765 The City Drive South, Orange Ca 92868

P&P #: 034	Affirmative Statement	Page 1 of 3
TITLE:	Astiva Health Utilization Management Policy for Dental Benefits	
APPROVED:	12/6/2023	
APPROVED:	Dr. Jason Chung, MD, Chief Medical Officer	
APPROVED:	Utilization Management Committee	
DEPARTMENT:	Utilization Management Department	
☒ MEDICARE	☒ MEDI-CAL	

POLICY:

Astiva Utilization Management department will not make any decisions based on any desire for incentives, financial or otherwise. At a minimum, the following associates must sign the Affirmation statement. Physicians and Health Professionals involved in UM decision making are required to review and acknowledge receipt of this Affirmation Statement on Incentives on an annual basis.

SCOPE:

This policy applies to all Internal and external customers/vendors.

PURPOSE:

To develop a consistent process for Astiva Health Plan and Contracted IPAs Utilization management (UM) Department in accordance with regulatory mandates and industry standards

To ensure practitioners, providers, including delegated entities and rendering providers, and employees making UM decisions are not unduly influenced by fiscal and administrative management incentives from any source.

DEFINITIONS:

CMS The Centers for Medicare & Medicaid Services oversees the federally and state funded insurance programs for seniors, persons with disabilities (Medicare) and low income (Medicaid) who are deemed eligible for these benefits.

NCQA National Committee for Quality Assurance is an accreditation body that is highly respected in the industry and has been appointed by Congress to aid in developing standards for Special Needs Plans (SNPs) including but not limited to the SNP

Model of Care requirements. Additionally, health plans and providers who voluntarily request NCQA Accreditation undergo an in-depth review and survey of their operations and quality improvement processes and results to prove their value to consumers and other purchasers of insurance. Accreditation may or may not be granted. When granted the accreditation is for specified functional areas and is for a specified timeframe.

FWA FWA is Fraud, Waste, and Abuse (a term used to reference the entire gamut of inappropriate behavior, activities, practices, etc. related to perpetrating crimes against members or related to government funding)

HHA The United States Department of Health and Human Services (HHS), is a cabinet-level executive branch department of the U.S. federal government created to protect the health of all Americans and providing essential human services. Its motto is "Improving the health, safety, and well-being of America. Various States also have a Health & Human Services Department for the citizens of their State.

PROCEDURES

- UM referral decisions are based only on appropriateness of care and service and existence of coverage.
- Practitioners are not specifically rewarded for issuing denials of coverage of service care.
- UM decisions makers and Plan Contracted Providers do not receive financial incentives that result in underutilization and/or inappropriate utilization. Affirmation Statements on incentives will be signed annually by all UM staff.
- All providers are notified at least annually via multiple levels of communication, fax, direct phone contact, e-mail and USPS.
- Measurement of UM activity is monitored for Over/Under Utilization. Members are notified of the grievance and appeals processes and decisions in a timely manner.
- Internal processes are in place to allow members the right to file a grievance about medical services and to appeal and request a fair hearing as the result of any adverse action or inaction taken by the entity.
- The Plan has a mechanism in place to detect both under-utilization and over- utilization of services.

- The plan has mechanisms to assess the quality and appropriateness of care furnished to members including with special health care needs.
- Utilization of departmental data collection systems used to monitor and evaluate care and service in relation to specific aspects of each department include Practitioner/Member satisfaction surveys, referral turnaround time audits, UM reviewer Inter-rater Reliability Surveys denial/appeal turnaround time audits.
- Astiva Health Plan encourages appropriate utilization of medically necessary member care and discourages under-utilization of service by the follow statements: UM decision making is based only on appropriateness of care and service and existence of coverage.

- **Policy Review and Updates**: This policy will be reviewed as needed by the Utilization Management Committee.

HISTORY:

Date	Summary of Significant Changes to P&P
11/1/2023	• Updates to existing policy
12/6/2023	• Approved by UM Committee