plans Board of Directors, annually to present Quality Improvement Program Description, Program Evaluation and Work Plan for review and approval.

QS is scheduled to meet bimonthly, but must meet not less than four times per year. QS is chaired by the Senior Director of Quality and Clinical Advancement and staffed by director- and manager-level stakeholders from Health Services and the business segments. Representatives from the Medica Board of Directors, including an employer representative, if designated as a consumer director of the Medica Board, may also be included. The committee chair is designated by the Medical Committee of the Board of Directors to advise, oversee and actively participate in the implementation of QI plan functions. QS is constituted as a peer review body, receiving and reviewing aggregate data on all aspects of clinical and service quality. QS maintains signed and dated contemporaneous meeting minutes.

© 2011-2023 Medica

Committees Reporting to QS

Several key committees and work groups, comprising subject matter experts from business units throughout the organization, report to QS.

- **Access and Availability Committee** (chair: Director, Quality Operations)
  Cross-functional committee that develops, monitors and maintains standards for provider network adequacy, including geographic availability, appointment access and cultural/linguistic competency.

- **Behavioral Health Quality Committee** (chair: Director, Behavioral Health)
  A partnership between Medica and behavioral health vendor Optum Behavioral Health (branded for members as Medica Behavioral Health, or MBH), the committee is responsible for developing, implementing and monitoring behavioral health quality initiatives and reviewing delegation performance reports.

- **Care and Utilization Management Committee** (chair: Director, Quality Operations)
  Provides strategic clinical direction to and oversight of the care management program and is responsible for assuring that the program meets all necessary quality, regulatory and organizational requirements. The Subcommittee also monitors utilization data for network usage patterns and over- and under-utilization. Committees and work groups reporting to CAUS include:
    - Medical Policy Committee
    - Medical Technology Assessment Committee
    - Prior Authorization Selection Committee

- **Clinical Quality Committee** (chair: Director, Quality Analytics and Improvement)
  Cross-functional committee that monitors and recommends action on clinical quality programs including medical record review, claims validation and skilled nursing facility quality reviews. This committee is primarily responsible for analyzing and recommending action on annual HEDIS results.

- **Health Equity Committee** (chair: Senior Director, Quality and Clinical Advancement)
  The Health Equity Committee proposes and guides projects aimed at reducing disparities in health care access, experience, and outcomes by removing barriers that may prevent our members from achieving their highest health care potentials. The HEC oversees four subgroups, each with their own guiding principles and projects: Leadership and Decision-Making; Data Practices; Access and Outcomes; and Policies and Procedures.

  The Health Equity Committee is responsible for:
    - Reviewing organization and department-level activities related to health equity and making recommendations targeted toward providing equitable clinical care and service delivery.

© 2011-2023 Medica

- Identifying potential barriers that may prevent our members for achieving their highest health care potentials and assigning projects to sub-committees aimed at mitigation.
- Tracking and evaluating sub-committee projects.
- Recommending changes to departments within Medica based on project results.

- **Provider Quality Metrics Steering Committee** (chair: Senior Director, Quality and Clinical Advancement)
  Responsible for directing, overseeing and evaluating product-specific quality measures to include in provider contracts. The group defines the quality metrics for which provider groups will be held accountable, approves any deviations from the standard measure set and monitors performance.

- **Population Health Committee** (chair: Senior Director, Quality and Clinical Advancement)
  The Population Health Committee is responsible for analyzing, creating and supporting a cohesive plan of action for addressing member needs across the continuum of products in alignment with the *Quintuple Aim:*
    - Improving members' experience of care (including quality & satisfaction)
    - Improving provider experience working with Medica
    - Improving the health of the population
    - Reducing the per capita cost of health care
    - Advancing health equity

  The committee convenes stakeholders with clinical, financial and operational expertise to design, direct and evaluate an actionable Population Health program that meets Medica's overall goals and objectives.

- **Quality Review Oversight Committee** (chair: Senior Director, Quality and Clinical Advancement)
  The Quality Review Oversight Committee (QROC) is a peer review body that reviews and analyzes network quality issues identified through quality of care complaint review; focused quality investigations; and internal and external case referrals. The committee review individual cases to identify clinical care and patient safety implications and tracks clinical and service quality complaint trends. The committee recommends and initiates action, which may include corrective action plans or escalation to the Credentialing Subcommittee, the Law Department and/or the executive team.

- **Service Quality/Member Experience Committee** (chair: Director, Quality Operations)
  Cross-functional committee that monitors and recommends action on service quality indicators relevant to member experience with the health plan, including call center performance and member complaints, appeals and grievances. This committee is primarily responsible for analyzing and recommending action on annual CAHPS results.

- **Special Needs Plans Model of Care Oversight Committee** (chair: Senior Manager, Regulatory Quality and Improvement)

© 2011-2023 Medica

Cross-functional team that oversees and evaluates the effectiveness of the Special Needs Plans (SNP) Models of Care. The committee establishes and monitors performance metrics, analyzes member feedback and reviews care coordination audit results

- **Stars Steering Committee** (chair: Senior Director, Quality and Clinical Advancement) The Stars Steering Committee directs, oversees and evaluates Medica's Medicare Stars rating strategy and ensures the Stars strategy is aligned with the organization's broader strategy and goals. Recommend strategies and tactics to improve contract-level Stars performance; identify priorities for action; and monitor strategic plan progress.

Credentialing Subcommittee

The Credentialing Subcommittee reports directly to the Medical Committee of the Medica Board of Directors. Chaired by a Medica medical director, the Subcommittee reviews Medica network providers' credentialing and recredentialing applications. It also reviews and approves oversight of delegated credentialing. As a peer review body, the Credentialing Subcommittee performs individual case reviews in response to quality of care concerns. The Credentialing Subcommittee retains final authority to suspend or revoke the network participation status of any provider, credentialed by Medica or its delegates, who does not meet Medica's performance standards. The Credentialing Subcommittee is described in greater detail in Medica's annual Credentialing Plan.

Minnesota Community Measurement

Minnesota Community Measurement (MNCM) was founded by the Minnesota Medical Association and Minnesota's nonprofit health plans to improve health care quality in the state. Its mission is to "accelerate the improvement of health by publicly reporting health care information". MNCM's collaborative reporting activities are intended to reduce costs and increase efficiencies for medical groups, health plans and regulators. MNCM makes data available to the public online and in published reports.

As one of MNCM's participating health plans, Medica supplies clinical quality data to MNCM for aggregate measurement and reporting. The Senior Director of Quality and Clinical Advancement serves on the MNCM board of directors. Medica staff also serve various MNCM advisory committees and work groups.

© 2011-2023 Medica

PROGRAM SCOPE

QI Program Scope

The QI program encompasses a wide range of clinical and service quality initiatives affecting members, providers, employer and brokers, as well as internal stakeholders throughout Medica. This section describes the program's key focus areas, which include:

Access and Availability
Appointment scheduling and waiting time for emergency, urgent, routine and preventive care; primary care, specialist and facility availability in Medica service area.

Behavioral Health
Inpatient and outpatient mental health and chemical dependency/substance abuse services.

Care Management
Interventions to improve health, coordinate care and reduce health care variation and cost.

Claims Validation
Medical record audits at participating providers' offices as needed to verify that medical record documentation is consistent with services billed.

Clinical Review
Medical record review and facility surveys at participating providers' offices and facilities.

Complaints/Grievances and Appeals
Member or provider challenges to a medical necessity or benefit determination; complaints/ grievances related to coverage, benefits, quality of service and/or quality of care.

Complex Member Health Needs
Care management and support services for members with complex health needs, including disabilities, multiple diagnoses, or concurrent medical and behavioral health conditions.

Continuity, Coordination and Transition of Care
Continuity and transition of care for members when benefits end or providers leave the network; coordination of care across providers and disciplines (such as medical and behavioral health).

Credentialing and Recredentialing
Initial and recurring credentials verification for network practitioners and facilities.

Delegation Oversight
Performance oversight for vendors or care systems delegated by Medica to manage select health plan services.

© 2011-2023 Medica

Health Equity
Services and resources to assist a culturally and linguistically diverse member population, to mitigate health care disparities among populations served and to promote health equity across the communities and populations Medica serves.

Medicare Stars
Data analysis and improvement activities supporting Medicare Stars ratings.

Member Experience
Assessment of member experience with the health plan and network based on complaints, appeals, satisfaction surveys, member feedback and related data sources.

Member Rights and Responsibilities
Written and online information and educational materials for new and existing members.

Patient Safety
Activities to support and/or promote safe clinical practices for health plan members and in the community.

Performance Improvement Projects (PIPs, QIPs, CCIPs)
Focused activities to improve clinical outcomes and/or service utilization for select Government Programs member groups.

Pharmacy
Formulary development and maintenance; prior authorization and formulary exception processes; oversight of pharmacy benefits manager (PBM) contracted for network management and claims processing.

Population Health
Enterprise-wide activities to assess and stratify members at the population and sub-population level, and to deliver targeted interventions based on risk level.

Preventive Health Guidelines
Development and dissemination of evidence-based preventive health guidelines.

Provider Relations and Provider Network Support
Provider education, best practice sharing, and community collaboration; partnership with providers on targeted projects to improve clinical outcomes; pay-for-performance program; medical home/clinic based chronic care management; provider-facing gaps in care.

Quality and Cost Information
Activities to collect, analyze and disseminate information about providers' quality and safety performance, as well as cost comparisons among physicians and hospitals.

© 2011-2023 Medica

Utilization Analysis
Program and data analysis to identify utilization patterns with potential adverse member impact: over-, under- or misutilization.

Self-insured health plan options or individual employer groups may opt out of selected aspects of the QI programs, such as disease management or behavioral health utilization management.

© 2011-2023 Medica

Access and Availability

Medica's Network Management and business segment departments work to ensure that provider networks have sufficient numbers and types of practitioners to serve the unique needs of each Medica population. Medica maintains standards for access to and availability of primary and specialty care practitioners and general hospitals. Geographic access reports, site visit reports, member demographics, member complaints and member satisfaction data, including CAHPS, are analyzed to evaluate performance against standards and identify improvement opportunities. Medica also measures appointment availability through practitioner surveys. The Access and Availability Committee, reporting to the Quality Subcommittee, reviews access and availability reports and recommends improvements when needed. The Access and Availability Committee also reviews health care access issues and improvement strategies identified by the Health Equity Committee.

Behavioral Health

Medica delegates medical management of mental health and chemical dependency services to its behavioral health vendor, Optum Health Behavioral Solutions (also known to members as Medica Behavioral Health, or MBH). Under this arrangement, MBH is responsible for behavioral health call triage and member referrals. MBH also provides a credentialed behavioral health provider network for all Medica products.

MBH's regional vice president, a licensed behavioral health practitioner, is ultimately responsible for the behavioral health QI activities Medica has delegated to MBH. MBH's medical director and its Director of Clinical Operations are also behavioral health practitioners; the Director of Quality Improvement is a licensed professional clinical counselor.

Medica collaborates with MBH to evaluate quality of care and service, implement improvement programs, and to measure the vendor's compliance with the performance standards in its contract with Medica. MBH partners with Medica on complex case management for Medica members with severe or complex behavioral health conditions.

Performance standards for MBH include, but are not limited to:

- Access and availability (geographic access, telephone statistics such as percent of calls answered within 30 seconds, call abandonment rate)
- Utilization measures (admission rates, average length of stay, penetration, ambulatory follow-up, re-admission rates, clinical non-authorizations and overturns, compliance with regulatory standards)
- Member services (complaints and turnarounds, appeal timeliness, requests for change of providers, member and provider satisfaction rates)
- Clinical quality measures (referrals to/from Medica Care Management, symptom reduction, medication compliance, appointment compliance)

© 2011-2023 Medica

Medica also monitors MBH's performance against benchmarks for claims payment, financial accuracy and credentialing of provider organizations and practitioners. The Delegation and Subcontractor Oversight Committee and its subcommittees are responsible for overseeing the vendor's performance.

Medica's Director of Behavioral Health supports the quality program through organization-wide leadership, strategy and consultation related to behavioral health programs and initiatives, including clinical leadership and oversight of Medica Behavioral Health.

Claims Validation

Medica's Claims Validation program evaluates potential inconsistencies between services billed by care providers and services documented in medical records. Claims validation may take place as part of a regulatory audit, or as requested to investigate a specific clinical quality issue. Nurse reviewers from Medica's Quality Improvement department visit primary and specialty care clinics to audit a sample of medical records against claims submitted to the health plan. Audit results are used to confirm regulatory compliance and to identify opportunities for clinics to improve coding and documentation practices. Any findings suggesting possible billing abuse or fraud are referred to the Medica Special Investigations Unit for follow-up. Findings suggesting possible clinical or service quality issues are referred to the Quality Improvement team for investigation.

Care Coordination

Medica offers care coordination services to eligible members in select Government Programs plans (such as Medicare/Medicaid dual-eligible and Special Needs Plans products). Care coordination services include an annual health risk assessment with person-centered plans of care. Care coordinators are RN's, LSW's or behavioral health specialists. Care coordination includes referrals to community resources, medical and or behavioral health providers, and other programs within Medica from which the member may benefit. The goal of the program is to identify and service members with high health care risks and utilization and to strengthen community partnerships with clinics providers, homeless shelters, counties, community resources that serve the same populations. Program outcomes are designed to ensure timeliness of health risk assessments, manage clinical and member utilization measures as well as member satisfaction with care coordination services all designed to improve the member's overall health care experience.

Care Management

Medica strives to improve member health outcomes by offering comprehensive, member-centric programs to support coordinated care across the continuum of health risk, offering programs for members who are healthy and those who are living with long-term chronic illness. Programs include, but are not limited to:

© 2011-2023 Medica

- Complex case management
- Condition management
- Healthy Pregnancy Program
- Tobacco cessation program
- Transitions of care
- Transplant case management
- Advanced illness management

Care management programs are described in greater detail in the Care and Utilization Management Program Descriptions section of this document.

Clinical Review

Medica conducts medical record reviews, broken out by patient population (Commercial and IFB, Medicare and State Public Programs), at participating clinics in each of the primary care specialties. Reviews may be virtual, on-site or both. The reviewers, registered nurses from Medica's Quality Improvement department, compare medical record documentation to measurable criteria based on USPSTF (US Preventive Services Task Force) guidelines. Medica designed its own review program, Clinical and Service Quality Review (C&SQR), for this purpose. C&SQR is a continuous quality improvement program that evaluates record-keeping systems, medical record contents and practice patterns. C&SQR supports patient care and desirable health outcomes by ensuring availability of complete medical record documentation. The program includes provider education to improve documentation and reduce practice variability. C&SQR data collection also supports Medica's access and availability and credentialing programs. The C&SQR review is administered to established clinics in the Medica network. Staff also perform initial site surveys as needed for new organizational providers lacking a current state or federal site audit.

Complaints/Grievances and Appeals

Medica reviews and tracks all types of written and verbal complaints (known as grievances for Government Programs and for Wisconsin-regulated plans) and appeals from members and practitioners. Medica's Customer Service centers manage non-clinical complaints and appeals and the Clinical Appeals team manages medical necessity appeals. Each department maintains procedures for registering, investigating and responding to complaints and appeals, and for notifying the petitioner of the outcome. For members eligible for external review, Medica has processes in place to forward appeals to the appropriate independent review organization.

The Quality Improvement team investigates quality of care complaints for all products. Medica investigates all quality of care complaints it receives according to established policies and procedures. Allegations may involve clinical or service quality performance. Quality Improvement staff review all reported complaints for trends and patterns that might indicate poor practitioner or provider quality, as well as for sentinel events that resulted in actual or

© 2011-2023 Medica

potential patient harm. Staff also review clinical or service quality issues discovered through sources such as referrals by other Medica departments, the Credentialing Subcommittee, publicly-reported state regulatory findings, or media reports. The Quality Review Oversight Committee reviews the cases in progress to ensure effective case handling and appropriate follow-up. The committee also identifies clinical care and patient safety implications and recommends action when needed. Such action may include a referral to the Credentialing Subcommittee, which retains final authority to recommend suspending or revoking the network participation status of any provider not meeting Medica's performance standards. Quality of care investigations are protected under state peer review laws; as a result, investigations and outcomes cannot be shared with members or with any internal or external stakeholders not covered under peer protection.

Complex Member Health Needs

Medica offers a variety of case management and support services to members with complex medical and/or behavioral health needs. Much of this activity occurs within Medica's case management and Integrated Care programs, described in detail under "Clinical Programs".

Medica offers additional supports for members enrolled in Special Needs Plans (SNPs) and Senior Care Dual Solution plans. Enrollees in these plans are assigned a care coordinator, who identifies members with complex health needs through initial and ongoing assessments. The frequency and type of support provided is determined by identified health risks, member wishes, available benefits and community support services.

Medica collaborates with its behavioral health vendor, Optum Behavioral Health branded for members as Medica Behavioral Health or MBH), to manage and support members with co-existing medical and behavioral health conditions. Multiple referral pathways are in place to forward cases to and from appropriate parties at Medica and MBH. Medica and MBH staff meet regularly to plan, implement and monitor medical/behavioral health collaborative initiatives.

For Medicaid members with physical disabilities or other transportation barriers, Medica offers Provide-a-Ride, a service providing transportation at no cost to the member to and from medical, dental and behavioral health appointments.

For all product types, Medica Customer Service serves hearing-impaired members through the National Relay Center, as well as offering local and long-distance TTY access. Medica employs bilingual customer service staff who speak the most common non-English languages used by Medica members. For other languages, Medica uses an external translation service for telephone translation assistance.

Continuity, Coordination and Transition of Care

Medica maintains policies outlining members' rights to continuity, coordination and transition of care. Medica follows state and federal laws governing members' rights to continue care or

© 2011-2023 Medica

maintain standing referrals with out-of-network practitioners. Care managers will help members with special needs (such as chronic illness or advanced pregnancy) arrange to continue care for a defined period with a provider whose Medica contract has terminated, and will help locate alternate providers appropriate to assume the patient's future care. Health Services staff also assist members with care transitions when their benefits end, or when pediatric members are ready for transition to adult care.

