

Exhibit H – Clinical Management (150 maximum points)

Mandatory Scored (unless otherwise specified)

1. Clinical Objectives (13 maximum points)

Please limit response to two (2) pages, excluding any visual aids/flow charts.

- 1.1. Describe the Bidder's clinical objectives for its MA-PD Health Plan(s). Are clinical initiatives centered on cost savings and/or increases to quality of care? How does the Bidder define success for its Clinical Management operations listed below (Sections 2-9)?
- 1.2. Describe how the Bidder tracks and monitors the success of Clinical Management operations listed below (Sections 2-9), including how the Bidder analyzes and measures outcomes. Provide specific examples for each section.

2. Clinical Management (22 maximum points)

Please limit response to four (4) pages, excluding any visual aids/flow charts.

- 2.1. Describe how the Bidder will facilitate transitions of care for Members switching from their previous coverage to Bidder's MA-PD Health Plan(s).
 - 2.1.1. Describe specific transition services for Members who have complex health conditions, a current active treatment plan or prior authorization, or who will be hospitalized between January 1 and March 31, 2021.
 - 2.1.2. Confirm that the Bidder will honor previously approved prior authorization requests provided that: 1) the request was made by a provider within the Bidder's network; and 2) the request is for covered services under the Bidder's MA-PD Health Plan(s).
- 2.2. The Bidder will be required to report annually on its primary care spend, broadly defined as the percentage to total cost of care devoted to primary care services. Does the Bidder currently measure primary care spend?
 - 2.2.1. If yes, how does the Bidder measure it? Does the Bidder have a target?
 - 2.2.2. Whether or not a current methodology is in place, is the Bidder willing to provide a report following the methodology provided by HCA, if awarded a Contract? What strategies has the Bidder undertaken to promote the integration of behavioral health into primary care? Include in the response:
 - 2.2.3. Whether the Bidder reimburses for collaborative care codes (as defined by Medicare).
 - 2.2.4. How the Bidder tracks behavioral health outcomes.
- 2.3. Does the Bidder collaborate with medical and health care communities, associations, and societies during the development and implementation of medical policies? If yes, which ones, and what is the extent of these collaborations? Give specific examples of collaboration efforts. If no, please describe the Bidder's intention for collaboration, and provide specific examples of future plans.

- 2.4. Describe Bidder's provider contracting strategy to promote clinical quality, Member experience, and patient outcomes.
- 2.5. Does the Bidder require network providers use an Electronic Health Records (EHR) system/software? If no, please explain why. If yes, please elaborate on the following:
 - 2.5.1. Is a specific EHR required across all providers in the Bidder's network? If yes, which one? Are there any exceptions or exclusions?
 - 2.5.2. For clinical, subcontracted health care systems, does the Bidder have an IT interoperability arrangement to facilitate data sharing for the calculation of clinical performance measures? If the Bidder has these arrangements for some but not all subcontracted systems, what number and percent have these arrangements?
- 2.6. Describe the Bidder's process and timelines for notifying providers of changes in the Bidder's medical policy, including any yearly changes instituted by CMS, which materially affects the way the plan pays for services.
- 2.7. Describe how the Bidder uses evidence-based practices to guide benefit design, plan coverage, and provider contracting.
- 2.8. Describe what the Bidder is doing to address the opioid epidemic. Include the following in the answer:
 - 2.8.1. How is the Bidder working with the provider community to improve opiate prescribing?
 - 2.8.2. What is the Bidder doing to provide and pay for evidence-based non-pharmacologic options for pain management?
 - 2.8.3. Describe risk reduction strategies for chronic opioid users.
 - 2.8.4. How is the Bidder increasing access to Medication-Assisted Treatment (MAT) in their provider network and ensuring that providers are offering MAT to Members diagnosed with opioid use disorder?

3. Quality Measurement & Reporting (18 maximum points)

Please limit response to two (2) pages, excluding any visual aids/flow charts.

