Implementation Council

Mar 8, 2022

Commonwealth Care Alliance

One Care Rating Categories Definitions

Data is shown by rating category in this presentation. See rating category definitions below for reference:

F1- Facility-based Care. Individuals identified as having a long-term facility stay of more than 90 days

C3- Community Tier 3. High Community Need. Individuals who have a daily skill need of two or more Activities of Daily Living (ADL) limitations AND three days of skilled nursing need; and individuals with 4 or more ADL limitations

-In CY2014, C3 split into two subsets:

C3B: for C3 individuals with certain diagnoses (e.g. quadriplegia, ALS, Muscular Dystrophy and Respirator dependence) leading to costs considerably above the average for current C3

C3A: for remaining C3 individuals

C2- Community Tier 2. Community High Behavioral Health. Individuals who have chronic and ongoing Behavioral Health diagnosis that indicates a high level of service need

-In CY2014, C2 split into two subsets

C2B: for C2 individuals with co-occurring diagnoses of substance abuse and serious mental illness

C2A: for remaining C2 individuals

C1- Community Tier 1 Community Other. Individuals in the community who do not meet F1, C2 or C3 criteria

Utilization Management Definitions

Approvals
A request is granted.

Approvals with Modifications (aka Partial Approvals)

A request is granted with a decrease or substitute.

Denials

A request has not been granted. Examples include:

- Procedural denials- claim filed incorrectly or duplicative
- Member's plan maximum benefit reached
- Request for out-of-network provider with in-network options available
- Medical necessity criteria not met

Prior Authorization – Decision Letters

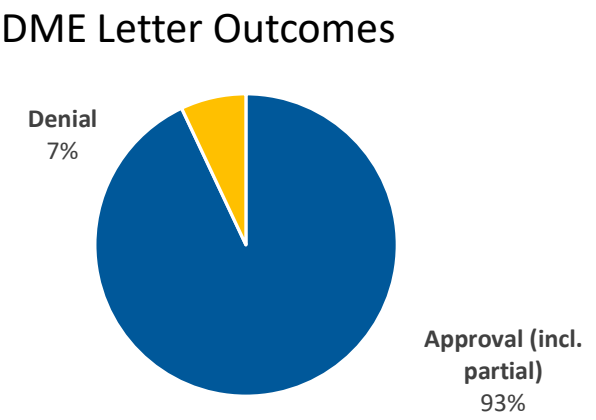
- Decision letters are sent in response to all prior authorization requests received
  - Services not requiring prior authorization do not result in a letter. Instead, the member is kept informed by their Care Partner and/or provider.
- Decision letters are sent to the member and their provider that explains the outcome of the request
- Decision letter content depends on outcome
  - Approvals outline:
    - Services being approved as well as amount approved
  - Approvals with Modification* (*Partial Approvals only*) outline :
    - What was approved compared to the original request
    - Why we made this change
    - Member appeal rights and instructions
  - Denials outline:
    - Why we denied this request
    - Member appeal rights and instructions
- Members can appeal modifications and denials themselves, or have a care partner/trusted individual guide the appeal process

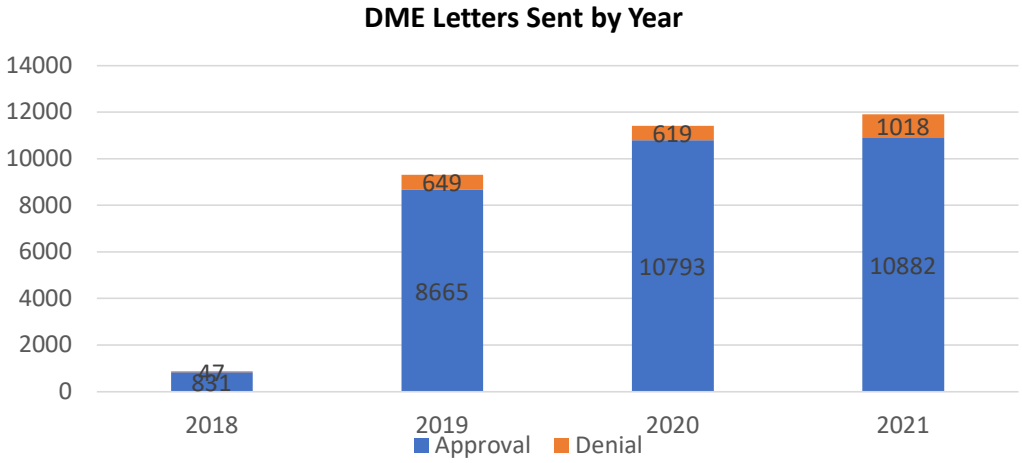
*Modifications considered "upgrades" are captured in the approvals category due to existing systems and processes