If a provider is terminated "for cause" (poor quality of care, legal violations or similar malfeasance), Medica does not authorize continued care that could jeopardize a member's health or safety.

Continuity, coordination and transition of care are described in greater detail in the Care and Utilization Management Program Descriptions section of this document.

Credentialing and Recredentialing

Medica evaluates all practitioners' qualifications and practice history before admitting them into the network. Providers with active contracts are recredentialed at least every three years, taking into account site survey data and quality of care complaint history. Medica maintains a credentialing plan and policies and procedures to support these processes. Complaints or concerns about a practitioner's quality of care or service are included in the Credentialing Subcommittee's review of recredentialing applications. As a peer review body, the Credentialing Subcommittee performs individual case reviews in response to quality of care concerns.

Medica maintains a Credentialing Plan, updated annually, that describes the credentialing program and processes in detail.

Delegation Oversight

Medica's delegates must comply with the same regulatory, accreditation and performance standards Medica follows itself. Medica remains ultimately accountable for its delegates' performance. Staff from the Clinical Services and Compliance departments coordinate oversight subcommittees and document oversight activity. The Delegation and Subcontractor Oversight Committee (DSOC) has the authority to approve new delegation, and may advise senior management to consider limiting or rescinding delegation if a delegate is consistently noncompliant.

Medica delegates to a limited number of vendors and care systems. Delegated functions may include quality improvement, network management, utilization management, complaint management, credentialing, and "member experience" functions such as grievances and appeals, health information line and online health and wellness tools. Each delegate must submit regularly scheduled activity reports and supporting data throughout the year. Medica staff analyze these reports and present findings and concerns to the DSOC and its oversight subcommittees.

© 2011-2023 Medica

The DSOC maintains procedures for assessing and approving requests for new delegation. After the applicant submits an assessment questionnaire, Medica conducts a site visit and file review. The DSOC reviews the results and recommends approval (with or without corrective actions) or denial. If the request is approved, the applicant's contract manager works with the DSOC to ensure that the new delegation agreement includes all required elements.

Health Equity

Medica is committed to providing equitable health services to the diverse communities and populations it serves. Medica's Senior Director for Diversity, Equity and Inclusion (DEI) leads the design, development and implementation of DEI strategies and programs, and serves as a collaborative partner to the community as well as a trusted advisor to Medica's senior leadership. The DEI director also serves on the Health Equity Committee.

To serve its culturally and linguistically diverse member population, Medica offers a variety of services, resources and tools to members, providers and employees. Medica employs call center representatives who speak Spanish, Russian, Vietnamese, Hmong and Somali, the non-English languages most commonly spoken by our members. Medica also contracts with an external translation service to assist members speaking other languages. Medica uses census data, member forum feedback and language line usage data to predict and measure demand.

Medica's online provider directory allows members to search for a physician by language spoken. Other online resources include an "Ask Your Doctor" checklist translated into four non-English languages and links to a statewide health resources directory listing services available to refugees and immigrants. Medica's Provider College developed the "Walking in Their Shoes" training program to help providers and office staff build cross-cultural communication skills. Medica also offers providers translated signage with messages in English, Spanish, Hmong, Somali and Russian, as well as multilingual checklists for patients to use when preparing for a visit. The provider pages on the Medica Web site also feature links to local and national cultural competency resources.

Health care disparities have been a long-standing priority for the Medica Foundation, which annually awards grants addressing health care needs in underserved, culturally diverse communities. Grants have been awarded to a variety of local nonprofit organizations to address health literacy, to provide information needed to navigate the health care system, and to improve quality and utilization of preventive care.

© 2011-2023 Medica

Medicare Stars

The Center for Medicare and Medicaid Services (CMS) has established a five-star rating system (Medicare Stars) for health plans offering Medicare products. CMS assigns Medicare Stars based on ratings of clinical measures, member survey data and health plan operations. Medicare Stars are publicly reported on the medicare.gov Web site as a plan selection tool for enrollees. Four- and five-star plans are eligible for CMS bonus payments; five-star plans are also able to offer year-round open enrollment. Medica is committed to achieving the highest possible Medicare Stars ratings to maintain profitable growth and a strong presence in the Medicare market.

The Medicare Stars team in the Quality Improvement department is dedicated to Stars data analysis and improvement. The team analyzes key data to establish baselines and targets, segmenting and stratifying data for specific population impact. Team members execute quality improvement initiatives for targeted measures and populations by working across the business segments, within Clinical Services and in collaboration with members and providers. These initiatives are documented on an action plan included in the annual Quality Improvement Work Plan. The Clinical Quality Committee monitors progress toward goals.

Member Experience

Medica responds individually to every complaint it receives. Complaints and appeals provide valuable information about drivers and causes of member dissatisfaction. Work groups made up of call center staff and other key stakeholders regularly analyze clinical and non-clinical complaints and appeals to identify trends and areas for improvement. Findings are reported to the Service Quality/Member Experience Committee, which also reviews member experience indicators including CAHPS and QHP survey results and market research data and member survey findings.

Member Rights and Responsibilities

Medica works to ensure that potential and current members receive the information they need to be informed health care consumers. Member materials, available online or in print, explain benefit coverage and the process for obtaining primary and specialty care. Medica offers translated materials for non-English-speaking members, relay and TTY services for hearing-impaired members, and has dedicated customer service staff to help members with language barriers or other cultural or special needs. Members may contact Medica Customer Service, or log on to the mymedica.com Web site, for information about health care costs, such as estimated costs for common procedures, physician reimbursement, and member out-of-pocket expenses. Medica also informs members how to complain or appeal to the health plan, to the appropriate regulatory agency, or to an external reviewer when applicable. Dedicated Customer Service staff are available to help members file complaints or appeals.

© 2011-2023 Medica

Patient Safety

Medica supports patient safety through a variety of programs and projects. Efforts vary in scope, focus and method, but all are designed to:

- Promote and ensure safe clinical practices;
- Reduce or eliminate errors;
- Protect and assist vulnerable patients; and/or
- Provide members with quality and safety information.

Ongoing programs that contribute to patient safety include, but are not limited to:

- Clinical Review (Clinical and Service Quality Review, medical record review)
- Credentialing and recredentialing activities
- Quality of care case investigations
- Targeted quality reviews: skilled nursing facilities, opioid prescribers
- Performance-based incentives that reward providers for implementing safe clinical practices

These programs are described in greater detail elsewhere in this section.

Medication therapy management (MTM) is a significant patient safety initiative for Medicare Part D enrollees. Specially trained pharmacists are contracted to work one-on-one with members to help them achieve safe and effective results from their drug regimens. The MTM program includes an annual medication checkup during which the pharmacist reviews the member's medication profile to detect any potential conflicts or duplications. Also included in MTM are compliance monitoring, patient education, drug therapy problem resolution and assistance with over-the-counter medications.

In addition to investigating quality of care complaints, Medica also conducts targeted quality of care investigations to assure safe clinical practices. Investigations may focus on a single practitioner or group, or on multiple providers with similar practice patterns. Recent investigations have addressed opioid prescribing patterns and patterns of treatment outside the community standard of practice.

Medica makes patient safety information available to members via Web links on medica.com that connect to consumer safety tools and to hospital safety data.

Performance Improvement Projects (PIPs, QIPs, CCIPs)

Each year, Medica undertakes several structured quality improvement activities targeted toward select Medicaid, MSHO (Minnesota Senior Health Options) or SNP (Special Needs Plans) members.

Performance Improvement Projects (PIPs) are approved by and reported to the Minnesota Department of Human Services (DHS). PIPs are often multi-year initiatives with several

© 2011-2023 Medica

measurement cycles, and are sometimes undertaken in partnership with other local health plans and community partners.

Quality Improvement Projects (QIPs) are required by the Centers for Medicare and Medicaid Services (CMS). PIPs and QIPs may address the same topics, or can vary depending on priorities for each population. CMS requires health plans to launch a new QIP each year and may direct plans to select a specific topic.

Chronic Care Improvement Projects (CCIPs) are also required by CMS. Like QIPs, they are focused on topics that CMS selects. The implementation team compares initial results to the project goal, with re-measurements set at appropriate intervals to monitor sustained improvement.

PIPs, QIPs and CCIPs are directed toward systematic improvements in member health status, functional status, and/or satisfaction. Project effectiveness is measured by indicators based on valid and reliable data. Each initiative addresses a clearly-defined problem or issue; is based on current clinical knowledge or health service research; has defined, measurable targets or goals; and is documented in the approved DHS or CMS format. Projects are designed to achieve and sustain demonstrable improvement.

PIPs, QIPs and CCIPs are documented annually in the Quality Improvement Work Plan. Formal project documentation is submitted to DHS and CMS as required.

Pharmacy

Medica contracts with a Pharmacy Benefits Manager (PBM) vendor, Express Scripts, Inc. (ESI), to administer Medica's pharmacy benefit. ESI has the capability to provide a full range of PBM services including claims processing, network management, clinical support, reporting and drug utilization review (DUR). Medica's own Pharmacy Management department is staffed with licensed registered pharmacists who manage Medica's outpatient prescription drug benefit.

The Pharmacy department also manages the Medication Therapy Management (MTM) program available to qualifying Medicare Part D enrollees. Members meet one-on-one with a pharmacist to review their medications, develop a care plan and arrange for follow-up as needed.

The Vice President of Health Services directs the Pharmacy staff responsible for overseeing network Pharmacy Benefit Manager (PBM) operations and supervising the Pharmacy Management department and its formulary management activities.

The Pharmacy program is described in detail in the Care and Utilization Management Program Descriptions section of this document.

© 2011-2023 Medica

Population Health

The goal of Medica's population health management program is to maintain and improve the physical and psychosocial well-being of individuals and to address health equity and disparities through cost-effective and tailored health solutions. Whether through program design, benefit design, network design, provider and vendor relationships, online resources or Medica Foundation grants, Medica focuses on addressing individual member health needs at all points along the continuum of care.

Medica's annual population health strategy document outlines activities and goals in the following areas:

- Keeping Members Healthy
- Managing Emerging Risk
- Patient Safety and Outcomes Across Settings
- Managing Multiple and Complex Conditions

Activities range from member resources and self-management tools to post-hospitalization transition support and complex case management. The annual Population Health Strategy document describes programs in detail.

Preventive Health Guidelines

Medica has adopted evidence-based preventive health guidelines from the US Preventive Services Task Force that address primary prevention and early detection of illness and diseases. Guidelines cover such topics as cervical cancer screening, breast cancer screening, child and teen check-up programs, and pneumococcal immunization. These guidelines and programs have been adopted with the involvement of actively practicing physicians in the Medica network.

Provider Relations and Provider Network Support

Medica collaborates with its provider network in several ways to support improved quality at the care delivery site: for example, by working directly with providers on targeted projects to improve clinical outcomes. Other examples include, but are not limited to:

- **Provider College**: Operated by Medica's Provider Commerce department, Provider College offers continuing education for practitioners and office staff. For example, Provider College offers all network providers a comprehensive "train-the-trainer" kit on health literacy and cultural competency. Other educational opportunities, on topics ranging from coding and billing to Medica health plan products, are offered on an ongoing basis.

- **Clinical Review**: Clinical reviewers from the Quality Improvement team gather data from clinics that achieve the best results in certain areas, including patient compliance with

© 2011-2023 Medica

treatment recommendations. Results are reviewed and shared with clinics on an individual basis.

- **Pay-For-Performance Program:** Medica offers its providers a pay-for-performance program that provide financial rewards to providers driving care improvements and achieving evidence-based outcomes. The incentives correspond to clinical priorities for the health plan that have reliable measures within providers' control.

- **Minnesota Community Measurement**: Medica is a member of Minnesota Community Measurement, a nonprofit organization founded by the Minnesota Medical Association and Minnesota's nonprofit health plans to improve health care quality in Minnesota. Minnesota Community Measurement is described in greater detail in the "Program Staff and Governance" section of this document.

- **Medical Home/Clinic-Based Chronic Care Management:** Medica works closely with its network providers to support the "medical home" model, in which-patients' care is coordinated through a primary care site and chronic conditions are monitored and managed. Medica supports medical homes in ACO contractual relationships by supplying information regarding member utilization inside and outside the ACO to promote care continuity and chronic condition management.

- **Total Cost of Care Contracts**: Medica works with providers to better manage quality and cost through risk-based contracts whereby providers are measured on their performance to specific quality metrics and their overall PMPM cost trends.

- **Accountable Care Organizations**: Medica contracts with providers to create accountable care organizations (ACOs). Medica and the ACOs share risk for member claims expense and work to remove duplicate care management services across the continuum of care.

Quality and Cost Information

Medica makes information about its providers' quality and safety performance available to members, providers and purchasers. Medica prepares "Provider Report Cards" for select large clinic groups. Medica's "Focus on Quality" Web page provides links to numerous quality resources, including Minnesota Community Measurement (clinic performance comparisons), ICSI (consumer-friendly care guidelines), and the federally-sponsored Hospital Compare tool (hospital quality and safety comparisons).

Medica also provides tools and resources for members to learn more about health care costs. The "Health Care Cost and Quality Toolbox", an online resource available to Commercial members through the mymedica.com Web site, allows members to compare costs for common outpatient procedures, as well as for clinic-based treatment for common medical conditions.

© 2011-2023 Medica

Utilization (over-, under- or mis-utilization of services)

Medica monitors the impact of its UM program to detect and correct potential under-, over- and mis-utilization of services. Utilization review data are reported to the Care and Utilization Management Committee. Opportunities for improvement are identified at least annually. Utilization monitoring is also included in Medica's oversight of behavioral health delegation. Medica staff, delegates, contractors and vendors are prohibited from accepting any financial incentives that may influence utilization decisions. The Care and Utilization Management Program Descriptions section of this document outlines utilization monitoring and the utilization-related activities planned for the year.

© 2011-2023 Medica

Care and Utilization Management Program Descriptions

Clinical Engagement

- ACO Value Based Program

Utilization Management

- Inpatient Notifications
- Prior Authorization
- Clinical Appeals
- Continuity of Care
- Clinical Resources
- UM and Coverage Policies
- Healthcare Guidelines
- Inter-Rater Reliability
- Staff Involved in Clinical Decision-Making
- Behavioral Health Utilization Management
- Auditing and Monitoring

Pharmacy Services

- Pharmacy Strategy
- Core Functions
- Formulary Development and Committees
- Vendor Oversight

Care Management

- Care Model Framework
- Complex Case Management
- Community Navigation
- Advanced Illness Program
- Transitions of Care
- Transplant Program
- Medica Kidney Care Program
- Complex Pregnancy Program
- High-Cost Member Program
- Care Coordination Program
- Disease Management
- Behavioral Health Care Management

Health and Wellness

- Health and Wellness Strategy
- Online Health and Wellness
- Nurse Triage and Advocacy Services
- Senior Fitness
- Tobacco Cessation

© 2011-2023 Medica

Clinical Engagement

ACO Value Based Program

Clinical Engagement Strategy

Medica establishes accountable care organization (ACO) networks through risk based contracts in which the ACO is financial encouraged to improve the quality of care delivery, health of their population while also reducing overall cost. These contracts have been successful in holding both the ACO network and Medica responsible to achieve overall healthcare delivery.

The purpose of the ACO Value Based program is to approach to clinical engagement with the intent to:

- Improve member care, service, experience, access and/or safety; and/or
- Improve service to practitioners, providers, employers, brokers and other customers and partners; and/or
- Improve Medica's internal operations related to population health, care management, utilization management, service, experience, access and patient safety

The ACO value based program is designed to engage our accountable care organization (ACO) networks and partners with clinical data, strategic clinical direction and risk based contract agreements. In order to ensure meaningful, actionable information for the ACO networks, these clinical reports provide strategies on improvement opportunities through quarterly meetings and on an ad hoc basis. The goal of the quarterly meeting is to establish strategic direction, monitor status towards population health goals and identify additional clinical opportunities.

The ACO Value Based teams works closely with the ACO case management team(s) to gain an understanding of how complex members are managed within that network, offering assistance, and guidance when needed to ensure that these members are receiving appropriate support. In addition the ACO value based team works in collaboration with Medica's case management teams to ensure complex members are receiving needed care and that resources are being used appropriately.

The ACO Value Based program works in partnership with Medica's utilization management team and ACO networks to manage referrals for specialists, transplant services, and Centers for Excellence to evaluate medical necessity, appropriateness and efficient use of health care services and resources.

Eligible Populations

The Medica DSS program serves the following Medica business segments.

Commercial Markets Division

- Medica Health Plans: HMO, POS
- Medica Insurance Company: PPO
- Medica Self-Insured: PPO

© 2011-2023 Medica

Government Programs

- Medicare Advantage

Individual and Family Business (IFB)

- Medica Health Plans: Marketplace POS
- Medica Insurance Company: Marketplace PPO (OK), Marketplace EPO (IA, NE, KS, MO)
- Medica Health Plans of Wisconsin: Marketplace PPO (MN, WI)

Data Sharing

The ACO Value Based program routinely monitors and analyzes data from a variety of sources, including:

- Claims (showing utilization rates, disease prevalence by population, potential over- and underutilization)
- Pharmacy data
- Emergency department and inpatient data
- Enrollment data
- Enrollment in health and wellness programs
- Enrollment in complex case management
- EBM Gaps in Care: data analytics showing gaps in members' health screenings and outcomes
- Hierarchical Condition Category (HCC) Gaps in Care
- Health Assessment (for select populations)
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Internal audits of Medica's utilization review, case management and grievance and appeals processes
- Medicare Stars current and projected ratings
- Member complaints and appeals
- Member demographic data
- Member and practitioner satisfaction surveys, including Consumer Assessment of Health Plans Study (CAHPS)
- Utilization data from care management software applications

Medica collects, manages and integrates data from a variety of sources and systems for its ACO Value Based programs. Medica uses both purchased and internally-developed software products to meet its ACO Value Based goals. Examples include, but are not limited to:

- **Altruista Guiding Care:** Used for care management, utilization management, appeal management and complaint/grievance management.
- **Johns Hopkins ACG Case-Mix System**: Risk assessment software that processes medical, behavioral and pharmacy claims to identify potential Health and Wellness coaching and case management participants, as well as Special Needs Plans (SNP) members at high risk for hospitalization.
- **Cosmos:** Claims processing platform
- **UNET**: Claims processing platform
- **Health Rules**: Claims processing platform

© 2011-2023 Medica

Medica's data systems have standard and customized reporting capability. Medica can generate reports on medical record and claims data sorted by multiple variables, including patient, provider, diagnosis and procedure. Other report types include program activity, history and performance trends.

