Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management – Utilization Management**		**SUBJECT (Document Title)** **Prohibiting the Use of Financial Incentives When Making Medical Necessity Determinations – Core Process**	
Effective Date 03/17/2010	**Date of Last Review** 01/23/2020	**Date of Last Revision** 01/23/2020	**Dept. Approval Date** 01/23/2020
Department Approval/Signature:			

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

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

POLICY:

To describe the process used by the organization to ensure that medical decisions are based solely upon medical necessity consistent with the accepted clinical protocols and/or criteria approved by the organization's Medical Operations Committee (MOC) or medical practice consistent with the medical community. Decisions resulting in a limitation or denial of services are not penalized or rendered in exchange for financial incentives or other nonfinancial incentives.

Utilization Management (UM) decision-making is based only on appropriateness of care and service and existence of coverage.

The organization does not reward or penalize practitioners, subcontractors or other individuals (including associates) for issuing denials of coverage of care for financial incentives or nonfinancial incentives such as paid time off. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denials of benefits.

Financial or nonfinancial incentives for UM decision-makers do not encourage decisions that result in under or overutilization or create barriers to care and services.

DEFINITIONS:

Financial Incentives: Any monetary compensation offered to a licensed professional.

Non-financial incentives: Any non-monetary compensation such as paid time off offered to a licensed professional.

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Provider: An institution or organization that provides services for members. Practitioner refers to professionals who provide health care services. Provider definition is inclusive of the term practitioner and is more commonly used.

PROCEDURE:

1) Health Care Management (HCM)/Precertification team receives a request for precertification for a service that requires a medical necessity determination prior to rendering of the service. The HCM/Precertification team reviews:
   a) Member eligibility;
   b) The request for contract and/or benefit limitations, if none then;
   c) The clinical information provided by the requesting practitioner, provider or designee and compares it to the appropriate approved criteria used to determine medical necessity for the service requested;
   d) If the clinical information presented by the practitioner, provider or designee meets the appropriate medical necessity guidelines for the services, the request for care is approved following standard approval process; and
   e) If the clinical information presented by the practitioner, provider or designee does not meet medical necessity guidelines, as outlined above, the request is referred to the health plan Medical Director (or appropriate practitioner) to make the final determination that is based solely upon the clinical situation, relevant clinical information, application of the appropriate approved medical necessity criteria and the existence of coverage.

2) Any violation of this procedure may result in disciplinary action, including termination of employment, and possible legal action, as per federal and state laws.

3) Annually, the organization distributes notifications to members, practitioners, providers, subcontractors and all associates that affirm the statements in the Policy section above. Notification mechanisms are:
   a) Email notifications to all subcontractors and associates;
   b) Mandatory Annual Ethics and Compliance training for all associates;
   c) Direct mailings of the member and provider newsletters; and
      i) Copies of the member and provider newsletters are available at each health plan.
   d) The organization's member and provider websites.

REFERENCES:

Colorado Community Health Alliance (CCHA) Regional Accountable Entity Contract, Section 14.8

Florida: Financial Requirements, Section XV.G Physician Incentive Plans
Florida Healthy Kids Contract
Indiana HHW, Ex. 1.C, Section 6.3.2; HIP, Ex. 2.C, Section 9.3.2; and HCC, Ex. 1.G, Section 7.3.1
Kentucky Medicaid Managed Care Contract Sections 21.2, 29.7
Kentucky Revised Statute KRS 304.17A.607
Louisiana Managed Care Contract, Sections 8.1.21, 8.1.22
Maryland HealthChoice Agreement; 42 CFR 438.6(i); 422.208; 438.210(e)
Medallion 4.0 Contract Sections 5.7 and 8.1.D
NCQA Accreditation Standards and Guidelines: Appropriate Professionals, Element: Affirmative Statement About Incentives
Nevada RFP 3260 § 3.7.4.G
Texas Insurance Code 843.314
Washington Integrated Managed Care Contract K4167 §11.1.26
West Virginia Contract, Article III, Section 5.4

Related Policies and Procedures:
Affirmative Statement About Incentives – TN
Clinical Criteria for Utilization Management Decisions – Core Process
Governance of Utilization Management Practice

Related Materials:
Utilization Management Program Description

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management – Utilization Management

Secondary Department(s):
Behavioral Health
GBD OPC Team – Clinical (Formally known as the NCC)
Legal

EXCEPTIONS:

Kentucky:
Each subcontract must provide that consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically

necessary services to an Enrollee.

The health plan shall assure that all covered services are as accessible to Enrollees (in terms of timeliness, amount, duration, and scope) as the same services are available to commercial insurance enrollees in the Medicaid Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Enrollees of medically-necessary services.

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

REVISION HISTORY:

Review Date	Changes
01/23/20	• Annual Review • Added NC and SC as applicable markets • Updated Procedure • Updated References and placed in alphabetical order • Updated Primary Department from HCM to HCM-UM • Revised Secondary Departments and placed in alphabetical order • Revised LA exception for new LA Emergency Contract • Revised KY, NV and WA exceptions • Removed MN exception
04/08/19	• Off-cycle addition of specific Florida Healthy Kids requirements related to prohibiting the use of financial incentives when making medical necessity determinations.
02/18/19	• Off-cycle adoption for Simply Florida Healthy Kids. No changes to document content.
01/14/19	• Off-cycle edit to add AR as an applicable market.
12/12/18	• Annual review • Added CO and DC as applicable markets • Revised References • Added exception for CO; revised exception for KY, LA & MN
08/10/18	• Off-cycle edit to add MN as an applicable market. Exception added to notate market go-live of 12/1/18.
06/07/18	• FL Only - 2/1/18 - Off-cycle review prior to Simply Utilization Management Committee vote to adopt in FL

	• Updated Plan name to Simply/Amerigroup/Clear Health Alliance to reflect legal rebranding of Simply, Better and Amerigroup to Simply and separate branding for Clear Health Alliance as Simply Healthcare Plans, Inc. dba Clear Health Alliance • No changes were made to the policy language • 2/16/18 - Adopted by FL Medicare Plan with no changes to the policy language
12/29/17	• Annual review • Removed bed-day reduction statement from Policy section • Revised #3b of Procedure section • Revised References section • Revised exception language for KY & WA
04/26/17	• Added MMP as an applicable product
10/27/16	• Annual review by PPOC and MOC • Added IN and NY-W as applicable markets • Revised HCM/Precertification team responsibilities • Added exception language for IN, IA, WA & WV
03/10/16	• Administrative task. Transferred to Shared Services template. No content revisions made.
12/03/15	• Off-cycle edit to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016.
09/24/15	• Annual review by PPOC and MOC • Update NCC Staff to Precert Committee • Update information used by Medical Director to make final decision • Update references • Add Kentucky exception, update Virginia exception
11/11/14	• Revisions to Exceptions for Louisiana based on 2015 Contract changes
06/25/14	• NJ Health made edits due to the MLTSS Project
06/24/14	• Annual Review
04/01/14	• Added Wisconsin as applicable health plan and removed New Mexico
01/01/14	• Added Kentucky health plan.
11/11/13	• Off-cycle review to add Virginia as an applicable market. Add VA exception and references. Moved to MBU template.