93% of sent DME letters are Approvals

Of the **33,504 DME requests** from **12,090 members** sent since 2018* which resulted in a decision letter[1]:

- **93%** were approvals (including partial)
- **7%** were denials





Year	Approval N (%)	Denial N (%)	Total
2018	831 (95%)	47 (5%)	878
2019	8,665 (93%)	649 (7%)	9,314
2020	10,793 (95%)	619 (5%)	11,412
2021 YTD	10,882 (91%)	1,018 (9%)	11,900
Grand Total	**31,171 (93%)**	**2,333 (7%)**	**33,504**

*2018 is partial data reflecting Nov and Dec

[1]Letters are sent for DME requiring prior authorization

DME[1] Letters - Rating Category

Most DME letters are sent to C3A members.

-C1: 6%

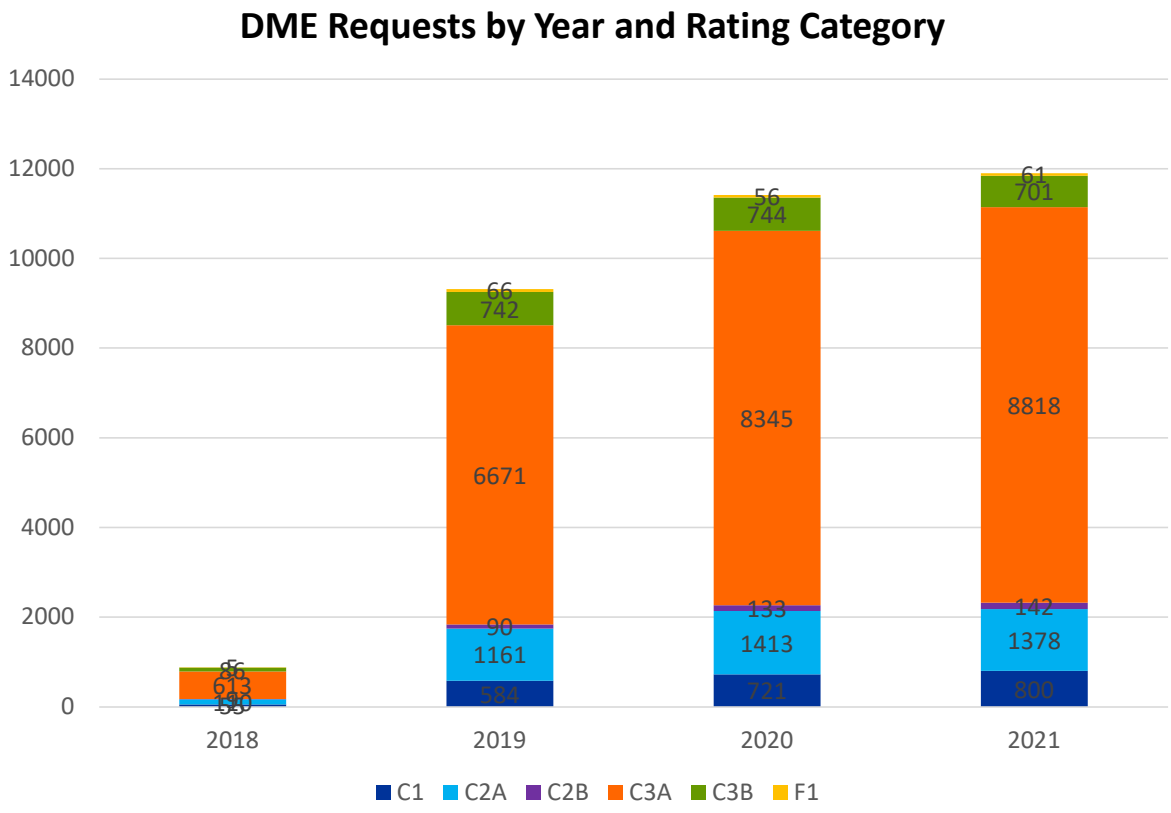
-C2: 13%

- C2A: 12%
- C2B: 1%

-C3: 80%

- **C3A: 73%**
- C3B: 7%

-F1: 1%



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[1]Letters are sent for DME requiring prior authorization

DME Letters[1] – Year and Rating Category

*2018 is partial data reflecting Nov and Dec

[1]Letters are sent for DME requiring prior authorization