Medica has mechanisms to ensure that information received from service providers is accurate, complete and readily available to the health plan or to regulators when needed. Data accuracy is monitored through activities including claim and coding audits, quality studies and fraud/abuse investigations.

Comprehensive data is then shared with the ACO networks to assist with delivery system support. This data is both transmitted electronically as "raw" data and as reports. This data is shared through a variety of reports on daily, monthly, quarterly, biannual and annual basis. Examples include, but are not limited to:

- Daily
    - **Daily admissions report:** Used to provide ACO networks with an understanding of members who have been readmitted, within the past 30 days, both inside and outside of their healthcare system. This report is able to provide ACO networks a view they have not traditionally been able to capture through internal readmissions reports as the ACO can capture admissions to out-of-network facilities.
- Monthly
    - **Monthly member list:** Used to provide ACO networks with a complete list of membership, including enrollment data. Examples of data provided include current and predictive ACG risk scores, utilization markers, care coordination and conditions along with the predictive medication possession ratio. Additional information on risk adjustment are also available within this report.
    - **Claims data file:** This is a full claims file sent to the ACO network on a monthly basis. There is no additional analysis done on this file by Medica and is designed to provide the ACO with their raw data for their analysis. Data in this file includes, that mentioned above as well as utilization by specialist, urgent care clinics and other care providers both in and out of network.
- Quarterly
    - **Population analysis:** Provides the ACO network with a high level overview of their member population compared to similar ACOs and open access networks. This data includes ACG risk indicators, ED inpatient and outpatient utilization rates, top diagnosis based on cost and treatment groups. This report also provides a look back over the past year so that the ACO network is able to track and trend performance overtime.
    - **Cost model report:** This report provides the ACO network with the ability to view claims and utilization across the inpatient, outpatient, professional, pharmacy and additional settings of care. Similar to the population analysis report ACOs are able to compare to similar ACO networks
    - **Direct and indirect cost report:** Provides the ACO the ability to view claims both in and outside the ACO network. This report provides the ACO network with the

© 2011-2023 Medica

ability to view claims and utilization across the inpatient, outpatient, primary care, specialty care emergency room and additional/other care areas.
    - **Indirect high user report:** This report provides further detail into out-of-network claims. It examines the top five high users for the top five out-of-network high spend facilities. This report also provides the ACO network with the ability to view claims and utilization across the inpatient, outpatient, primary care, specialty care emergency room and additional/other care areas.
    - **Pharmacy utilization reports:** The pharmacy reports provide ACO networks with the ability to view high cost prescriptions across settings of care and top opioid prescribers.
        - The top opioid prescriber report provides additional information on provider, member, prescription, total prescriptions and total quantity dispensed.
        - The high cost prescription report provides additional information on PMPM utilization, drug mix, and cost per unit. The report provides data analysis on the top ten prescription drug claims, top five providers by claimed amount and top five places of service by claimed amount.
- Annual
    - **Inpatient report:** Provides ACO networks with an annual look back at their total inpatient admissions with comparison to similar ACO networks. ACOs are provided data analysis on their top 20 DRGs, both by admits and visit count, average length of stay, 30-day readmissions along with top 10 readmission DRGs, as well as hospital admission locations. This provides the ACO with the ability to see both in and out-of-network admissions that may not have had the ability to see otherwise.
    - **Emergency department report:** Provides the ACO networks with an annual look back at their total emergency department utilization. ACOs are provided data analysis on their top 20 DRGs, both by number of ED visits and by rate difference expressed as visit count, potentially avoidable ED visits, ED visits resulting in hospitalization, as well as a breakdown of ED visit locations. This provides the ACO with the ability to see both in and out-of-network ED utilization that they may not have had the ability to see otherwise.
- Additional reporting
    - **Ad hoc reports:**
        - **Gaps in care:** Provides ACO networks with an understanding of which members are or are not utilizing appropriate care. This report identifies patients who miss routine preventative testing based on their age and sex. These gaps in care align with HEDIS measures.

To continue to enhance the abilities of the ACO networks to care for their population we provide additional support based on emerging trends and needs identified through data analysis and collaborative discussion.

Practice transformation support

Medica is committed to assisting healthcare organizations and systems to become an integrated practice. With each of the ACO networks we are conducting an ACO assessment. The assessment is completed in partnership with the ACO and is meant to capture the ACOs

© 2011-2023 Medica

progress, real and perceived, on the continuum of ACO performance using the current best available information. It is a snapshot in time and is viewed as an opportunity for structuring dialogue and targeting key areas together, as the ACO moves forward to improve the care of patients and members involved in the performance of the ACO product.

Key areas reviewed with each ACO include organizational culture, population management (patient care), population management (technology, analytics and HIM), and member experience and outcomes measurement (quality and financial). These were chosen from both internal documents and national evidence based literature. Medica identified these 5 areas as key components for a successful payer-provider ACO partnership.

Results will be discussed with the ACO with the goal to develop a meaningful work plan to address identified areas of improvement. The ACO assessment and work plan will be an ongoing collaborative dialogue aimed at improving population health.

Comparative quality and cost information on selected specialties

Annually ACO networks are provided a Provider Quality Metrics Report. Medica tracks a select number of quality metrics from the Healthcare Effectiveness Data Information Set (HEDIS) for each population and provider system. The measures selected for the report are of the highest priority for movement and impact among all HEDIS measures for Medica in the current year.

Attribution methods used in this report to determine a member's provider include first using assigned relationships at enrollment, then World attribution methods for open access members. Risk adjustment is performed for the utilization metrics to ensure that changing risk profiles will be accounted for when comparing performance from one year to the next. General Linear Modeling is used to estimate utilization probability at an individual level based on age, gender, product, months enrolled, and ACG Concurrent CRI Risk Factors. This utilization probability was incorporated into the utilization metric by adjusting exposure (i.e., the Denominator). Therefore, the higher the exposure risk the lower the utilization metric. In this report ACO networks are able to compare their performance to other ACO as well as the total population in that particular product (i.e. commercial, individual and family business).

ACO networks are also provided with an annual Episode Treatment Group (ETG) report. In this report Medica uses the episodes attributed based on the provider with the maximum of professional allowed. Providers must have at least 30% of professional allowed to be included in the report. Episodes are limited to complete, non-outlier and exclude low volume and ambiguously defined ETG categories. Similar to the Provider Quality Metrics Report ACO networks are able to compare how they are performing to other ACOs as well as the total population for that product (i.e. commercial, individual and family business).

Comparative pricing information for selected services

Medica provides ACO networks with comparative pricing information through our cost model report and population analysis report.

The cost model report provides a summary of the major service category, for inpatient, outpatient, professional and pharmacy. In this summary the ACO network is able to view their total allowed, PMPM and PMPM % of total. The ACO can then compare their costs to other ACO

© 2011-2023 Medica

PMPM, their cost variance compared to other ACO networks, the average cost per unit and utilization per 1,000 members. ACOs are also provided additional information cost information and comparison for top Milliman HCG categories both for facility inpatient and facility outpatient services.

The population analysis report provides the ACO network with a high level overview of their population compared to similar ACOs and open access networks. This data includes ACG risk indicators, inpatient, ED and outpatient usage rates, top diagnosis based on cost and treatment groups. This report also provides a look back over the past year so that the ACO network is able to track performance overtime.

Additional activities

To continue to enhance the abilities of the ACO networks to care for their population, we provide additional support based on emerging trends and needs identified through data analysis and collaborative discussion.

Examples of this additional analysis included a focused look at emergency department utilization and inpatient readmissions to uncover any trends in which there would be opportunities to decrease utilization through evidence based practice decision making resources. ACO networks that are experiencing a higher utilization are provided their data, areas of opportunity and resources to assist in engaging providers in utilization discussions.

Another area in which Medica engages its ACO networks is through an annual summit in which all of our ACOs come together to learn best practices from one another. This two day event is focused on predictive modeling, analytics for population stratification, leveraging EMRs for population health management, evidence based practice for population health management, innovations in care delivery and best practices in clinical practices and models to achieve improved quality and reduced cost and best practices in addressing health disparities and access, i.e. access to rural health care, behavioral health integration.

© 2011-2023 Medica

Utilization Management

Utilization Management delivers a variety of interventions to improve health and reduce health care variation and costs. Utilization Management interventions include traditional utilization review including prior authorization, retrospective review, clinical appeals and inpatient admission notification management. In addition, Utilization Management is responsible for medical policy management, staff assessment, and adherence to all regulatory requirements.

The Medica Utilization Management (UM) program is aligned with the Medica Population Health Management strategy and supports the delivery of appropriate care through a variety of interventions intended to improve health, improve clinical and service quality and reduce health care variation.

Inpatient Notifications

Daily admission notification information is captured in Medica's documentation systems via electronic (278) transactions, provider portal transactions or faxed notifications entered by Medica Review Coordinators on the Utilization Management team. This information is extracted from the documentation systems and combined with claims, the Johns Hopkins Adjusted Clinical Group System (ACG®) and prior admission notification data to identify members at greatest risk for hospital readmission. The output of this admission risk stratification process is a daily admission report that is distributed to appropriate Medica care management teams, Accountable Care Organization (ACO) partners and member-specific Behavioral Health Homes (BHH). Upon receipt of the daily admission report, Medica care management staff reach out to our highest risk members post-hospitalization to assess and address member post discharge needs. The Medica approach to discharge support is based on the "four pillars" outlined in the evidence-based Eric Coleman Care Transitions model.

Prior Authorization

Medica requires prior authorization of certain medications, technologies, services and procedures. Clinical services requiring prior authorization are differentiated by product and included on the Medica prior authorization list found on Medica.com, addressed in plan documents and supported by a Utilization Management policy. As applicable, related coverage policies and clinical guidelines may also be referenced by the Utilization Management nurses and medical directors when making a decision regarding a prior authorization request.

Eligible Populations

All served populations are subject to prior authorization requirements as defined in their plan documents.

Timeliness of Utilization Management Decisions

Medica establishes and adheres to a set of standards that govern the timeframes for resolution and notification of utilization management decisions. Timeframes for decisions are determined by Federal and state requirements dependent on line of business. Utilization management decisions are made in a timely manner to accommodate the clinical urgency of the situation. Medica tracks turnaround time standards on a daily and monthly basis. Cases found not to meet

© 2011-2023 Medica

the established standards are reviewed by department supervision and affected staff. Corrective actions are implemented as appropriate.

Utilization Review of Pre-Service Prior Authorization Requests

Medica completes review of pre-service prior authorization requests and delivers notification of decisions in compliance with state and federal regulatory guidelines. Medica will make UM decisions as soon as possible, taking into account the urgency of the situation. A pre-service prior authorization decision is any case or service that an organization must approve, in whole or part, before the member obtains medical care or services.

a. Pre-service, prior authorization, prospective or standard decisions refer to any case or service that the organization must review in advance of the member obtaining medical care or services.
b. Non-urgent concurrent decisions refer to any review for an extension of a previously approved ongoing course of treatment over a period of time or number of treatments; i.e. Skilled Nursing Facility.

Expedited Pre-service Prior Authorization Review

Expedited pre-service prior authorization review and notification is completed as expeditiously as the member's condition requires, but no later than 72 hours (24 hours for pharmacy requests) from receipt of the request for all products. Expedited pre-service prior authorization reviews are completed for any request for medical care or treatment, with respect to which the application of the time periods for making non-urgent care determinations:

a. Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function based on a prudent layperson's judgment, or;
b. In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request; or
c. The attending provider (either participating or non-participating) is making the request or believes an expedited determination is warranted; or
d. The service involves coverage of a concurrent hospital stay for medical care or mental health/substance abuse or the service involves the continuation of care in progress, such as
Skilled Nursing Facility (SNF) stay.

Inpatient Prior Authorization for Post-Acute Facilities

Post-acute facilities, including Skilled Nursing Facilities (SNF), Long term acute care hospitals (LTACH) and acute inpatient rehabilitation, are required to obtain a prior authorization for most member population admissions; requirements may vary based on member benefit plan. The requests for post-acute facility prior authorization are reviewed and managed by the utilization management team. Following prior authorization, inpatient utilization reviews are conducted for post-acute care facility stays; focusing on member transitional care needs. As appropriate, the utilization management team collaborates with case management and care coordination teams to support discharge planning and transition activities.

The purpose of an inpatient transition of care review is:

1. To determine that the patient's condition and/or course of treatment continue to require the level of care and the individual's care needs are being met.

© 2011-2023 Medica

2. To assure progression of care/advancement of the plan of care.
3. To identify and address issues and barriers related to discharge readiness and transitions.
4. To comply with contractual requirements.
5. To ensure efficient and effective use of resources.

Medica's inpatient utilization management (UM) policies and MCG Care Guidelines® are used for post-acute facility reviews to assist in the determination of medical necessity and appropriateness of admissions and/or continued stays. The criteria is not intended to be used without the independent clinical judgment of a qualified health care provider taking into account the individual circumstances of each member's case. The policies and guidelines are available for review upon request. When post-acute facility stays are found to be not medically necessary or not appropriate for the level of care, the provider is notified in order to obtain additional information to support the post-acute facility stay. If additional information does not present justification of appropriateness or medical necessity for the post-acute facility stay, a medical director review is conducted. When opportunities for supporting the care needs at the appropriate level of care are identified, an interdisciplinary approach across services and departments is solicited to respond to the opportunity.

Post-Service Retrospective Reviews

Post-service reviews are for care or services that have already been received (retro review). The review and notification of decision is completed within the same timeline as a pre-service review. This process applies to instances where a claim for the service has not been received or denied. Once a claim has been denied, the retro review process does not apply and the applicable appeal process should be followed.

Medical Information

When making a determination of coverage based on medical necessity, Medica obtains relevant clinical information and consults with the treating physician if necessary. Documentation that is consistently gathered to make relevant decisions (minimum data set) includes pertinent clinical information which should include, but is not limited to: outpatient and inpatient medical records, results of diagnostic studies, consultant reports, discharge reports/summaries and clinical notes. Additional documentation would include covered benefits as outlined in the benefit document, clinical criteria, and regulatory directives. When needed, a physician advisor or medical director may request a literature search and/or other relevant clinical or scientific information from the Medical Affairs Department as per department policies and procedures.

Denials

When Medica delivers an adverse determination related to coverage of a service, an initial determination to deny letter is sent to the member and requesting physician. The denial letter clearly explains the reason(s) for the denial and states appeal rights. In addition, a Medica physician advisor or medical director is available to discuss denials based on medical necessity.

Clinical Appeals

An appeal is a formal request, either orally or in writing, to reconsider a denial of benefits. The appeal may be a pre-service, post-service, or expedited appeal. Instructions on how to navigate the appeals process are available to the member, member representative, and/or the

© 2011-2023 Medica

requesting provider as described in the benefit document, by calling Medica's Customer Service Department and in the initial denial letter.

Information on how to initiate an appeal is sent to both the member and requesting provider upon any denial and is also provided in each benefit document. When additional assistance is required, the member is referred to the Customer Service Department or to a Medica Clinical Appeal staff member, who will facilitate their navigation of the appeals process.

Member appeals are received by any of Medica's Customer Service departments (Commercial, Individual and Family Business or Government Programs). The appeals are reviewed and classified as either an appeal for medical necessity (clinical) or as an administrative (contractual) appeal. Appeals involving medical necessity are forwarded to the Utilization Management and Clinical Appeals Department. The Customer Service departments manage administrative appeals or PBM appeals (Part-D appeals only).

Provider medical necessity appeals submitted by a practitioner/provider are received by the Utilization Management and Clinical Appeals Department directly or forwarded from the Provider Service Department.

Medica's appeal process includes the opportunity for the member or the member's representative to submit written comments, documents or other information relating to the appeal. The appeal process provides for individuals who were not involved in the initial determination and who are not subordinates of any person involved in the initial determination to review appeals. A physician of the same or similar specialty reviews clinical appeals, unless the initial determination did not involve a physician advisor or medical director decision and the appeal can be overturned. If Medica is unable to provide same or similar specialty review by their physician advisor or medical directors, the appeal review will be sent to Medica's contracted Independent Review Organization.

Timeliness of Appeal Decisions

Medica establishes and adheres to a set of standards that govern the timeframes for clinical appeal resolution and notification of appeals decisions based upon Federal and state requirements. Clinical appeal decisions are made in a timely manner to accommodate the clinical urgency of the situation. Medica tracks turnaround time standards on a daily and overall monthly basis. Appeal requests not meeting the established standards are reviewed by the department manager and affected staff.

Standard Review

Standard clinical appeal completion time for a first-level pre-service appeal process is 30 calendar days from the receipt of the request by Medica, except where individual state laws require a different timeframe. Commercial products may require a preliminary determination if Medica changes its denial rationale and notifies the member that they have an opportunity to submit additional information if desired. The Minnesota Department of Health requires appeal case completion in 15 calendar days from the receipt of the request by Medica. The Department of Human Services (Medicaid) requires an organization to make an appeal determination within 30 calendar days from the receipt of the request by Medica for written and verbal appeals. CMS (Medicare) requires that reconsideration be completed within 30 calendar days, for pre-service,

© 2011-2023 Medica

or 60 calendar days, for post-service, of the receipt of the request by Medica and seven days for Medicare Part D appeals. Medica's second-level appeal process, as described below, is considered to be voluntary as the member can bypass this appeal level and can proceed to either the external review described in the next section or Medica's second-level appeal process. The second-level appeal process is only applicable to certain lines of business as described in the member's benefit document.