- 3.1. Describe the Bidder's use, collection, and reporting of Patient Reported Outcomes.
- 3.2. How does the Bidder align, or have plans to align, quality measures from the Medicare Advantage Stars program with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Merit-Based Incentive Payment System (MIPS)? Include in the response a sample report with the Bidder's proposed measures set for clinical quality reporting to HCA.
- 3.3. How do the Bidder's business practices align with:
 - 3.3.1. National Committee for Quality Assurance (NCQA) and/or Utilization Review Accreditation Commission (URAC) standards?
 - 3.3.2. Healthcare Effectiveness Data and Information Set (HEDIS) standards?

- 3.3.3. Pharmacy Quality Alliance (PQA) standards?
- 3.3.4. MACRA standards?
- 3.3.5. Medicare Advantage Star Rating program standards?
- 3.4. Describe the Bidder's performance on the Medicare Advantage Star Rating program metrics, including:
 - 3.4.1. Average and median score across the Bidder's Medicare Advantage Book-of-Business (employer group and individual market plans) for the past 5 years.
 - 3.4.2. Any metrics that the Bidder does not report on for its employer group Medicare Advantage plans, and why.

4. **Utilization Management (UM) (15 maximum points)**

Please limit response to twelve (12) pages, excluding any visual aids/flow charts. Describe the Bidder's:

- 4.1. Organizational approach, philosophy and process for UM and address the following:
 - 4.1.1. Process through UM to reduce medically unnecessary care.
 - 4.1.2. Ability to use UM to support timely and appropriate health care services for the right care for the right Member at the right time at the right level of care.
 - 4.1.3. How the Bidder's UM facilitates appropriate and timely referrals to other benefit programs (e.g., Complex Case Management).
 - 4.1.4. How the Bidder's UM supports Member safety and quality of care.
 - 4.1.5. How the Bidder's UM supports Shared Decision Making.
 - 4.1.6. How the Bidder's UM improves Member and provider satisfaction.
 - 4.1.7. Process for analyzing utilization trends in health care services. What steps has the Bidder taken in the last five (5) years to manage patterns of over- and under-utilization?
 - 4.1.8. How the Bidder selects services and/or procedures to track for over- and under-utilization. What services and/or procedures does the Bidder track?
 - 4.1.9. Vision for the future of UM, including the roles of providers in optimally managing utilization and promoting the delivery of evidence-based care.
- 4.2. Clinical leaders responsible for the UM program, such as medical director/clinical director and operational director, by providing a professional biography for each.
- 4.3. Clinical and non-clinical UM team members. How many team members are there, and what are their qualifications, roles, and functions?
- 4.4. Clinical peer reviewers. Provide the number of reviewers and their qualifications.
- 4.5. Credentialing process for clinical/medical directors, clinical peer reviewers, and all other licensed clinical reviewers.

- 4.6. Specific location (city and state) of UM operations, if any, including the identification of U.S.-based and any offshore based operations. If distant UM operations are used, describe the Bidder's process for ensuring that CMS and/or local standards are appropriately applied.
- 4.7. Use of a subsidiary subcontract or an external subcontract, if applicable. If these are used, please describe the subcontractor's services and the Bidder's oversight process in detail.
- 4.8. Process for utilization review, including prior authorization, concurrent review, retrospective review, etc. Please address the following in your response:
 - 4.8.1. Process for how a provider submits a prior authorization or concurrent review request to the Bidder.
 - 4.8.2. Process for determining medical necessity. Include the source of clinical guidelines and criteria the Bidder uses in UM decision making.
 - 4.8.3. Process for reviewing health care services when there are no clinical guidelines/criteria (e.g. potentially experimental or investigational health care services).
 - 4.8.4. Process and timeframe when a case does not meet clinical review guidelines/criteria.
 - 4.8.5. Processes to notify Members of UM policies that may impact their benefits. Please provide copies of Member-facing materials or communications, including a schedule of when these materials are released.
 - 4.8.6. Specific processes for the review of behavioral health services.
 - 4.8.7. Specific processes for the review of inpatient/acute health care services.
 - 4.8.8. Specific processes for the review of ambulatory healthcare services.
 - 4.8.9. Specific processes for the review of services provided by Centers of Excellence (COEs). If the Bidder does not currently use COEs, please explain why and whether it intends to offer them in the future.
 - 4.8.10. Process for notifications when there is a denial.
 - 4.8.11. Process for notifications when there is an Appeal.
 - 4.8.12. Hospital or skilled nursing preadmission counseling process.
 - 4.8.13. Hospital or skilled nursing discharge planning process.
 - 4.8.14. Hospital or skilled nursing post-discharge follow-up process.
 - 4.8.15. Process for referrals to other services, such as Complex Case Management services.
- 4.9. Approach to minimizing the administrative burden of UM.
- 4.10. Processes for interacting, coordinating, and integrating UM with Complex Case Management, Chronic Condition Management, and other Clinical Management Services. What is the Bidder doing to further integrate these solutions, generate Member awareness, and track utilization?
- 4.11. Quality Assurance and Quality Improvement processes related to UM.

