No. QM-003	Separation of Medical Services from Fiscal and Administrative Management	
Effective Date: 1/1/2021	POLICY AND PROCEDURE	
Committee Approval: 01/19/2021 Previous Versions: see revision history on last page		
DMHC TAG: Quality Management		

Separation of Medical Services from Fiscal and Administrative Management Policy

Canopy Health employs a Medical Director who reports to the Chief Physician Enterprise Executive. The Medical Director is responsible for managing clinical operations and for overseeing how covered medical services are provided or arranged for enrollees. The Medical Director also oversees the Quality Management Program. The Medical Director shall have sole responsibility for the medical decisions that are made by Canopy Health.

The Medical Director is not a shareholder of Canopy Health. Canopy Health's clinical operations and medical management staff report to the Medical Director and, together, oversee clinical aspects of the enrollees, utilization management, provider grievances, and coordination with the upstream full service health plans on enrollee grievances. Medical necessity decisions are based on criteria as outlined in this policy and the Referral Management policy and procedure and adherence to that criteria is monitored through periodic, but at least annual, inter-rater reliability studies. Outcomes of these studies and any corrective actions are reported through

the Delegation Oversight Committee. The Board of Directors does not take part in any form of medical decision making.

Lack of financial incentives in Utilization Management decision making: Utilization Management decision making is based only on appropriateness of care and services and benefit coverage. Canopy Health does not specifically reward practitioners or other individuals for issuing denial of coverage. Financial incentives for Utilization Management decisions do not encourage decisions that result in underutilization.

Lack of economic profiling: Economic profiling is any evaluation of a particular physician, provider, medical group, or IPA based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or IPA. Economic profiling is not used in the utilization review process, peer review, incentive and penalty program, or in provider retention and termination decisions. The criteria below are applied to evaluate the medical services offered by providers and reviewed for authorization by the Utilization Management medical directors.

Canopy Health adheres to its Utilization Management Referral Policy which requires that all UM decisions are made by licensed professionals and in compliance with regulatory and health plan requirements and are made independent of financial incentives and obligations. Only a Medical Director or a pharmacist may render a decision to deny a service or medication based on medical necessity.

Denials are only issued when the services requested are not covered benefits or do not meet the following UM criteria:

1. Health Plan eligibility and coverage (benefits)
2. Medicare Advantage (If applicable) – CMS Criteria
    a. National Coverage Determination (NCD)
    b. Local Coverage Determination (LCD) used only for the area specified in LCD
    c. Local Coverage Medical Policy Article (LCA)
    d. Medicare Benefit Policy Manual
3. Federal or State Mandate;
4. Upstream Health Plan Medical Policy or Clinical Guideline;
5. Standardized Criteria (MCG® or InterQual®);
6. Standardized Behavioral Health Criteria (DSM-V® or VI-TR®);
7. Provider Group Criteria or Guideline;
8. Community Resources (peer reviewed journals or published resources);
9. If none apply, professional judgment is used.

Canopy Health's "Referral Policy" and "Referral Management Policy" outline what steps must be taken if a referral is denied.

Canopy Health delegates responsibility for day-to-day medical management functions to its partner medical groups under a capitated professional services agreement. Canopy Health will employ a variety of methods for ongoing oversight of medical management, including joint operations meetings, routine periodic reports, on-site reviews and review of inter-rater reliability studies. Canopy Health will have a contractual right to institute corrective or disciplinary actions, including decreasing the scope of services delegated its partner medical groups or on-site monitoring. Each partner medical group employs its own Medical Directors who chair its various medical management and decision-making committees. The Medical Directors are employed to review and make decisions based on clinical criteria. He/she will not become involved in the financial aspects of Canopy Health. Financial and administrative decisions are kept separate from medical decision

making and are the province of other staff and committees of Canopy Health including the Finance Committee.

The structure of the Canopy Health's Board of Directors reflects the separation of clinical matters from fiscal and administrative management. The Utilization Management and Credentialing Committees operate independently and report to the Quality Management Committee, which reports directly to the Board of Directors.

Canopy Health's contracted providers are evaluated according to the utilization management and quality improvement policies and procedures defined by Canopy Health and the upstream, full-service Health Plans.

Additional safeguards exist because Canopy Health has a restricted Knox-Keene license. The upstream full service Health Plans retain control over all marketing, enrollment, benefit determinations, and enrollee grievances and appeals. The Health Plans also retain the right to exercise oversight over Canopy Health with respect to delegated functions. They also remain accountable to the Department of Managed Health Care with respect to all of the Canopy Health enrollees.

Revision History:

Version Date	Edited By	Reason for Change
11/9/15	M. Stevens	Creation date
7/19/16	M. Durbin	Created standalone policy from applicable sections of Exhibit O
7/25/17	M. Durbin	Updated in response to the Health Net UM audit to add in the lack of financial incentives paragraph

3/21/19	R. Scott	Correct references to Canopy Health policies and wording and substitute Canopy Health for "The Network."
5/21/20	M. Durbin	Changed CMO reporting from CEO to Chief Physician Enterprise Executive.
12/22/20	R. Scott	Updated Criteria to include Medicare Advantage criteria.