To support and remain compliant with specific Minnesota Department of Health requirements in which Medica does business, Medica completes first-level pre-service and post-service clinical appeals within 15 calendar days of the receipt of the request by Medica. Medica follows this standard in all other states except where individual state laws require a different timeframe.

Expedited Appeal

Expedited appeals are filed in situations in which the standard appeal process timeframe could jeopardize the life or health of the enrollee, the enrollee's ability to maintain maximum function, or would subject the claimant to severe pain that cannot be adequately managed without the care or treatment. Appeals will be expedited when the services are needed to treat an illness or injury in which delay in receiving these services could result in serious deterioration of the member's health or anytime a physician requests the appeal be expedited. Expedited appeals are completed no later than 72 hours from the initial request, except where individual state laws require a different timeframe.

Expedited appeals may be initiated by a member, member representative or by a practitioner acting on behalf of the member. The criteria for expedited appeals are listed in the member's appeal rights located in the denial letter sent to the member and requesting provider.

When an expedited initial determination is made not to certify, Medica will notify the member and the attending healthcare professional of the right to submit an appeal as well as the procedure to initiate an internal expedited appeal.

First-Level Pre- & Post-Service Appeal

Medica offers a first-level appeal to any member, member representative or requesting provider on behalf of the member disagreeing with the initial determination decision. Appeal rights are communicated to the member in writing with each denial of service.

Second-Level Pre- & Post-Service Appeal for select business segments (voluntary)

If a member is dissatisfied with the outcome of the first level appeal, the member can bypass the Medica second level appeal process and proceed to the external review described in the next section. The alternative appeal route and options, described below, are dependent upon the health plan the member is enrolled in.

Second Level Appeals – Commercial and MHPS

For some fully insured Commercial products, the member may request an internal hearing, also referred to as a second level appeal, before the Clinical Appeals Committee, which consists of three participants: a Medica Medical Director, as well as a Utilization Management/Clinical Appeals nurse and a member from another Health Services department who serve on a rotational basis. Conversely, the member may request a written reconsideration, which is

© 2011-2023 Medica

reviewed by a senior medical director and one other committee member. Medica's Individual and Family Business products, as well as other fully insured commercial products, do not offer members second level appeal rights.

External Review Process
In compliance with health care reform regulations, an external review of disputed coverage determinations, when requested, is available.

Denial letters instruct the member to contact the appropriate entity to initiate the external review process. The entity then forwards the request to Medica. An appeals staff member prepares the case summary and all supporting and case related documentation for submission to the external agency.

The external review agency will issue its written determination to each party within the time frame for the case type (72 hours for expedited, 30 or 45 days for standard depending on the member's plan). The external agency's decision will be binding.

- **Commercial and MHPS**
  If the member has utilized the second-level internal appeal process and continues to be dissatisfied with the outcome, the external appeal option is always available. The alternative appeal route and options are dependent upon the health plan the member is enrolled in.

- **Medicare members**
  If upon appeal Medica upholds the initial denial, the member's case is automatically forwarded to MAXIMUS for final review (Part C only). Members are required to provide a written request to MAXIMUS for Medicare Part D appeal denials.

Continuity of Care

Continuity of care is provided to members as stipulated by state law and as contractually required. Medica will authorize continuity of care when a member is required to make a change in health plans or when Medica terminates its contract with the member's current provider without "cause" and; the member is engaged in an active course of treatment

The eligibility to continue care with a provider (PCP, specialists, and general hospital providers including SNF and hospice) at the in-network benefit level:

- After termination of a contract with the member's current provider *without* cause.
- If the member's employer changes health plans and the member's established provider is not a Medica network provider.
- If the member is a new enrollee to a Medica plan for the State Public Programs population or Prime Solutions (group-sold plans).

Termination for cause
If a provider is terminated "for cause," Medica does *not* authorize continued care since it could jeopardize a member's health or safety. "For cause" may include poor quality of care, legal violations or similar malfeasance.

© 2011-2023 Medica

Emergency Services

Emergency coverage for Commercial members, including Individual and Family Business, is provided according to "prudent layperson" standards. Emergency services that are within the member's plan description are covered. Prior authorization is not required. Medica will cover emergency services for Medicaid member claims in accordance with Minnesota Statute 256B.0625 Subd.1a., emergency services provided in an emergency room that are for emergency and emergency post-stabilization care or urgent care. Detailed procedural information is found in Utilization Management Policy UM0051P.

Clinical Resources for Utilization Management Decisions

Medica utilizes the following policies and guidelines to assist in making care authorization decisions:

- Medica Utilization Management policies
- Medica Coverage policies
- Magellan Utilization Management Policies (Approved by Prior Authorization Selection Committee) for medications covered and requiring prior authorization under the Medical Benefit
- Medical Technology Assessment Position Statements
- Medica Clinical Guidelines
- Selected MCG Care Guidelines®
- Medica Utilization Management (Operations) policies and procedures
- Medica Pharmacy Policies and Standard Operating Procedures
- Medical affairs Standard Operating Procedures

Note: UM Pharmacy criteria for Part D members are maintained and administered by ESI.

Utilization Management (UM) and Coverage Policies

A Utilization Management (UM) Policy is a document containing clinical criteria used by utilization management (UM) staff, appeals staff and medical directors for prior authorization, appropriateness of care and coverage determinations. Medica UM staff follow established written clinical criteria appropriate to the member's requested service/item/drug. Staff consider each member's individual circumstances and the capabilities of the local delivery system. Individual characteristics considered, include, but are not limited to the following: Age, comorbidities, complications, progress of treatment, psychosocial situation, and/or home environment, when applicable. The Medical Policy Committee (MPC) reviews and endorses all clinical criteria found in utilization management policies.

Coverage policies are developed to communicate Medica decisions about coverage and benefits for various medical services. Each coverage policy contains a description of the medical service, as well as the coverage determination, product application, coding considerations and requirements for prior authorization.

Pharmacy Services Utilization Management and Coverage Policies

Medica's PBM and Medical Pharmacy Services partner are responsible for the creation and maintenance of Utilization policies. The vendor-managed policies are reviewed and approved by the vendor's respective Pharmacy & Therapeutics Committees no less frequently than annually.

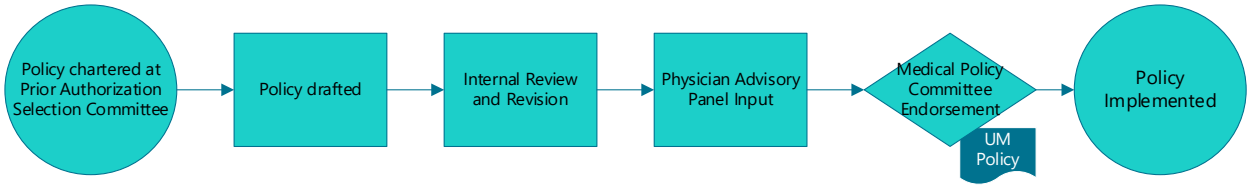
© 2011-2023 Medica

The Medica Pharmacy Services Team is responsible for creating Coverage Policies for medical pharmacy drugs desired to be managed through a coverage policy (as opposed to a UM policy that would require prior authorization). The Medica MTAC Committee approves new pharmacy-managed Coverage Policies initially and then re-evaluates and re-approves every three years thereafter. New medical pharmacy drug candidates recommended for Prior Authorization by Medica's Medical Pharmacy Program partner (Magellan Rx) are reviewed by the Pharmacy Services team who will present the targeted new additions to the Prior Authorization Selection Committee for final approval.

Policy Development and Access

1. **Utilization Management Policies:** Utilization Management (UM) policy development is determined by Medica's Prior Authorization Selection Committee (PASC). UM Policies are developed by collaboration between the Medical Affairs department program managers and Medica Medical Directors based upon the medical literature and input from appropriate specialists on the Physician Advisory Panel (PAP), a group of approximately 100 appointed, actively practicing network physicians. The criteria that are developed are reviewed, revised if needed, and then endorsed by the Medical Policy Committee. All new UM policies as well as existing policies with a material change in benefit considerations are sent to the Benefit Interpretation Committee (BIC) for review and approval prior to submission to the Medical Policy Committee for final endorsement. These policies are reviewed with input from practicing physicians and updated on an annual basis, or sooner if a clinical issue warrants.

   UM Policy Development Process

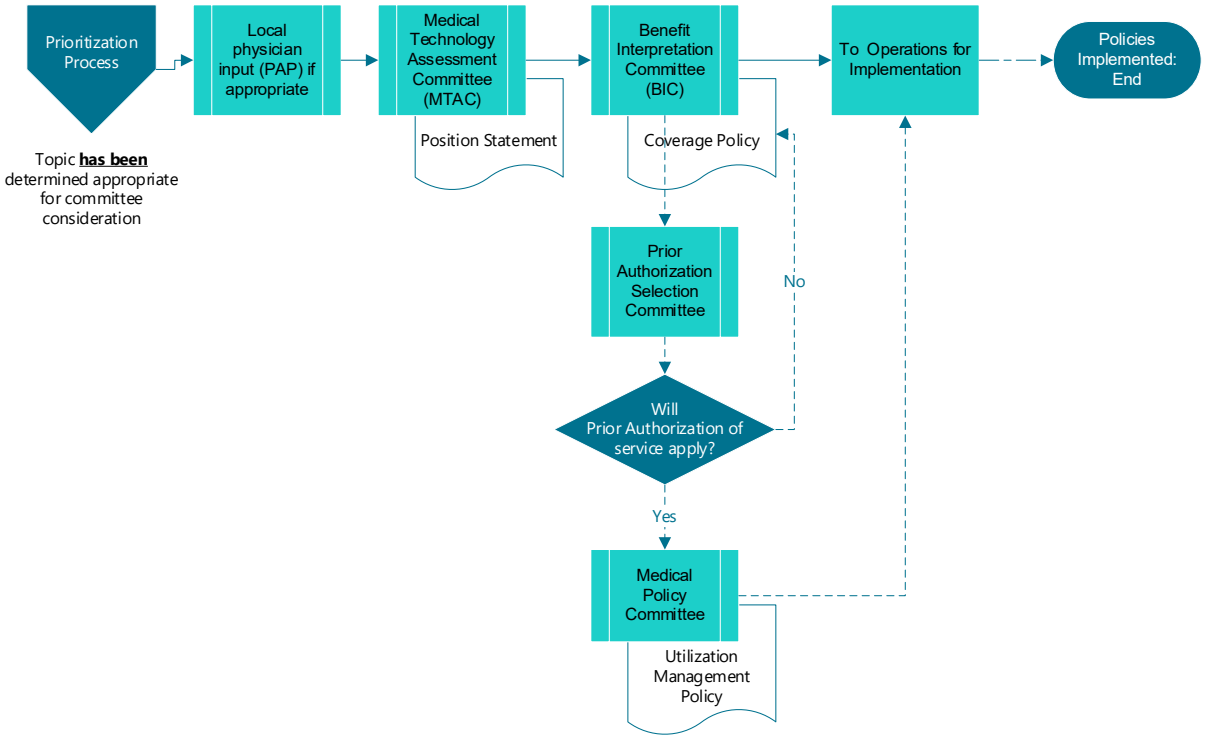


2. **Coverage Policies:** Coverage policies are developed by Medica's Medical Technology Assessment Committee (MTAC) and the technology assessment process. The output of MTAC is an evidence-based position statement. Following development of the position statement, the Benefit Interpretation Committee (BIC), a cross-functional internal committee chartered to provide benefit interpretation and assessment, and to make coverage determinations for each business segment and across all of Medica's business segments reviews position statements and other topics brought to BIC from departments throughout Medica. Through this process a coverage policy is developed and contains a description of the topic, as well as the coverage determination, product application, coding considerations and requirements for use with Utilization Management policies for prior authorization, retro review or when reviewing an administrative denial. Coverage of specific services may vary based on the terms of specific member/enrollee contracts (including state and federal government program contracts), administrative policies, and state/federal mandates. Following BIC approval, the coverage policy goes directly to Operations for implementation or, as appropriate,

© 2011-2023 Medica

may go on the Prior Authorization Selection Committee and Medical Policy Committee for consideration as an addition to the Prior Authorization list and development of a UM policy.

Coverage Policy Development Process



Medica Utilization Management policies, coverage policies and clinical guidelines are sent to Medica practitioners upon request, and monthly updates are published in the provider publication Connections. They are also available on Medica's website: medica.com.

Monitoring Technologies

Medical Affairs staff continually monitors technologies addressed in Medica coverage policies as well as technologies that have the potential to be addressed by a coverage policy. Existing coverage policies are reviewed and revised at least every three years or when monitoring indicates changes in the scientific validity of a technology or community standard of care, or potential business considerations have emerged. If prior authorization is required, a UM policy is developed, as described previously. BIC is chaired by Medica's Product Development Department, with executive sponsorship by the GM, VP Commercial Finance and Underwriting.

Medical Technology Assessment Position Statement

A Medical Technology Assessment Position Statement is developed by the Medical Technology Assessment Committee (MTAC). This committee is charged with determining whether new and emerging medical technologies are investigative as defined in Medica's coverage documents. Each technology is evaluated for its safety, effectiveness, and effect on health outcomes.

© 2011-2023 Medica

Determinations are made following a thorough analysis and consideration of clinical and scientific evidence, applicable laws and regulations, and community practice standards.

A Medical Technology Assessment Position Statement communicates whether a particular medical technology is investigative as defined in Medica's coverage documents. Medical technologies include devices, diagnostic or screening procedures, medical or behavioral treatments or procedures, and surgical procedures. Medical benefit drug UM policies are developed by Magellan Rx.

The Medical Affairs staff, with guidance and participation from a Physician Services Medical Director, facilitates the medical technology assessment process. Medical Affairs staff may identify a new technology, or may receive suggestions from Medica staff or external sources. The medical directors evaluate proposed topics and set priorities. Members of the Physician Advisory Panel (PAP) provide local physician opinion to MTAC. Medica solicits input from PAP by mailed survey, medical director telephone contact, or ad hoc meetings. The position statement is reviewed by the Benefit Interpretation Committee (BIC) for coverage policy determination.

Health Care Guidelines and Medica Clinical Guidelines

Medica uses recognized health care guidelines from various professional organizations; including the US Preventive Task Force and MCG. Medica's clinical guidelines align with national professional organizations and other health care specialty societies that develop clinical guidelines.

Clinical guidelines are intended to be used to encourage quality of patient care, but cannot guarantee specific patient outcome, and should be used only as a reference guide. The guidelines are not intended to replace a clinicians own judgement with regard to the care needed by individual members or to establish protocols for the care of all members.

A Medica Clinical Guideline is developed when a need is identified for which no corresponding MCG or other recognized healthcare guideline exists. Medica develops its clinical guidelines from regional or national credible sources with input from members of the Physician Advisory Panel (PAP), a work group of appointed, actively practicing network physicians, and endorsement by the Medical Policy Committee. Medica reviews and updates its clinical guidelines every two years or sooner, when changes in scientific validity and/or community standard of care warrant.

MCG Health Care Guidelines and Medica Clinical Guidelines are accessed and referenced by the Utilization Management and Clinical Appeals staff and Medical Directors. They may also be used as a reference when providing case management services to members. These clinical guidelines are used internally at Medica to develop member education materials, disease management recommendations, and conduct various quality studies. Clinical guidelines are sent to Medica practitioners upon request, and monthly updates are published in the provider publication "Connections".

Clinical guidelines are intended to be used to encourage quality patient care, but cannot guarantee specific patient outcome, and should only be used as a reference guide. The guidelines are not intended to replace a clinician's own judgment with regard to the care

© 2011-2023 Medica

needed by individual members or to establish protocols for the care of all members. Clinical guidelines are not coverage policies, but may be used as a reference in making clinical decisions.

Medica Utilization Management creates policies and procedures to provide guidelines for utilization management staff to assure consistency in administering programs and work processes. These policies and procedures provide for compliance with federal and state law, contractual obligations and requirement of the Minnesota Department of Health and Human Services (DHS) and Centers for Medicare and Medicaid Services (CMS), as well as accreditation standards. These policies are submitted for review or revision on an annual basis.

Inter-Rater Reliability (IRR)
Medica is responsible for ongoing monitoring and evaluation of its staff responsible for clinical decision-making to ensure consistent use and application of all utilization management criteria. Medica has established an Inter-Rater Reliability (IRR) assessment of UM clinical reviewers. IRR testing is performed per the National Committee for Quality Assurance (NCQA) standards to measure the accuracy and consistency with which clinicians apply policy criteria when completing reviews requiring medical necessity decisions. Case studies and tests are customized to the role of clinician reviewers to improve the validity and relevance of the activity. The annual goal is to have all clinicians, who review Prior Authorization (PA) requests, review the IRR case studies and complete the quizzes in order to identify learning opportunities and plan subsequent trainings.

Staff Involved in Clinical Decision-Making
Licensed health professionals supervise review decisions and licensed clinical staff performs clinical review, prior authorization, and clinical appeals activities. The utilization staff, care coordinators, and appeals staff are all registered nurses, licensed social workers or licensed practical nurses. Clinical staff are licensed professionals in good standing in the state or jurisdiction of licensure. The nurses receive extensive orientation and training in the principles of care and utilization management, criteria and discharge planning. Utilization Management nurses review prior authorization and appeal requests against prior authorization and coverage policies to determine medical necessity. Under no circumstances may they independently deny a service determined to not meet medical necessity criteria. All potential denials require review and oversight by a licensed physician (referred to as a physician advisor or medical director). Utilization management decisions for medications are reviewed and managed by licensed pharmacists in good standing in the state or jurisdiction of licensure. Under no circumstances may they independently deny a service determined not to meet medical necessity criteria for Non-Part D Prior Authorization requests. All Non-Part D potential denials require review and oversight by a licensed physician (referred to as a physician advisor or medical director). Utilization management decisions are based only on the appropriateness of service and existence of coverage. Utilization management decision-makers do not receive financial incentives from Medica as a means of encouraging them to make decisions that result in the under-utilization of services.