5. **Quality Management (QM) (15 maximum points)**

Limit response to three (3) pages, excluding any visual aids/flow charts. Describe the Bidder's:

- 5.1. Quality committees responsible for overseeing and ensuring high quality health care services to Members, including membership, activities, and scope of authority.
- 5.2. Role of clinical leadership in promoting optimal health care service delivery to Members. What specific authority and assignments are within the jurisdiction of the clinical leader(s)?
- 5.3. QM work, including its governance, scope, measurable goals and objectives, staffing structure, and staff responsibilities.
- 5.4. QM activities in the Washington Medicare Advantage group or individual market, or one alternate similar Medicare Advantage group or individual market, that demonstrates improvement in coordination or management of individuals with chronic medical and/or behavioral health conditions (mental health or substance use disorder) as a result of the Bidder's QM process. Include in the answer:
 - 5.4.1. What data, information, or deficiencies supported the change effort?
 - 5.4.2. What actions were taken to address data, information, or deficiencies?
 - 5.4.3. What were the structural changes, quantitative and qualitative process improvements?
 - 5.4.4. What were the Member outcomes from these change efforts?
 - 5.4.5. What additional actions were taken to reinforce change (both structural and procedural) once outcomes were achieved?
 - 5.4.6. What was the Bidder's role in relation to providers?

6. Complex Case Management (23 maximum points)

Limit response to ten (10) pages, excluding any visual aids/flow charts. Describe the Bidder's:

- 6.1. Organizational approach, philosophy, and processes for Complex Case Management.
- 6.2. Subcontractors (subsidiary or external) used for Complex Case Management, if applicable. If subcontractors are used, describe their roles and the Bidder's oversight process in detail.
- 6.3. **Number of clinical and non-clinical case management staff, their qualifications, and the criteria they use to assign case management.**
- 6.4. Specific location (city and state) of Complex Case Management operations, including the identification of U.S. based and offshore operations, if any. If distant operations are used, describe the Bidder's process for ensuring that CMS and/or local practice standards are appropriately applied.
- 6.5. **Number of clinical specialists who perform clinical consultations for complex case management, their qualifications, and the criteria used to assign complex case management to clinical specialists.**
- 6.6. Complex Case Management service delivery model.

- 6.7. Common health care conditions targeted for Complex Case Management.
- 6.8. Approach to addressing Social Determinants of Health in the Case Management assessment or in interventions provided by the case manager.
- 6.9. Communication channels available for interaction between patients/families and providers for the purpose of Complex Case Management, including telephone, email, chat, text messaging, etc.
- 6.10. Complex Case Management protocols, assessment tools, and other resources used in the Case Management process.
- 6.11. Past achievements as a result of Complex Case Management for the Bidder's Medicare Advantage Book-of-Business.

7. Chronic Condition Management (23 maximum points)

Limit response to ten (10) pages, excluding any visual aids/flow charts. Describe the Bidder's:

- 7.1. Organizational approach for Chronic Condition Management.
- 7.2. Chronic Condition Management programs offered through its Medicare Advantage (individual market and employer group) Book-of-Business. Include whether these programs will be offered to HCA at no additional charge.
- 7.3. Training process for the Chronic Condition Management clinical team. How are they specifically trained to address the chronic conditions they manage, including the role and function of the clinical chronic condition manager, and the role and function of clinical specialists (including physicians and Behavioral Health specialists)?
- 7.4. Clinical team. Provide the staffing ratio per 1,000 members, and qualifications of licensed chronic condition managers and non-clinical staff members.
- 7.5. Non-clinical support team members. What is their role and function in the Chronic Condition Management process?
- 7.6. Provider groups and delivery systems that are delegated for the provision of Chronic Condition Management.
- 7.7. On-site (i.e., non-telephonic) Chronic Condition Management service delivery model.
- 7.8. Chronic Condition Management service delivery model that is telephonic and integrated with the patient's primary care provider or team.
- 7.9. Communication channels available for interaction between patients/families and providers for the purpose of Chronic Condition Management, including telephone, email, chat, text messaging, etc.
- 7.10. Process for identifying/selecting chronic conditions to include in the program.