Non-clinical staff provide intake, support, and review of non-clinical and referral services. Non-clinical staff are supervised by clinical professionals. Under no circumstances may non-clinical staff deny a service determined to not meet medical necessity criteria.

© 2011-2023 Medica

The utilization management physician advisors, the senior medical director and the SVP, Chief Medical Officer are board-certified physicians who hold unrestricted licenses. They are responsible for:

- Utilization management review decisions.
- Determination for all authorization requests that cannot be approved based on the established utilization management criteria.
- Interaction with network physicians and/or facilities regarding utilization management concerns.
- Peer review and review of unresolved clinical quality of care issues, and recommendations for actions and follow-up monitoring.

In addition, the Senior Medical Director is responsible for:

- Chairing the Medical Policy Committee and Medical Technology Assessment Committee.
- Facilitation of policy and guideline development and endorsement.
- Co-chairing the Care and Utilization Management Subcommittee.

A licensed physician reviews all potential denials based on medical necessity. Only a licensed physician can make a denial determination for medical necessity reasons for Non-Part D members. When specialized judgment is needed, board-certified physicians from appropriate specialties are consulted to assist in making determinations of medical necessity. Medica contracts with Allmed for board-certified clinicians to provide same/similar specialty consultation and utilization management review for medical necessity determinations.

Further information regarding qualification and responsibility for the above-mentioned roles can be found in department position profiles.

Behavioral Health Utilization Management

Medica offers two behavioral health programs that are differentiated by member populations as described separately below. The programs are designed to meet applicable state and federal regulations and align with Mental Health Parity Addiction Act of 2008 and its underlying (MHPAEA) regulations.

Medica Health Plan Solutions (MHPS) Behavioral Health

The Medica utilization management program provided for Medica Health Plan Solution (MHPS) members includes the same evidence-based clinical guidelines and policies that are leveraged to make consistent, fair and impartial determinations across all Medica member populations. One differentiating factor for MHPS members is inclusion of behavioral health in the Medica UM program. While behavioral health utilization management is delegated to Optum (branded for Medica as Medica Behavioral Health (MBH)) for other products, the Medica UM team and behavioral health medical director refer to a Medica behavioral health policy and MCG behavioral health guidelines when making medical necessity determinations for behavioral health and substance use care requests or appeals.

© 2011-2023 Medica

Medica contracts with Allmed for board-certified psychiatrists to provide behavioral health case consultation and utilization management review for MHPS Behavioral Health determinations. An MBH medical director, who is a board-certified psychiatrist, participates on the Care and Utilization Management Subcommittee as does our Director of Behavioral Health, who is employed by Medica and is a clinically licensed social worker.

Medica continues to improve reporting capabilities to monitor turnaround times and evaluate prior authorization and appeal trends as well as program impacts on cost and utilization.

Medica Behavioral Health (Optum)
Medica delegates medical management of mental health and chemical dependency services to its behavioral health vendor, Optum Behavioral Health (also known to members as Medica Behavioral Health, or MBH) for all products other than most Medica Health Plan Solutions (MHPS). Under this arrangement, MBH is responsible for behavioral health call triage, member referrals, prior authorization and concurrent review and denials. MBH also manages first-level member and provider appeals.

Clinical Operations: MBH offers triage, referral and crisis management services by telephone 24 hours a day, seven days a week, 365 days per year.

Intake staff makes triage and referral decisions not requiring clinical judgment. Utilization staff making triage and referral decisions requiring clinical judgment must be independently licensed in psychology, social work, nursing, chemical dependency, counseling or marriage and family therapy and are supervised by the MBH Associate Vice President of Clinical Operations, who is also an independently licensed clinician. MBH's Regional Medical Director or Associate Medical Director make the final medical necessity decisions to deny any service request, The MBH Regional Medical Director and Associate Medical Director are board certified licensed psychiatrists and hold unrestricted licenses.

The MBH Associate Vice President of Clinical Operations supervises the triage and referral processes, and oversees all utilization management and care advocacy processes. Qualifications for this position include a Ph.D. or master's degree in psychology, social work or related field and five years' experience in managed care.

The Associate Vice President of Clinical Operations must have a current, non-restricted clinical level license, prior clinical experience, and significant supervisory experience in a managed care setting.

The MBH Regional Medical Director and Associate Medical Director are responsible for the following:

- Utilization management decisions.
- Peer review and determinations for all authorization requests that cannot be approved based on the established utilization management criteria utilizing medical necessity criteria. .
- Facilitation of policy and guideline development and approval.

© 2011-2023 Medica

- Interaction with physicians and/or facilities regarding utilization management concerns.
- Review of unresolved clinical quality of care issues, and recommendations for action and follow-up monitoring.
- Managing first level appeals.

Experience requirements for the medical directors include three years' related clinical experience, two to three years' supervisory/ management experience in a clinical setting, and experience in utilization review of psychiatric services. The supervising psychiatrist must have post residency experience in direct patient care.

Medica's Director of Behavioral Health coordinates oversight of MBH's clinical performance in partnership with other Medica stakeholders outside of health services, like Network, Segment Leadership and Compliance. Oversight includes regular review of clinical performance, utilization reports, and frequent meetings with the delegate's representatives.

In addition, Medica conducts a comprehensive quarterly review of quality metrics and initiatives to track vendor performance and assert rigor in assuring vendor performance related to behavioral health quality and other performance indicators.

Auditing and Monitoring

Medica monitors its compliance with federal, state, CMS, DHS, NCQA and any other applicable UM requirements including but not limited to timeliness in decision making and oral and written notification to members and providers. The monitoring consists of quarterly prior authorizations and clinical appeals audits completed by Compliance. The audit results are reviewed with business segment leads to discuss findings, compliance and/or business risks, and opportunities for improvement.

Medica may, at its discretion, perform focused or real-time audits in addition to those noted above. Corrective actions are implemented as needed based on root cause analysis of issues identified. Audit results are reported to senior management through various structures.

Purpose

Routine monitoring to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective across all lines of business.

Eligible Populations

- Commercial Fully Insured and Self-Insured
- Medica Health Plan Solutions (MHPS)
- Minnesota Health Care Programs (Medicaid)
- Medicare Part C
- Individual and Family business (qualified health plans on both federally-facilitated and state-based marketplaces)

© 2011-2023 Medica

Member Experience with Utilization Management

Medica monitors the level of member satisfaction with the UM process through CAHPS survey question(s) related to ease of obtaining services or authorizations through the health plan. Medica will continue to monitor this quality indicator for opportunities for member service improvements.

Pharmacy Services

Pharmacy Services is responsible for development and implementation of clinical programs designed to manage cost and ensure appropriate utilization. The team is dedicated to effectively managing its key vendor's, including the Pharmacy Benefits Manager (PBM) (Express Scripts/ESI), Medical Pharmacy Program partner (Magellan Rx Management), and specialty/mail order provider (Accredo Health Group, Inc.). It is also accountable for specialty pharmacy management, Medication Therapy Management (MTM), pharmacy network administration, rebate strategies, and integration of drug claims within Medica's overall Health Management program. The Pharmacy Services team provides support to the business segments and many other functional areas within Medica regarding pharmacy-related issues. Pharmacy services strive to meet best practices to ensure UM activities meet accreditation and regulatory requirements. The program is designed to be in compliance with such standards, including that of Federal and individual state laws and parity considerations.

All Medica members that have pharmacy benefits through Medica's various lines of business are eligible to receive pharmacy services.

Pharmacy Strategy

The Pharmacy Services team focus is to drive maximum value of drug therapy from a financial, clinical outcome, and consumer experience perspective. This is done by working closely with business partners and vendors to develop programs that positively impact drug utilization and cost across both the pharmacy and medical benefit, and through engaging with internal and external partners to improve the member experience. The Pharmacy Services team supports each of Medica's business segments by the following:

- Strategic partnerships with each business segment in supporting pharmacy-related needs and strategy
- Lead formulary and utilization management strategy, communications, publications, and regulatory submissions
- Driving pharmacy strategy with ACO partnerships
- Assistance in developing Medicare STARs and HEDIS programs
- Developing/managing/maintaining pharmacy dashboards and other assessments of pharmacy financial performance
- Developing/managing all pharmacy related member and provider mailings/communication
- Oversight of pharmaceutical manufacturer rebate contracts
- Management/oversight of all regulatory and compliance issues relating to pharmacy
- Oversight of mail order vendor
- Oversight of pharmacy and medical pharmacy benefit coding and testing
- Developing and maintaining pharmacy web content

© 2011-2023 Medica

Support for all functional areas providing consultative clinical, operational, and analytic services relating to drug utilization and spend across both the pharmacy and medical benefit.

The team is results-oriented and partners with internal stakeholders to address key needs and areas of opportunity. Subsequently, the team develops and implements programs and initiatives that are strategically aligned and focused on improving quality and reducing medical expense. For example, the team develops the strategy for formulary management, the specialty drug program, medical benefit drug management, clinical programs and offerings, vendor audit and oversight, and drug trend analysis. Additionally, the team works collaboratively with key stakeholders to consult on benefit design, product enhancements, and business development to provide a competitive advantage for Medica in the marketplace and to ensure our members are receiving the highest quality experience.

Core Functions

- Oversight of pharmacy benefit manager vendor and medical pharmacy manager
- Oversight of specialty pharmacy vendor
- Developing/managing/maintaining clinical pharmacy programs within Medica on pharmacy issues
- Management of pharmacy reports
- Developing/managing/maintaining Medication Therapy Management strategies and partnerships
- Support for Commercial RFPs, Medicare Part D Bids, IFB On/Off Exchange drug template, SPP RFPs
- Support for Clinical Appeals
- Support for CMS/MDH/DHS/NCQA Audits

All served populations are included and subject to benefits and prior authorization requirements as defined in their plan documents. Pharmacy benefits are included in standard Commercial, Individual and Family Business (IFB), Medicaid and Medicare product offerings. Medical pharmacy programs are applied to Commercial members (residing in Medica service area), as well as IFB, Medicaid, MSHO and Medicare Advantage members.

Formulary Development and Committees

Medica's pharmacy benefits manager, Express Scripts, Inc. (Express Scripts) has many years of formulary development expertise and an extensive clinical pharmacy department. Express Scripts develops formularies through a four-step process involving the work of the following committees:

- **Therapeutic Assessment Committee:** The Therapeutic Assessment Committee (TAC) is an internal clinical review body, consisting of clinical pharmacists and physicians who are employed by Express Scripts. From a formulary development perspective, the committee is tasked to review specific medications following approval by the Food and Drug Administration (FDA). Before discussing a new drug at TAC, Express Scripts' clinical

© 2011-2023 Medica

team conducts a search of the medical literature, evaluates published data from clinical trials, and develops comprehensive drug evaluation summary documents. The drug evaluation documents are developed with the aid of a wide range of resources including, but not limited to: primary literature, clinical practice guidelines, and FDA-approved package inserts. The drug evaluation documents include, at a minimum, a summary of the pharmacology, safety, efficacy, dosage, mode of administration, and the relative place in therapy of the medication under review compared to other pharmacologic alternatives. Following a review of the drug evaluation summary document, TAC ultimately provides a formulary placement recommendation which is shared with the Express Scripts' National Pharmacy and Therapeutics (P&T) Committee. TAC formulary recommendations are merely a suggestion and cannot be formally implemented without the approval of the P&T Committee.

- **National Pharmacy & Therapeutics Committee:** Express Scripts' National P&T Committee is a group of independent, actively practicing physicians and pharmacists who are not employed by Express Scripts. The P&T Committee is tasked to review medications from a purely clinical perspective. **The Committee does not have access to, nor does it consider, any information regarding Express Scripts' rebates/negotiated discounts, or the net cost of the drug after application of all discounts. The Committee does not use price, in any way, to make formulary placement decisions.** The Express Scripts' P&T Committee reviews a much broader range of formulary placement topics than TAC, including: new drug evaluations, new FDA-approved indications for existing drugs, new clinical line extensions, and new published or clinical practice trends that may impact previous formulary placement decisions. For new drug evaluations, the P&T Committee reviews the relevant drug evaluation summary documents as well as the formulary placement recommendation from TAC. In addition, members of the P&T Committee provide their insight into the quality of the published literature, share their clinical practice experience, and assess the relative place in therapy of the medication and therapy class. The P&T Committee can establish one of the following four formulary placement designations: *include*, *access*, *optional*, or *exclude* from a formulary.

  Drugs with a designation of ***include*** are recommended for placement on all formularies. A drug may be given an *include* designation if it meets at least one of the clinical basis enumerated in the next sentence AND is anticipated, or validated via claims data, to treat a relatively large patient population. The clinical bases include: unique indication for use addressing a clinically significant unmet treatment need, efficacy superior to that of existing therapy alternatives, a safety profile superior to that of existing therapy alternatives, a unique place in therapy, and/or drugs which treat medical conditions that necessitate individualized therapy and for which there are multiple treatment options.

  A drug may be given an ***access*** designation if it meets the clinical basis enumerated in the sentence before AND is anticipated, or validated via claims data, to treat a relatively small patient population. Access medications are forwarded to the Value Assessment Committee (VAC) for further analysis.

  A drug may also be designated as ***optional*** on a formulary. A drug may be given an *optional* designation based on the conclusion that a significant proportion of its use is

© 2011-2023 Medica

clinically similar to other currently available drug alternatives. Optional medications are forwarded to the VAC for further analysis.

Finally, a drug may be designated as ***exclude***. Drugs may be given an *exclude* designation for one or more of the following clinical reasons: efficacy inferior to that of existing therapy alternatives, a safety profile inferior to that of existing therapy alternatives, and/or insufficient data to evaluate the drug. Medications recalled from the market for safety reasons take an automatic *exclude* status, and are formally reviewed at the next P&T Committee meeting.

- **Value Assessment Committee:** The Value Assessment Committee (VAC) considers the value of drugs by evaluating the net cost, market share, and drug utilization trends of clinically similar medications. VAC consists of Express Scripts' employees from formulary management, product management**,** finance**,** and clinical account management. No member of VAC can serve in any capacity on TAC (and vice-versa). VAC reviews drugs designated as *access* or *optional* by the P&T Committee, and develops a formulary placement recommendation. VAC is required to add medications with an *include* designation to formulary, while drugs with an exclude designation may not be preferred on the formulary. In both cases, economic considerations are superseded by the clinical requirements of the P&T Committee. Once complete, formulary and tier placement recommendations are then forwarded to the P&T Committee for final approval.

- **National Pharmacy & Therapeutics Committee (Annual Review):** On an annual basis, the National P&T Committee will review the final formulary recommendations, by drug class, for the upcoming plan year. The Committee uses this opportunity to ensure adherence to previously established formulary placement recommendations, and to validate continued alignment with best medical practices. The Committee also ensures that all Express Scripts national formularies cover a broad distribution of therapeutic classes and categories, and that the formularies neither discourage enrollment by any group of enrollees nor discriminate against certain patient populations.

Medication Safety and Monitoring Committee

The Medication Safety & Monitoring program, administered by Express Scripts, targets high-risk drug classes, focusing on controlled substances, and inappropriate use and misuse related indicators such as poly-pharmacy, provider shopping and high-total controlled substance claims volume. An algorithm evaluates the 90-day pharmacy history (mail & retail) and identifies high risk profiles and reports of suspicious claims. Express Scripts clinical pharmacists evaluate controlled substance claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity. Situations identified as being potentially inappropriate are referred to Medica for further review.

© 2011-2023 Medica

Medica's Clinical Pharmacy team receives these reports for all lines of business on a quarterly basis. Upon receipt, the responsible Clinical Pharmacist reviews the report, summarizes concerns with the case, and shares the case information with Medica's Case Management, Clinical Quality and Special Investigations/Restricted Recipient Program teams, and ACO team (if ACO member). Cases are reviewed at quarterly Committee meetings to ensure coordination of care between all involved parties. Partnership from Medica Behavioral Health team is available to ensure that the appropriate substance abuse related resources are identified and available upon request for the member or care manager.

Vendor Oversight

Annually, Pharmacy conducts a review of previous years' data and auditing to assess experience with the Pharmacy Utilization Management processes. This review includes oversight of both pharmacy and medical benefit Utilization Management programs as well as the results of UM determinations, vendors' self-assessment through their provider survey, and results of Medica's auditing and monitoring. For Express Scripts, Medica conducts monthly prior authorization case review audits to ensure that case specific turn-around times are met, appropriate clinical review is applied, all necessary medical records are reviewed and compliant letters are sent. Additionally Medica completes an annual audit of Express Scripts policies and procedures to ensure compliance with necessary regulatory guidance. For Magellan, Medica completes an annual audit which assesses both policies and procedures and case review.

Routine case review assessing turnaround times, letter appropriateness, and appropriateness of clinical decision making are done throughout the year.

<u>Program Goals/Performance Targets</u>

- For both Express Scripts and Magellan, continue monthly auditing process assessing turnaround times, appropriate application of clinical criteria, appropriate clinical decision making, and letter template selection/accuracy.
- Report results from audits to Pharmacy Continuous Quality Improvement and creating corrective action plans as needed based on significant findings.
- Maintain regularly scheduled compliance calls to monitor performance, discuss findings, create process improvements, and drive corrective action plans to completion.
- Perform annual audit Magellan including evaluation of their UM procedures and audit of prior authorization and appeal cases.
- Seek improvement in physician satisfaction with UM processes.

© 2011-2023 Medica

Care Management

Medica's Care Management Services provide a member-centered, model of care that serves members experiencing complex conditions, advanced Illness and/or transitions of care throughout the continuum of products. The Care Management model provides for the integration of medical and behavioral interventions for members who would most benefit from telephonic or community-based coordination. The model focuses on improving members' quality of life by honoring and supporting the individual's unique traditions, attitudes, beliefs and addressing issues related to physical, behavioral, environmental and spiritual needs.

Care Model Framework
The Care Management framework combines the principles of care management, care coordination, behavioral health, public health and palliative care. The program provides specially trained nurses, social workers and behavioral health professionals to provide the case management/ care coordination services. An inter-disciplinary team, including pharmacy, behavioral health specialist and Medica's Health Services Medical Director, supports the member and the case manager/ care coordinator and is available for consultation on an ad hoc as well as on a bi-weekly basis to review cases and provide insight and education.

Medica's Care Management program utilizes structured models of care to provide a consistent approach to case management/care coordination. Interventions and program focus are unique to the member and the population. Medica implements care management interventions founded in evidence-based practice combined with critical thinking and experiential knowledge to achieve Medica's strategic objectives. Medica has three primary approaches embedded into our Care Management model which are based on evidence-based medicine and best practice for effectiveness in cost reduction and reduction of illness burden. Those approaches are Transition of Care, Complex Case Management and Advanced Illness. Medica also has defined models of care for our Care Coordinated Products, which include MSHO, MSC+, SNBC, and SNBC SNP.

Complex Case Management
The purpose of the Complex Case Management Program is to assist members in complex or acute situations in need of services to manage their health and coordination of their care and services across the continuum. Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the services and supports required to meet an individual's health needs. Medica's definition of case management services provided by case managers is consistent with the Case Management Society of America (CMSA) definition: "Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality and cost-effective outcomes."

Eligible Populations
Populations eligible for Complex Case Management are members identified by our Coordinated Member Identification (CMI) algorithm as meeting criteria for the program or those referred by

© 2011-2023 Medica

internal or external partners. Our complex case management program is available to members enrolled in Commercial, Medica Health Plan Solutions (MHPS), Individual and Family Business (IFB), Medicaid, Medicare Advantage and Medicare Cost (by referral) products.

Program Description
The Complex Case Management program provides specially trained nurses and social workers to deliver case management services. An interdisciplinary team including pharmacy, behavioral health specialists and Medica's Health Services Medical Director supports the member and the case manager and is available to provide insight, education and guidance.

Case Management programs target impactable conditions for members at risk using population-based algorithms. Identification may include: high-cost, high-risk, high-needs or emerging-risk members. Interventions are focused on helping the member to achieve their stated health outcomes, educating the member on their disease trajectory, reviewing the risk and benefits of treatment decisions, helping to support and clarify goals of care, completion of a comprehensive medication review, fostering healthy patient/ provider relationships, identifying and resolving barriers to care, and assisting with community resources to address social determinates of health that impede desired health outcomes. Care plan goals are established based on member health priorities with consideration to their unique traditions, attitudes, and beliefs.

Advanced Illness Program
Medica's Advanced Illness program provides comprehensive care for members facing life-limiting illness, generally defined as the last twelve months of life. The model is focused on reducing the burden of illness impacting the physical, psycho-social, emotional, spiritual and environmental well-being of our members while supporting and honoring their unique traditions, culture and goals of care. The goal of the program is to identify and address quality of life and health care goals with the member, and to align the member's goals with those of their caregivers, family and the health care team.

Eligible Populations
Populations eligible for Advanced Illness case management are members enrolled in a Medicare Advantage product and identified by our Coordinated Member Identification (CMI) algorithm as meeting criteria for the program or those referred by internal or external partners. Beginning in 2021, the program began accepting referrals from other products including; Commercial, Medica Health Plan Solutions (MHPS), Individual and Family Business (IFB), and Medicaid.

Program Description
The Advanced Illness program provides a specially trained nurse to deliver case management services. An interdisciplinary team including pharmacy, behavioral health specialist, social work, and Medica's Health Services Medical Director supports the member and the case manager and is available to provide insight, education and guidance.

Key aspects of the Advanced Illness program include:
- Early identification and enrollment
- Focus on addressing current, future and advanced care planning
- Timely introduction of the topic of advanced illness with a focus on illness trajectory

© 2011-2023 Medica

- Alignment of the member's health goals with caregivers, family and health care team
- Advocate for informed choice and member autonomy
- Connections to Palliative Care and Hospice, as appropriate

Transitions of Care (TOC) Program
The purpose of the Transitions of Care program is to assist members who are at risk of a readmission with a safe transition between care settings to improve health outcomes and reduce unplanned readmissions.

Eligible Populations
Populations eligible for the Transitions of Care program are members identified by our Daily Admission Report, or those who have been referred by internal or external partners, in particular Utilization Management. The program is available to members in the Commercial, Medica Health Plan Solutions (MHPS), Individual and Family Business and Medicare Advantage products.

Program Description
Case management services focused on the members' first 30 days following discharge from an acute or post-acute facility. Members are identified by a Daily Admission Report that utilizes an algorithm to identify members most at risk for an unplanned readmission. Telephonic intervention is derived from the Eric Coleman model, an evidence-based model that and focuses on supporting the member in becoming more autonomous in the management of their health by identifying opportunities to improve quality of care and mitigating risk for adverse health outcomes.

The "Welcome Home" call includes:

- Assessment of health literacy; including the member's understanding of their condition(s)
- Assessment and education around the member's understanding of the appropriate action steps to be taken with the potential development of any red flags
- Completion of a comprehensive medication review
- Ensuring member has a follow-up appointment with PCP or PTP and any barriers to access have been identified and removed
- Assessment of needs in the home; includes behavioral health, home safety and an assessment of Social Determinant of Health (SDoH) needs
- Assess the need to enroll the member in complex or specialty case management for ongoing care

For complex adult or pediatric discharges and Neonatal ICU members, the Care Management team will work with the hospital discharge planning teams to assist with supporting and planning for home or facility discharge.

Transplant Program
The purpose of the Transplant Case Management program is to provide support, education and coordination of care to members in need of a solid organ, bone marrow or stem cell transplant.

© 2011-2023 Medica

Case managers assist members in decision-making related to transplant site of care with the goal of increasing member understanding of the benefits of listing at a Center of Excellence (COE), Transplant Access Program (TAP) or a Medica-designated Transplant Center of Excellence.

Eligible Populations

Populations eligible for Transplant case management are members identified by our Coordinated Member Identification (CMI) algorithm as meeting criteria for the program or those referred by internal or external partners. Most notably through receipt of a prior authorization request or referral from Medica Kidney Care. Our Transplant program is available to members in Commercial, Medica Health Plan Solutions (MHPS), Individual and Family Business, and all integrated Government products.

Program Description

The Transplant program provides access to specialized case managers who assess, educate and coordinate with members with the goal that members receive the right care, at the right place, at the right time. This includes guiding members to the best in class location for the type of transplant they need, utilizing Medica- or Optum-designated transplant centers (Centers of Excellence(COE)/Transplant Access Programs (TAP), assisting each member through the evaluation and listing process, helping them maintain transplant readiness while awaiting an organ transplant, prevent unplanned admissions, provide support after discharging post-transplant and continue to support the member in maintaining their health through one-year post-transplant. Transplant case managers complete both utilization management and case management functions to provide a consistent, integrated touchpoint through the continuum of care.

Medica's Transplant Case Managers have extensive clinical experience and specialization in the renal and transplant field, with many holding advanced transplant-specific certifications.

Medica Kidney Care Program

The purpose of the Medica Kidney Care Program, administered by OptumHealth, is to provide support and education to members with late-stage chronic kidney disease (CKD) or end-stage renal disease (ESRD). The program is designed to improve clinical outcomes, improve quality of life, increase productivity and reduce medical costs by early identification of individuals living with chronic kidney disease through ongoing engagement with specialized renal nurses.

Eligible Populations

Populations eligible for Medica Kidney Care are members identified through Optum analytics as meeting criteria for the program or those referred by internal or external partners. Members must have a diagnosis of Chronic Kidney Disease Stage IV or V or End-Stage Renal Disease. Medica Kidney Care programming is available to members in Commercial FI, Medica Health Plan Solutions (MHPS), Individual and Family Business (IFB), Medicaid, and Medicare Advantage.

Program Description

The Medica Kidney Care program provides access to specialized renal Registered Nurse case managers, dieticians, social workers, and other supportive services. Through telephonic management, the Medica Kidney Care team takes an integrated approach to assisting members

© 2011-2023 Medica

in managing their kidney disease. Members are guided to nephrologists, in-network dialysis centers, home therapies, preferred access placement, and exploration of the option of a kidney transplant, as appropriate. Members are empowered to make lifestyle changes and provided educational materials via secure texting with their Nurse who helps them better manage their condition. Community providers may receive notification of patients who may be eligible to take advantage of these services.

Complex Pregnancy Program

The purpose of the Complex Pregnancy program is to help pregnant women understand and better manage their pregnancy with the goal of improved health outcomes for mothers and babies.

Eligible Populations

Populations eligible for Complex Pregnancy case management are members identified by our Coordinated Member Identification (CMI) algorithm, which includes the ACOG (American College of Obstetricians and Gynecologists) guidelines, as meeting criteria for the program or those referred by internal or external partners. Identification includes data sources such as the Ovia application and Medicaid-specific Health Risk Assessments. Our complex pregnancy program is available to members in Commercial, Medica Health Plan Solutions (MHPS), Individual and Family Business (IFB), and Medicaid products.

Program Description

Medica's Complex Pregnancy program targets members with factors that put them at higher risk for adverse health outcomes for either mother or baby. High-risk designation includes members with the following risks:

- Multiple gestation
- History or current incompetent cervix
- Previous preterm delivery
- Current preterm labor
- Current premature rupture of membranes
- Uterine anomaly
- History of or current diabetes
- History of or current hypertension
- Teen less than 18 years old
- Substance abuse in the last six months
- Advanced maternal age
- Tobacco Use during pregnancy

The Complex Pregnancy program provides access to specialized OB-trained Registered Nurse (RN) case managers. Through telephonic management, case managers encourage early and ongoing prenatal care including prenatal vitamin and medication compliance. Education materials are provided and members are referred to resources such as; childbirth classes, WIC, smoking cessation programming, doulas and other community resources.

© 2011-2023 Medica

Involvement does not stop with delivery of the newborn. Medica's Complex Pregnancy program continues to support the member through the postpartum period and is focused on; assessing for behavioral health related needs, supporting new mothers on their breast feeding journey which may include lactation support, and assisting with planning for return to work, if applicable.

Medica has an established partnership with Ovia Health to make their popular mobile pregnancy application available to Medica members across all lines of business. The partnership with Ovia Health assists Medica with the identification and education of pregnant members, members who are considering becoming pregnant or members who have recently delivered a baby.

High Cost Member Program

The purpose of the High Cost Member program is to identify and understand Medica's high-cost population, which includes understanding cost drivers and likelihood for continued cost, to support an enterprise-wide approach to member management and cost containment.

Eligible Populations

Populations eligible for the High Cost Member program are members that meet a designated claims threshold of $250,000 in a rolling twelve month period. Members whom meet this threshold are identified on a High Cost Claimant dashboard updated and distributed monthly by Enterprise Analytics. Members reviewed include those in Commercial, Medica Health Plan Solutions (MHPS), Individual and Family Business (IFB), Medicaid, and Medicare Advantage products.

Program Description

The High Cost Member program reviews high-cost members for cost drivers and likelihood of ongoing cost which are both documented within the clinical documentation platform monthly. High cost value drivers that correlate with key interventions are documented in the clinical documentation platform for each member reviewed by the clinical team. Care Management is just one approach to qulaity of care evaluation, cost containment and improved health outcomes for these very medically-complex members. Other enterprise-wide approaches include; pharmacy review of high-cost drugs or site of service, contracting, network, coordination of benefits, and payment integrity. High Cost Member specific interventions are tracked at the member level.

For members that are appropriate for case management intervention, members are managed in complex or specialty case management programs according to Medica's standard process. See program descriptions for additional detail on each program intervention.

Community Navigation

The Community Navigation intervention is designed to support members with social determinant-led needs. Navigators offer support assessing members for SDOH needs to

© 2011-2023 Medica

connect members to resources. Members are referred to a community navigator for support both telephonically and in person.

Eligible populations
Members are referred by internal and external partners. The following member populations are eligible: Medicaid, MNcare, PMAP, SNBC, MSC+.

Care Coordination Program (MSHO, MSC+ and SNBC and SNBC SNP)
Medica offers care coordination services for four Minnesota Health Care Programs, MSHO, MSC+, SNBC and SNBC SNP. Enrollment may either be on a voluntary or mandatory basis. DHS contracts with Medica to provide health care to eligible individuals and provides programs to special needs populations in specific Minnesota counties.

Eligible Populations
The program is currently available for the following Medica Minnesota Health Care Program (State Public Programs):

- Medica DUAL Solution (Minnesota Senior Health Options-MSHO)
- Medica Choice Care (Minnesota Senior Care - MSC+)
- Medica AccessAbility (Special Needs Basic Care-SNBC)
- Medica AccessAbility Enhanced (Special Needs Basic Care-SNBC Special Needs Plan)

Minnesota Senior Health Options (MSHO), or Medica DUAL Solution, is one of the four managed health care programs Medica offers. It is a fully integrated program where the member receives one member card and all services and claims including Medicaid, Medicare, and Part D benefits are managed by Medica. This helps to reduce member confusion as only one card is needed for all benefits. All Medica DUAL Solution members are assigned a care coordinator (CC) and Care Coordination continues throughout the member's enrollment. Care Coordinators conduct a person centered health risk assessment, develop a care plan with the member and assist the member in navigating the healthcare system and accessing supports. Additional support benefits are included through the Elderly Waiver program (if eligible). MSHO is a voluntary program.

Medica Senior Care (MSC+), or Medica Choice Care, is a program for people over the age of 65 enrolled in Medical Assistance (MA). The MSC+ program includes all regular Medical Assistance benefits, as well as Elderly Waiver services (if eligible). All MSC+ members are assigned a Care Coordinator, who supports the member throughout their enrollment in the program. MSC+ is the State of Minnesota's default program.

Special Needs Basic Care (SNBC), or Medica AccessAbility Solution®, is a managed care program Medica offers for people with disabilities ages 18 through 64 who have Medical Assistance. Individuals are also assigned a Medica care coordinator in this program, which is also a voluntary program.

Special Needs Basic Care Special Needs Plan (SNBC SNP), or Medica AccessAbility Solution Enhanced®, is a managed care program Medica offers for people with disabilities ages 18

© 2011-2023 Medica

through 64 who are enrolled in both Medicare and Medical Assistance. All SNBC SNP members are assigned a Care Coordinator.

Medica employs RN and licensed social work care coordinators to work with members enrolled in the above health care programs. Medica also partners with various county, care system and community agencies to provide care coordination for program enrollees. This model is unique in that individuals can receive assistance across all setting of care, transitions, and stages of the aging process. Medica's care coordination model provides each individual an assigned care coordinator (CC) to manage benefits and care. The CC is the primary contact for accessing services which include Medical Assistance and Elderly Waiver benefits, when applicable, for DUAL Solution or Medica Choice Care members. For SNBC, the CC is the primary contact for Medical Assistance benefits. SNBC SNP members receive assistance from their CC in accessing Medicare and Medical Assistance (Medicaid) benefits.

Care Coordinators collaborate with members and their providers to ensure that the members obtain the appropriate services they need to maintain a healthy independent lifestyle.

Additional responsibilities of the care coordinator include:

- Conducting health risk assessments within 30 days of enrollment and on an annual or as needed basis. Medica's model for MSHO requires face to face assessments with members. For MSC+, SNBC, and SNBC SNP face to face is preferred, but telephonic is allowed in certain circumstances.
- Developing a person centered care plan with the member based on the individual assessed needs of each member. Care plans are monitored and updated throughout the year.
- Transition of care assistance including support following hospitalizations and nursing home stays. Care Coordinators are required to check in with members following each transition of care to ensure that the member's care plan continues to meet their needs. Follow-up assessment may be conducted if member has experienced a significant change of condition.
- Member education on preventative and wellness activities including: advance directives,
- Facilitation of other social service needs.
- Support and referrals for mental health and member physical health needs as identified through the health risk assessment process.

<u>Collaboration with other programs</u>
Case Management: Care coordination members may be identified for a designated case management intervention, including the specialized case management programs described above. As needed, case managers will reach out to Care Coordination staff or leadership for member care collaboration.

<u>Audits and Reporting</u>
Medica performs a formal review of each Care Coordination Delegate at least annually. A variety of processes/documents are requested and reviewed to monitor: Timeliness and appropriateness of services (largely from the annual audit of assessments and care plans); Timely submission of requested materials; Delegate attestations and documentation about

© 2011-2023 Medica

processes; and key services provided by the Delegate, for example timely MMIS data entry, managing DTRs, and staying within a manageable monthly case mix for CCs. In addition, Medica annually audits member assessment and care plans following a DHS required audit protocol. These audits are conducted on-site with the delegate partners and are in addition to the formal review described above.

Disease Management

Medica's Disease Management program is designed to help members improve the management of chronic health conditions; including diabetes, asthma, and heart disease.

Eligible Populations

- Government Programs Care Coordinated products (MSHO, MSC+, SNBC, SNBC SNP) – Asthma, Diabetes, Heart Disease, Weight Management (MSHO only)
- Medicaid Families & Children (F&C, PMAP) – Asthma (Adult & Pediatric), Diabetes and Heart Disease
- Medicare Cost – Diabetes and Heart Disease

Program Description

The Health Support Condition (disease) Management program is administered through a delegated partnership with an NCQA accredited vendor called ActiveHealth. The program, targeting diabetes, asthma, and cardiac disease, delivers evidence-based interventions for members preselected due to condition and patterns of care. This program is designed to support member, provider and care coordinator referrals. Information about this program is available through internal phone messaging and Medica.com.

Member outreach and engagement is initiated either by a Medica care advisor for Minnesota Health Care Programs members or by ActiveHealth for Commercial product members. Once engaged, the care advisor uses intervention-specific tools and resources to triage members to appropriate program interventions relative to their identified level of risk.

Measurement/Evaluation Commercial and Medicaid

Program performance measurement and evaluation reporting is provided by ActiveHealth and typically consists of engagement and utilization metrics as well as outcomes, performance management and tracking. These metrics are designed to align with established goals based on industry best practice benchmarks and book of business experience over time.