- 7.11. Process for assigning patients to chronic condition managers.
- 7.12. Process and timeframe for:
 - 7.12.1. Initial patient contact;
 - 7.12.2. Obtaining consent;
 - 7.12.3. Assessment;
 - 7.12.4. Chronic Condition Management care plan finalization; and
 - 7.12.5. Care plan distribution to the Member, family, providers, and any others (as applicable).
- 7.13. Tools and resources used for patient education and Shared Decision Making.
- 7.14. Processes to assist practices in identifying and connecting patients to community resources that support patients to better manage chronic illnesses. Provide at least one specific example.
- 7.15. Resources to help participants pursue their health goals, such as active living, healthy diet, etc.
- 7.16. Capability to support Member tracking and communication across providers and community support systems.

8. Other Clinical Management Services (9 maximum points)

Limit response to four (4) pages, excluding any visual aids/flow charts.

- 8.1. Does the Bidder have any other condition-specific (including co-morbid conditions) or non-condition specific Clinical Management Services and programs offered in the Bidder's Book-of-Business to individual market or group Medicare Advantage enrollees or other large employer group health plans? If yes, provide a list of the programs and a brief description answering the questions below. If no, explain.
 - 8.1.1. Describe the appropriate sub-population for each of the Clinical Management Services offered by the Bidder.
 - 8.1.2. Are these programs managed in-house, through a subsidiary subcontract, or an external subcontract?
 - 8.1.3. What are the qualifications and number of staff and other resources assigned to each program?
 - 8.1.4. Describe how these services/programs have impacted costs, quality, member outcomes, and member and provider satisfaction.
 - 8.1.5. Describe how the other Clinical Management Services coordinate and communicate with provider delivery systems, provider groups, etc.
 - 8.1.6. Describe the Bidder's process for identifying/selecting other Clinical Management Services to include in their Medicare Advantage Book-of-Business.
 - 8.1.7. Identify whether these programs would be offered to HCA at no additional charge.

9. Benefit Design & Experience (12 maximum points)

Limit response to three (3) pages, excluding any visual aids/flow charts.

- 9.1. For an MA-PD plan offered by the Bidder in 2018 to an employer group with 10,000 or more members, describe:
 - 9.1.1. How the Bidder uses benefit design to encourage members to use high-value services (such as preventive care) and reduce member and plan costs.
 - 9.1.2. The average and median annual member out-of-pocket medical spend (including prescription drugs covered under Part B) per member.
 - 9.1.3. UM experience for 2018, including:
 - 9.1.3.1. Volume of reviews, including types of reviews (i.e., prospective, concurrent, retrospective, etc.), health care services reviewed, and review outcomes (i.e., approved, denied, partial approval/partial denials).
 - 9.1.3.2. Volume of Appeals, including percentage of denials appealed, and number and percentage of Appeal outcomes (upheld, overturned or partially upheld/partially overturned).
 - 9.1.3.3. Volume of Independent Review Organization (IRO) cases, including percentage of outcomes (upheld, overturned or partially upheld/partially overturned).
 - 9.1.3.4. Percentage of reviews completed within the CMS specified timeframes.
 - 9.1.3.5. Percentage of reviews denied for medical necessity.
 - 9.1.3.6. Percentage of reviews denied for reasons other than medical necessity (e.g., lack of information, administrative denials, etc.).
 - 9.1.4. The volume of cases actively enrolled in Complex Case Management in 2018 and outcomes.
 - 9.1.5. The volume of cases actively enrolled in Chronic Condition Management, conditions covered, and outcomes.
 - 9.1.6. The volume of cases actively enrolled in other Clinical Management services, conditions covered, and outcomes.