Intervention Detail/Member Flow

1. Identification
    a. Use predictive modeling tools, claims data, pharmacy and utilization data to target and engage member based on condition and situation.
    b. Identified members are automatically loaded into systems for outreach. A Medica Care Advisor or ActiveHealth engagement staff reaches out to identified members to
        - Facilitate discussion and confirm willingness to engage

© 2011-2023 Medica

- Enroll member in appropriate program intervention per established protocols and process flows

2. Interventions
    a. Self-Care Tools/Information Letter - Low Risk
        - Select members receive an educational letter encouraging them to access disease specific educational material, resources and online support via CCMS generated letter.
        - Utilize MCG library/content for those members that do not have internet access/prefer paper solution.

    b. Condition-Specific Digital (Web-based) Coaching Program (Active Health Management) - Moderate Risk
        - Select members invited to enroll in the digital coaching program (Active Health Management).
        - Personalized, web-based learning experience provides an exciting, fun way to engage in health improvement.
        - Providing a personalized, highly relevant experience.
        - Offering content that helps individuals manage chronic conditions.
        - Meeting members on their terms, 24/7 based on their schedules.
        - Available Modules - Diabetes, Heart health, High blood pressure, Asthma, Cholesterol (up to 35 conditions).

    c. Targeted Telephonic Disease Management (ActiveHealth Management) – *Moderate and* High Risk
        - Active Health Management, focusing on targeted, high-impact chronic diseases (up to 35 conditions).
        - Condition specific evidence-based guidelines used to drive telephonic nurse interventions.
        - Initial focus on Diabetes, Heart Disease, Asthma Adult, and Asthma – Pediatric (F&C Only).

        - Access to ActiveHealth mobile App for self-management tools and the ability to message their personalized nurse
        - Real-time scheduling of members into the program during Care Advisor conversations as well as live warm transfer direct to an Active Health Management nurse disease manager.

3. Referrals
    a. Internal Medica Programs: Care Support, Care Coordination, Medica Behavioral Health, Customer Service

© 2011-2023 Medica

Identified participants will receive an initial assessment. This assessment may consist of the following:

- Confirmation of condition(s)
- General health status questions that apply to most patients
- Related condition-specific questions
- Questions about use of prescriptions and over-the-counter (OTC) medications

Data collected from the assessment will be used to automatically generate a customized care plan tailored to the specific conditions and needs of the identified participant. The care plan will consist of outreach specific to deficits and goals identified during the assessment process.

Cognitive-behavioral and motivational interviewing approaches are used during nurse condition management coaching calls to enhance motivation, build self-efficacy, offer support, provide accountability, restructure beliefs about health, examine and resolve ambivalence about changing, identify trigger situations for destructive habits, develop self-management skills and coping strategies, and build a relationship with the member. Coaching includes identifying issues, exploring base motivation to make lifestyle changes, establishing SMART goals, and establishing a plan or strategy to achieve the goals. Each coaching session explores the success in sticking to the plan and moving closer to goal achievement, as well as education and support to encourage and motivate the member to continue on the path towards lifestyle changes that last.

Behavioral Health Care Management

Medica offers two Behavioral Health programs that are differentiated by member populations as described below. The programs are designed to meet applicable state and federal regulations and align with the Mental Health Parity Addiction Act of 2008 and its underlying (MHPAEA) regulations.

Medica Health Plan Solutions (MHPS) Behavioral Health

Most Medica Health Plan Solutions (MHPS) health management programs include case management of members with behavioral health and substance abuse disorders.

Purpose

The purpose of the MHPS behavioral health program is promotion of overall self-efficacy, reduction of illness burden and improvement of behavioral health status for members of Individual and Family Business and a subset of members in Medica Health Plan Solutions plans.

Eligible Populations

Populations eligible for the MHPS Behavioral Health programs are members identified via our Coordinated Member Identification (CMI) algorithm or Daily Admission Report, or who are referred to the program by internal or external partners and who are select members of the MHPS populations.

Program Description

© 2011-2023 Medica

The MHPS behavioral health program is an internal program and includes case management of members with behavioral health and substance abuse disorders. A customized algorithm is used to identify members with high risk behavioral health and substance abuse diagnoses. Following identification and member engagement, behavioral health and substance abuse assessments are used to assist the care manager in collecting and interpreting data in the following categories:

- General information
- Member communication methods
- Depression screen via use of the PHQ-9 tool
- Screening for alcohol and other substance use disorders
- Members knowledge of their diagnosis and treatment
- Self-reported adherence to the treatment plan
- Psychosocial support availability
- Social Determents of Health, barriers and challenges in meeting the members goals of care and mutually agreed upon care plan

The completed assessment will trigger a list of associated opportunities which will then be used to develop an individualized care plan. The goals of the care plan target knowledge deficits, areas of potential risk, identified gaps in care, self-management opportunities and focus on promotion of overall self-efficacy, referral to behavioral health resources or providers, reduction of illness burden and improvement of behavioral health status.

Intake staff make triage and referral decisions not requiring clinical judgment. Case Management staff making triage and referral decisions requiring clinical judgment must be independently licensed in social work or nursing, and are supervised by the Medica Director of Care Management.

The Medica Director of Care Management is responsible for the following:

- Interact with BH care management staff on addressing needs of and developing care plan for members.
- Participates in interdisciplinary rounds, providing clinical insight to BH concerns and integrated health decisions.

Medica Behavioral Health (Optum)

Medica delegates medical management of behavioral health services to its behavioral health vendor, Optum Behavioral Health (also known to members as Medica Behavioral Health, or MBH) for all products other than Medica Health Plan Solutions (MHPS). Under this arrangement, MBH is responsible for behavioral health call triage and member referrals. MBH offers triage, referral and crisis management services by telephone 24 hours a day, seven days a week, three hundred and sixty five days per year. MBH clinical staff use the ESCII (Early Childhood Service Intensity Instrument), CASII (Child and Adolescent Service and Intensity Instrument) and LOCUS (Level of Care Utilization System – adults), as well as ASAM (American Society of Addiction Medicine) criteria, to determine appropriate levels of care based on risk, acuity of symptoms, individual/family/community safeguards, and level of functioning. These assessments help to guide decisions related to the level of urgency and the appropriate setting of care for behavioral health services. Delegated MBH utilization management services, including prior authorization,

© 2011-2023 Medica

concurrent review, denials and appeals, are described in the Utilization Management section of this document. MBH submits the Medica Behavioral Health Utilization Management Program Description on an annual basis. This document further describes the continuum of processes associated with behavioral utilization management and coordination of care.

Medica and MBH actively collaborate on efforts to improve care for members with co-existing medical and behavioral needs. Collaboration activities include:

- Coordination of case presentations in joint-shared medical rounds on Medica members presenting with complex comorbid conditions. Joint rounds with case managers and clinical leadership from both programs collaborating on case presentations.
- Training for MBH and Medica staff in assessment of complex medical and behavioral health cases, and developed dedicated consult and referral process between specialized case management programs. Establishing dashboard recurring report to track and monitor cases coordinated between programs, with coordinated manager oversight and reviews.
- MBH has provided training for the Medica Case Managers on motivational interviewing skills, identification and techniques in working with chronic pain and use of pain medication and use of the PHQ-2 and PHQ-9 in care planning, as well as approaches in supporting members who are challenged by care plan recommendations and/or interpersonal engagement.
- Use of the same electronic documentation system for some functions, which further integrates the understanding of the member's situation, and the applicable treatment plan with cross-referrals to specialized programs.
- Real-time consultation offered for the medical staff who have a member with behavioral health concerns.
- Case management interventions that include operational structure to support co-management between behavioral health and complex case managers.

Data are collected and reviewed annually to identify opportunities for improvement and address gaps in performance.

Eligible Population

All Medica members except MHPS are eligible for MBH services. Optum's networks of behavioral health providers are available to Medica members across all lines of business unless carved out.

Member Identification

Optum (Medica) Behavioral Health analytic tool is used as the predictive modeling tool for members receiving services through MBH. Medica collaborates with Optum by providing data feeds of eligible members for use in this tool. The Optum tool identifies those members whose medical and/or behavioral needs are resulting in high utilization of services, including numerous Inpatient, Residential Detox and/or ER services. Interventions are developed to assist members in optimizing their health and reducing negative impact of chronic or acute conditions.

© 2011-2023 Medica

Measurement and Evaluation
Data are collected and reviewed annually to identify opportunities for improvement and address gaps in performance. A number of clinical, financial and operational metrics are reviewed on a monthly, quarterly and annual basis including performance relative to performance guarantees and quality metrics. Results are reported to Medica in the Annual Quality Improvement and Utilization Management evaluation report.

Health and Wellness

Health and Wellness Strategy
Medica is committed to offering members a variety of solutions to help them meet and exceed specific and targeted health and wellness goals and objectives. This is accomplished through online, telephonic and paper-based programs that allow members to engage at a level that best meets their needs. Additionally, these programs are designed to provide tailored feedback and recommended action steps. Collectively, these programs align with Medica's broader Population Health Management strategy and help drive positive health outcomes for the populations served.

Eligible Populations
Fully Insured and Self-Funded Commercial, Medicare, Medicaid and Individual and Family Business (IFB).

Online Health and Wellness
Online vendor websites, tools and resources are available to eligible members as part of personalized health and wellness programs. Medica is dedicated to offering solutions that deliver value by focusing on individuals' needs. These websites provide tools and resources to enable individuals to be managers of their own health through a self-directed online experience.

My Health Rewards by Virgin Pulse
My Health Rewards is a personalized online and mobile app health program that helps individuals become successful managers of their own health. It is another Medica solution that delivers value by focusing on individuals' needs by recognizing that everyone manages their health in different ways.

Purpose
The purpose of Medica's My Health Rewards program is to provide a flexible, online and mobile app, self-directed tool to allow eligible members to identify gaps in self-care, learn new health behaviors and adopt behavior changes for health improvement.

Eligible Populations
Fully Insured and Self-Funded Commercial

Program Description
An important part of Medica's My Health Rewards program is the health assessment, which individuals may take during their first sign-on to the tool. Results from the assessment help to provide personal and relevant information and support for the member as they use the tool.

© 2011-2023 Medica

Regardless of where they fall within the health and wellness spectrum, the assessment provides each member with immediate, actionable feedback.

There are over 50 focus areas members can select, and completion of the health assessment personalizes the member experience. Current focus areas of the online modules include:

- Manage your COPD
- Be Tobacco Free
- Blood Pressure in Check
- Diabetes Type 2
- Eat Healthier
- Get Active
- Healthy Back
    - Heart-Healthy Cholesterol
    - Live Well with Asthma
    - Sleep Well
    - Stress Well
    - Financial Fitness
    - Weigh Less

Identification Methodology

Members are provided with wellness program options based on a prioritization rating that takes into account health status, perceived motivation and stated interest, risk, and readiness to change. In matching individuals to available and relevant programs, the wellness program collects a variety of critical data points-health assessment responses and self-reported data. This information is incorporated into a proprietary intelligent engagement engine that evaluates health status and drives program recommendations and related communications. After members complete the health assessment, they receive real-time program recommendations and personalized results, including a health score summary.

Member Outreach

Promotion of the tool primarily occurs within the employer groups. Medica Account Managers will provide information to the benefit administrators and brokers and promote at open enrollment or health fairs.

Members can also learn about the online health and wellness tool and mobile app in newsletter features and promotions on the website. Other programs encourage the use of the online health and wellness tool and mobile app for those who have it available as part of their benefit plan.

Logistics

Members access the program by downloading the mobile app or going to www.medica.com/MyHealthRewards.

Interventions

© 2011-2023 Medica

- Next-Steps Consult provides members with a phone consultation with My Health Rewards Guide. They'll receive help creating a personalized plan and recommended programs to improve their health and earn rewards.
- Journeys™ are purpose-built to help consumers shape new health habits and represent an advanced implementation of BJ Fogg's behavior model developed at the Stanford University Behavior Design Lab. Journeys are uniquely designed to rapidly iterate the "small steps" – presented within a choice architecture that puts the person back into personalization. Journeys are "open social" by design: enabling easy posting and integration of support from friends and family via Facebook, Twitter, Google+, Pinterest, Yammer, or email.

- Tracking physical activity, nutrition and gives you reward points. By logging, syncing a wearable device or syncing an app your healthy accomplishment such as physical activity, healthy eating and life balance encourages you to set, and beat, your personal best every day.

Staffing

The online tool is supported by a My Health Rewards Program Manager. This staff member works in conjunction with Medica's online health and wellness partner, Virgin Pulse.

Integration with Other Programs

Members that are identified for other Medica Programs (such as Complex Case Management, High Risk Pregnancy or Disease Management) will be prompted through telephone outreach by a Medica Care Advisor to enroll in these programs. When a member completes an identified Medica program; that information is reflected in the member portal experience and given reward points to earn gift cards (see Rewards)

Program Goals/Performance Targets

Program performance measurement and evaluation reporting typically consists of engagement and utilization metrics as well as outcomes or performance management and tracking. These metrics were designed to align with established goals based on industry best practice benchmarks and book of business experience over time. Consumer awareness, engaged population, increased knowledge of health risks, improved appropriate health care utilization.

ActiveHealth Management

Medica's Individual and Family business offers their members a unique health and wellness program to meet the health needs of eligible enrolled members. The Health and Wellness Program is available to eligible members who have a desire to improve their health. Individuals are provided program information through new member materials, member newsletters, and referrals from Customer Service and product-specific Health Management staff.

Purpose

The program addresses the whole person and focuses on health behavior change, increasing motivation and self-efficacy, teaching the member self-management skills and how to become a more active participant in their health. The Health and Wellness program is an online self-directed program offered through ActiveHealth Management.

© 2011-2023 Medica

Eligible Populations
Individual and Family Business (IFB)

Program Description
The ActiveHealth Management Wellness Program addresses an inherent need to live better, live longer, and live happier. ActiveHealth Management health and wellness tool delivers a personal health engagement platform that supports the need and wants of the member.

Members receive:

- Evidence-based population health solutions
- Tailored programs, coaching and digital tools
- Advanced analytics.
- Online Library which includes all sorts of resources including:
- Social communities – Online support for cancer, cholesterol, depression, diabetes type 2 and hypertension
- Extensive resource library includes articles, recipes, webinar and more.
- Engagement platform that syncs with a wide variety of fitness trackers (i.e. Apple HeathKit, Fitbit, Garmin, MyFitnessPay, etc.)

The ActiveHealth program blends personal and digital support to tailor an experience that promotes engagement. Members complete an assessment to assess risk across six different health dimensions. CareEngine health actions are generated for each member. The CareEngine continually analyzes member data to generate new health actions as member act on their personalized actions. Members can address these identified health risks in two different sections: Your Health Goals and Your Health Education. Members earn Hearts by completing any type of digital coaching activity. Hearts (50) can be traded for a single prize drawing entry. Members can enter up to 5 times per month.

Health Goals:

- Members set a health goal and commit to working on it for seven days
- Each day there are 3-5 action items (Gamified skill-building activities, fun and educational quizzes and Inspiring stories) the member completes which lead to achieving their goal. Members earn Hearts for each action item completed.

Health Education:

- Members choose topics that are relevant, and complete a variety of activities to help increase awareness and education
- Over 30 categories available, with hundreds of different health topics.

<u>Program Goals/Performance Targets</u>
Program performance measurement, evaluation and oversight consists of monitoring website registration, engagement and completion metrics as well as relevant website application program performance management and tracking. These metrics are designed to align with established goals based on year over year group specific performance as well as comparisons to industry best practice benchmarks and book of business experience over time.

© 2011-2023 Medica

24/7 Nurse Triage and Advocacy Services
Nurse line vendor services are available to eligible Medica members 24 hours a day, seven days a week. Through these services, members can consult with a registered nurse to receive guidance on appropriate treatment options, non-urgent illnesses and behavioral health as well as more administrative support for claims, appeals, benefits education, provider searches and transportation. Medicare Advantage and Cost members also have access to a behavioral health crisis line through Medica Behavioral Health.

Nurse line vendors, services and eligible populations are described below.

Call Link by Optum®
Members may access the Call Link® line by calling a toll-free number to be connected with an advisor or nurse who can answer member questions about health conditions, discuss medications and symptoms and offer self-care tips for non-urgent concerns. A Call Link advisor or Nurse is also able to recommend options for care in the appropriate setting to meet their immediate health care needs and assist with finding a health care provider.

Purpose
Over program goals from the member's perspective are defined as:

- Single point of contact for all health and wellness needs, including health plan customer service referral if needed in existing model.
- This integrated offering maximizes the value of inbound phone calls by connecting members with the most appropriate resource to service their unique needs and connect them into their broader benefits.
- Robust advocacy service that integrates advanced clinical support, 24/7 access for symptomatic or general health questions, guidance for ER and urgent care usage, benefit and system navigation.

Eligible Populations
Fully Insured and Self-Funded Commercial

Program Description
Medica CallLink® connects eligible members with advisors and nurses around the clock. When members call, they'll receive trusted answers, information and support for a wide range of health concerns. This service is available at no additional cost to eligible members, as part of their health plan.

Get answers to your health-related questions:

- Learn more about a diagnosis
- Decide what type of care meets their needs
- Understand symptoms and treatment options
- Create a plan for adding healthy habits to their routine
- Understand how to take medications safely and effectively
- Find a doctor or hospital and schedule an appointment

© 2011-2023 Medica

- Get information about preventive screenings services like health screenings and immunizations

Program Goals/Performance Targets

Program evaluation reporting typically consists of engagement and utilization metrics as well as outcomes or performance management and tracking. These metrics are provided to Medica on a quarterly basis through standardized reporting 45 days after the end of the quarter.

Performance targets are set for those parameters which are part of the agreement's withhold performance guarantees. These metrics are designed to align with established goals based on industry best practice benchmarks and book of business experience over time and include:

- Average Speed of Answer (Target = 80% of calls answered in >30 seconds)
- Call Abandonment Rate (Target = > 5%)
- Percentage of participants who respond "satisfied" or "very satisfied" to the question: "Overall how satisfied were you with the staff helping you address your health care need?" (Target = 90%)

NurseLine and Advocacy Services by HealthAdvocate™

Eligible members have access to the Nurse Line and Health Advocate service through a dedicated toll-free number designated by eligible plan benefits. This includes support in the areas of 24/7 nurse triage, health information, care coordination, benefits education, claims and appeals assistance and transportation support.

Purpose

Access to medical information and help from registered nurses anytime, 24/7. Finding the right answers at the right time is at the heart of what we do. Health Advocate's NurseLine offers unlimited access to highly trained registered nurses for help and information, 24/7.

Eligible Populations

Medicare, Medicaid, Individual and Family Business (IFB) and Medica Health Plan Solutions (MHPS)

Program Description

Solution Features:

- Healthcare information at any time 24/7, 365 days a year
- Information about simple home care measures for non-urgent conditions
- Evaluation and direction to appropriate care (911, ER or urgent care for life-threatening conditions)
- Answers about symptoms and medication usage

In addition to 24 hour nurse line support, eligible members also receive unlimited Personal Health Advocacy services. Health Advocacy provides members and their families with confidential, one-on-one help from an industry expert who knows the ins and outs of the complex healthcare system. Our team of trained Personal Health Advocates is skilled at working with healthcare providers, insurance plans and other health-related organizations to resolve complex clinical and administrative issues. Whether it's deciding the right course of treatment,

© 2011-2023 Medica

understanding care options, or resolving a billing issue, our experts will help members no matter what the issue — saving time, money and worry.

A Personal Health Advocate can:

- Resolve health care claim issues and assist with negotiating billing and payment arrangements
- Find the best doctors, hospitals, dentists, and other leading health care providers anywhere in the country
- Schedule appointments with providers, including hard-to-reach specialists and critical care providers
- Estimate costs of specific medical procedures and services
- Address elder care and related health issues
- Obtain unbiased health information to help you make informed health care decisions
- Answer your questions about medical test results, treatments, or medications recommended by your physician
- Help you transfer medical records"

NurseLine and Advocacy Services Program Goals/Performance Targets

Program performance measurement, evaluation and oversight consists of monitoring cases created, interactions completed, clinical vs. administrative reasons for calls as well as member satisfaction rates and call center telephony data. These metrics are designed to align with established goals based on year over year group specific performance as well as comparisons to industry best practice benchmarks, book of business experience over time and targets based on contractual performance guarantees metrics and include:

- Average Speed of Answer (30 Seconds or Less)
- Call Abandonment Rate (5%or less)
- Satisfied with services (90%)

Senior Fitness

OptumHealth Care Solutions, LLC has developed a fitness program called One Pass™ Fitness Program (One Pass), through which members receive free access to tools and resources to help them become more physically fit, lowering risk for disease and improving quality of life. The program includes a fitness club or exercise center membership, on-demand and live-streaming fitness classes and online resources to educate and motivate members (referred to as "One Pass"). Medica makes the One Pass program available to certain Medicare eligible members who are enrolled in Medica's Medicare and Medicaid programs.

Purpose

One Pass promotes a next generation fitness and wellness-based program offering with greater access to whole body wellness activities that include physical, digital, mental and social engagement options and promote health engagement.

Eligible Populations

Medicare Cost, Advantage, Supplement and Dual Eligible (MSHO, SNBC SNP)

© 2011-2023 Medica

Program Description

One Pass by OptumHealth Care Solutions, LLC offers a complete fitness solution for mind and body. Our Medicare and Medicaid members have the flexibility to choose from a large network of more than 20,000 gym locations nationwide, including leading national brands and boutique studios.

Acknowledging the convenience and health safety of working out at home in a post COVID world, One Pass offers over 20,000 on-demand and livestreaming classes that improve heart health, strength, and balance through a variety of modalities including cardio, pilates, yoga, meditation and more. Home kits focused on strength, yoga or dance are available annually. Workout builder demonstrates how to perform more than 2,500 exercise movements in over 800 workout videos. This expansive online option promotes virtual health activities 24/7 from locations anywhere around the world.

One Pass programming supports whole body health including memory training. Personalized online brain training by Brain HQ offers fun and engaging activities to help improve memory, attention, focus and brain speed.

One Pass also connects members to social activities through virtual and community based offerings. Programming is available for a variety of interests to encourage physical well-being and social interaction. Options include walking, tennis, pickleball, book clubs, fishing, board games, cycling, swimming, bowling, gardening, dancing, walking and arts & crafts.

A comprehensive approach for qualified health plan members, One Pass provides:

- A standard fitness membership
- access to group exercise classes led by certified instructors
- On-demand and live-streaming fitness classes
- Health education
- Fun social activities and networking
- Brain HQ, a memory training platform to support brain speed, memory and cognitive resilience

One Pass includes all the key components for success built into the program, including strategic marketing and public relations services, collaborative account management, proactive network management, and more. Partnering health plans and participating locations are listed at www.Medica.com/Fitness.

One Pass Program Goals/Performance Targets

Program performance measurement, evaluation and oversight consists of monitoring enrollees' percentage active, percentage participating and average visits by product. These metrics are designed to align with established goals based on year over year group specific performance as well as comparisons to industry best practice benchmarks and book of business experience over time.

© 2011-2023 Medica

Tobacco Cessation
Medica's telephonic tobacco cessation program is designed to help members work through the quit process with an individual quit plan and provide Nicotine Replacement Therapy, as medically appropriate.

Eligible Populations
Includes MSHO, MSC+. SNBC, SNBC SNP and IFB (select populations)

Program Description
Medica's Tobacco Cessation Program helps members reach their goal of living tobacco free. The program takes a comprehensive approach that recognizes the member's lifestyle, triggers and challenges are as unique as they are. This is reflected in a customized quit plan prepared by the tobacco cessation coach. Equipped with their plan, members participate in phone sessions with their coach, who helps with goal setting and motivation while providing overall support. Member enrolled in Care Coordination Products are eligible for telephonic tobacco cessation. All pregnant IFB and SNBC members are referred to Tobacco Cessation through their Case Manager/Care Coordinator.

Program Goals/Performance Targets
Maintain the program engagement rate of 80% or higher for members referred to into the program.

Identification Methodology
Members self-refer into the Medica Tobacco Cessation Program by: contacting Medica directly, Provider Referral Program, Quit Plan Referral, and internal referrals.

Telephonic Program
The telephonic program offered through our vendor partner, ActiveHealth Management includes eligible member outreach, engagement and a personalized approach to quitting. Medica receives program referrals; enroll members, and warm transfer the member to an ActiveHealth coach to start the intervention.

Engagement/Outreach
Once a member has indicated that they are interested in participating in the Tobacco Cessation Program, they receive an outreach phone call to schedule their initial interview with a Tobacco Coach.

Medica promotes the program on Medica.com and highlights these services through conversation with customers, providers and brokers. There is a brochure and program flyer available for Health Fairs and Medica-supported community events.

Interventions
The Tobacco Cessation program is 12 months supporting members weekly at the onset and then 2- month, 6-month, 12-month. Members are also welcome to call in at any time for additional support. A health coach trained in tobacco cessation will help members develop a personalized plan.

© 2011-2023 Medica

Once a member has been enrolled in the Tobacco Cessation program, they receive an initial assessment. Following the assessment and as appropriate, the Medica delegated vendor sends a letter to the member's selected provider requesting approval for NRT delivery with consideration of member preferences and any identified contraindications. This helps the health coach to build a rapport with the member and learn about the member's needs and wants related to their health. In addition, the initial assessment will assess the member's readiness to make lifestyle and behavior changes and their level of self-management understanding. Telephonic coaching sessions, tailored educational mailings, proactive coordination and referral to services and resources.

Incentive
All IFB and SNBC pregnant members whom successfully achieve 30 consecutive days tobacco free are eligible for an incentive.

Language and Ethnicity Needs
Medica recognizes that its members come from diverse cultural backgrounds and may speak languages other than English. Medica and our vendor delegate utilize translation services as appropriate.

Nicotine Replacement Therapy
Medica's program includes free over-the-counter (OTC) nicotine replacement therapy (NRT) as part of the coaching program for all members over the age of 18. An 8-week supply of the patch, gum or lozenge NRT will be sent in two shipments via mail order at no additional cost to the member. Members are assessed medically for appropriate medication use (i.e., members who are pregnant or members with certain chronic conditions are not eligible for NRT). NRT is normally received within 10 days of ordering.

Prescription nicotine replacement therapy such as bupropion (Zyban), Chantix, Nicotrol Inhaler, and Nicotrol nasal spray are available with a physician prescription only. These NRTs are not fulfilled as part of the Medica Tobacco Cessation Program. Based on medical pharmacy benefits, members may have a co-pay or co-insurance for this medication.

Individual and Family Business
Members enrolled in an Individual and Family Business product have access to a tobacco cessation program through ActiveHealth Management self-management tools; an on-line health and wellness tool and tobacco specific Care Pathways in the CareManager application; and the state-funded program Free and Clear.

All IFB pregnant members have access to Medica's telephonic Tobacco Cessation Program and the opportunity to earn an incentive for achieving 30 consecutive days of tobacco cessation.

Commercial Markets
Members enrolled in Commercial products have access to a tobacco cessation program through My Health Rewards; an on-line health and wellness tool. Commercial members referred to Medica through Minnesota Quitline Program (formerly the Call it Quits program).

© 2011-2023 Medica

QUALITY IMPROVEMENT WORK PLAN

Quality Improvement Work Plan

- **Clinical quality**: Clinical care and outcomes.
- **Member experience**: member experience with health plan products and services.
- **Patient safety**: Safe clinical practices, safe member self-care and medical error reduction.
- **Provider quality**: Clinical care and service provided by Medica's provider network.
- **Service quality**: Member and customer service provided by the health plan.

Activities related to Population Health fall into one of the following stratification levels, from lowest to highest complexity:

- Keeping Members Healthy
- Managing Emerging Risk
- Patient Safety/Outcomes Across Settings
- Managing Multiple/Chronic Conditions

Activities related to Health Equity are categorized by:

- Access and Outcomes
- Leadership and Decision-Making
- Data Practices
- Policies and Procedures

The Work Plan also addresses the ongoing work throughout Medica that supports the quality improvement program. Though these efforts may not involve discrete quality improvement projects, they do contribute to clinical, service and safety improvements for Medica's members. The Work Plan lists:

- **Measurement and Monitoring:** Ongoing measurement and monitoring work that supports the quality improvement program.
- **Delegated Quality Improvement/Utilization Management**: Activities performed on Medica's behalf by vendors delegated for quality improvement and/or utilization management.

Work Plan Development, Review and Approval

The Quality Improvement department compiles the QI Work Plan with input from business units and stakeholders throughout Medica. The Quality Subcommittee (QS) reviews and approves the plan annually. Upon QS approval, the work plan is presented to the Medical Committee of the Medica Board of Directors, which the Medica Board of Directors has designated as the company's "quality assurance entity". Both the Medical Committee and the Board of Directors review the work plan, with the Board of Directors retaining final approval authority.

© 2011-2023 Medica

The QI Work Plan is a fluid document. Activities may change during the year based on the results of quarterly assessments, or as goals and priorities change. The Quality Improvement department monitors overall work plan progress and presents quarterly status reports to QS.

© 2011-2023 Medica

QI PROGRAM EVALUATION

Program Evaluation

Medica's annual QI program evaluation outlines the previous year's clinical and service quality activities, as reported in the annual QI Work Plan. The evaluation also includes an assessment of the QI committee structure, adequacy of program resources, and the key challenges and barriers encountered during the year. The program evaluation document includes:

- Descriptions of the year's principal QI activities
- Measurements and trending to assess performance
- Analysis of Medica's success in demonstrating improvements
- Evaluation of the overall effectiveness of the QI program
- Recommendations for changes in areas that did not meet annual goals

The QI Program Evaluation forms the basis of the next year's QI Work Plan.

Because the QI Work Plan is subject to change during the year, the annual QI Program Evaluation aligns with the most recent quarterly Work Plan update. It may not exactly match the first iteration of the Work Plan released at the beginning of the year.

Review and Approval

The Quality Improvement department completes a program evaluation at the end of each calendar year and presents it to QS for review. Upon QS approval, the program evaluation is presented to the Medical Committee of the Medica Board of Directors, which the Medica Board of Directors has designated as the company's "quality assurance entity". Both the Medical Committee and the Board of Directors review the program evaluation, with the Board of Directors retaining final approval authority.

© 2011-2023 Medica

QUALITY IMPROVEMENT AND UTILIZATION MANAGEMENT DELEGATION

Delegation Oversight

Medica holds its delegates to the same performance standards that apply to Medica itself. Medica is ultimately responsible to the applicable regulatory and accrediting bodies for its delegates' performance. Medica delegates only to entities that demonstrate the infrastructure and capacity to meet regulatory and accreditation standards. Delegation oversight involves:

- **Pre-delegation assessment**
  Medica performs a comprehensive assessment of prospective delegates prior to delegating any activities to ensure they have the infrastructure and capacity to meet federal and state requirements, regulatory, and accreditation standards. Medica reserves the right to limit or rescind delegation if the delegate is unable to meet Medica's standards or expectations.

- **Ongoing oversight**
  Medica uses a risk ranking model to conduct ongoing assessments of delegate performance to ensure business goals and compliance outcomes are achieved. This may include monthly monitoring and/or annual audits of delegates. Identification of deficiencies or process gaps are documented and managed when appropriate through corrective action plans to remediate concerns or bring delegate into a compliant state.

The Delegation and Subcontractor Oversight Committee (DSOC) oversees QI and UM delegation, along with other delegated and vendor functions.

QI and UM Delegates

Delegated for QI and UM

- Optum Behavioral Health (Medica Behavioral Health)

Delegated for UM

- Optum Physical Health
- Delta Dental of Minnesota
- ActiveHealth Management
- Express Scripts Inc.
- Magellan (specialty pharmacy, administered in-clinic)
- Accredo Health Group (specialty pharmacy home delivery)

© 2011-2023 Medica

REVIEW AND UPDATE OF QI PROGRAM DESCRIPTION

Review and Approval

The QI Program Description is reviewed and updated not less than annually. The QI Department coordinates the review and presents the updated document to QS. Upon QS approval, the program description is presented to the Medical Committee of the Medica Board of Directors, which the Medica Board of Directors has designated as the company's "quality assurance entity". Both the Medical Committee and the Board of Directors review the program description, with the Board of Directors retaining final approval authority.

Administrative Service Agreements

Medica Health Plans holds administrative services agreements with legal entities Medica Insurance Company (MIC); Medica Self-Insured (MSI); Medica Community Health Plan (MCHP); and MMSI. These agreements permit Medica Health Plans to provide services for the named legal entities that include quality assurance and improvement programs. All quality improvement structures, processes and activities described in this Program Description apply to Medica members enrolled in MHP, MIC, MSI, MCHP and MMSI health plans. The Medical Committee of the Medica BOD has the authority to serve as the quality assurance committee for all Medica legal entities.

© 2011-2023 Medica

APPROVALS AND SIGNATURES

Cara Broich, RN, CPHQ
Senior Director, Quality and Clinical Advancement

February 24, 2023

Charlotte Hovet, MD
Senior Medical Director, Quality Improvement

February 24, 2023

Committee approvals

Quality Subcommittee	February 24, 2023
Medical Committee of Medica Board of Directors	March 20, 2023
Medica Board of Directors	March 20, 2023

© 2011-2023 Medica

APPENDIX: QI PROGRAM DESCRIPTION APPROVAL HISTORY, 2012-2022

2022

March 18, 2022	Approved by the Quality Improvement Subcommittee
April 26, 2022	Approved by the Medical Committee of Medica Board of Directors
April 26, 2022	Approved by the Medica Board of Directors

2021

March 26, 2021	Approved by the Quality Improvement Subcommittee
April 27, 2021	Approved by the Medical Committee of Medica Board of Directors
April 27, 2021	Approved by the Medica Board of Directors

2020

March 27, 2020	Approved by the Quality Improvement Subcommittee (e-vote)
April 21, 2020	Approved by the Medical Committee of Medica Board of Directors
April 21, 2020	Approved by the Medica Board of Directors

2019

March 8, 2019	Approved by the Quality Improvement Subcommittee
April 15, 2019	Approved by the Medical Committee of Medica Board of Directors
April 23, 2019	Approved by the Medica Board of Directors

2018

April 18, 2018	Approved by the Quality Improvement Subcommittee
April 24, 2018	Approved by the Medical Committee of Medica Board of Directors
April 24, 2018	Approved by the Medica Board of Directors

2017

March 31, 2017	Approved by the Quality Improvement Subcommittee
April 25, 2017	Approved by the Medical Committee of Medica Board of Directors
April 27, 2017	Approved by the Medica Board of Directors

2016

March 18, 2016	Approved by the Quality Improvement Subcommittee
April 26, 2016	Approved by the Medical Committee of Medica Board of Directors
April 26, 2016	Approved by the Medica Board of Directors

© 2011-2023 Medica

2015

March 13, 2015	Approved by the Quality Improvement Subcommittee
April 28, 2015	Approved by the Medical Committee of Medica Board of Directors
April 28, 2015	Approved by the Medica Board of Directors

2014

March 21, 2014	Approved by the Quality Improvement Subcommittee
April 29, 2014	Approved by the Medical Committee of Medica Board of Directors
April 29, 2014	Approved by the Medica Board of Directors

2013

March 29, 2013	Approved by the Quality Improvement Subcommittee
April 23, 2013	Approved by the Medical Committee of Medica Board of Directors
April 23, 2013	Approved by the Medica Board of Directors

2012

April 3, 2012	Approved by the Quality Improvement Subcommittee
April 24, 2012	Approved by the Medical Committee of Medica Board of Directors
April 24, 2012	Approved by the Medica Board of Directors

2011 and previous: approval dates available on request.

© 2011-2023 Medica