2021
Utilization Management
Program Evaluation

2021 Utilization Management Program Evaluation

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2021
Utilization Management (UM) Program Evaluation

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (the Alliance) Board of Directors and Quality Management Committee (QMC), senior management and the Health Care Quality Committee (HCQC), the Health Services 2021 Utilization Management Programs were successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2021 through December 31, 2021.

Membership and Provider Network

The Alliance products include Medi-Cal Manage Care beneficiaries eligible thorough one of several Medi-Cal programs, e.g. Temporary Assistance for Needy Families (TANF), Seniors and Persons with Disabilities (SPD), Medi-Cal Expansion (MCE) and Dually Eligible Medi-Cal members who do not participate in California's Coordinated Care Initiative (CCI). For dually eligible beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan services by the Alliance that provides low cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County. The Alliance provides services to IHSS workers through the commercial product, Group Care.

Figure 1. 2021 Trended Enrollment by Category of Aid and Age Groups:

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Dec 2019	Dec 2020	Nov 2021	Dec 2021	Dec 2019	Dec 2020	Nov 2021	Dec 2021	Dec 2019 to Dec 2020	Dec 2020 to Dec 2021	Nov 2021 to Dec 2021
Adults	32,066	38,150	42,623	43,077	12.9%	13.8%	14.4%	14.5%	19.0%	12.9%	1.1%
Child	89,056	94,969	97,935	98,150	35.8%	34.5%	33.2%	33.1%	6.6%	3.3%	0.2%
SPD	25,687	26,339	26,427	26,450	10.3%	9.6%	9.0%	8.9%	2.5%	0.4%	0.1%
ACA OE	78,154	91,050	101,508	102,264	31.4%	33.0%	34.4%	34.5%	16.5%	12.3%	0.7%
Duals	17,776	19,127	20,832	20,964	7.1%	6.9%	7.1%	7.1%	7.6%	9.6%	0.6%
Medi-Cal Total	242,739	269,635	289,325	290,905	97.6%	97.8%	98.0%	98.0%	11.1%	7.9%	0.5%
Group Care	6,092	5,954	5,826	5,823	2.4%	2.2%	2.0%	2.0%	-2.3%	-2.2%	-0.1%
Total	**248,831**	**275,589**	**295,151**	**296,728**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.8%**	**7.7%**	**0.5%**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Age Category Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Dec 2019	Dec 2020	Nov 2021	Dec 2021	Dec 2019	Dec 2020	Nov 2021	Dec 2021	Dec 2019 to Dec 2020	Dec 2020 to Dec 2021	Nov 2021 to Dec 2021
Under 19	91,641	97,399	100,206	100,408	37%	35%	34%	34%	6%	3%	0%
19 - 44	78,271	93,280	104,239	105,212	31%	34%	35%	35%	19%	13%	1%
45 - 64	54,210	57,679	60,571	60,685	22%	21%	21%	20%	6%	5%	0%
65+	24,709	27,231	30,135	30,423	10%	10%	10%	10%	10%	12%	1%
Total	**248,831**	**275,589**	**295,151**	**296,728**	**100%**	**100%**	**100%**	**100%**	**11%**	**8%**	**1%**

Before 2020, the Alliance membership had been slowly declining over time with a total enrollment loss of 6% between 2018 and 2019. However, the 2020 pandemic and economic downturn, as well as a freeze on MCP disenrollment statewide correlated with an increase in enrollment in the Alliance, resulting in an overall increase of an additional increase 8% by the end of 2021. The biggest jump in enrollment was in the Adult category (13% increase) and ACA/Optional Expansion category (12%.) The percentage of Child members to total membership declined from 37% in 2018 to 34% in 2021 but had remained stable at 34% from 2020 to 2021. The percentage of younger adults (19-44) increased from 31% in 2018 to 35% in 2021. There has also been an increase in the percentage of adults over 65 from 9% to 10%. The economic downturn is a likely driver of the percentage increases in the adult and ACA/OE membership as adults lost employer-based health coverage.

Medical services are provided to beneficiaries through one of the contracted provider networks. Currently, the Alliance provider network includes:

Figure 2 2021 Provider Network by Type, Enrollment and Percentage

Provider Network	Provider Type	Members (Enrollment)	% of Enrollment in Network
Direct-Contracted Network	Independent	52,288	17.6%
Alameda Health System	Managed Care Organization	58,590	19.7%
Children First Medical Group	Medical Group	32,573	11.0%
Community Health Clinic Network	Medical Group	109,059	36.6%
Kaiser Permanente	HMO	44,218	14.9%
TOTAL		296,728	100%

The percentage of members within each network has been relatively steady from 2018 to 2021, varying by less than 1%.

The Alliance offers a comprehensive health care delivery system, including the following scope of services:

- Ambulatory care
- Hospital care
- Emergency services
- Behavioral health (mental health and addiction medicine)
- Home health care

- Hospice
- Palliative Care
- Rehabilitation services
- Skilled nursing services - Skilled
- Managed long term services and support (MLTSS)
    - Community based adult services
    - Long Term SNF Care (limited)
- Transportation
- Pharmacy
- Care coordination along the continuum of care including arrangements for linked and carved out services, programs, and agencies.

These services are provided through a contracted network of providers that include hospitals, nursing facilities, ancillary providers, and contracted vendors. Currently, the Alliance provider network includes:

Figure 3 The Alliance Ancillary Network

The Alliance Ancillary Network	
Hospitals	17
Skilled Nursing Facilities	64
Health Centers (FQHCs and non-FQHCs)	75
Behavioral Health Network	1
DME Vendor	1 Capitated, 19 Non-Capitated
Transportation Vendor	1
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200

The delegates or vendors are responsible for the provision of identified functions or services through contractual arrangements. Functions may be delegated to Hospitals, PBMs, and Behavioral Health Organizations. Vendor services include Transportation, Health Risk Appraisal, and Self-Management tools. A full description of delegated activities is provided below.

Delegation

The Alliance delegates UM activities to provider groups, networks and healthcare organizations that meet delegation standards. The contractual agreements between the Alliance and delegated groups specify the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities; how performance is evaluated; and corrective action plan expectations, if applicable. The Alliance conducts a pre-contractual evaluation of delegated functions to assure capacity to meet regulatory and accreditation standards and requirements—no new delegates were added in 2021. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department works with the UM Department and other respective departments to conduct the annual delegation oversight audits. When delegation occurs, the Alliance requires the delegated entity to comply with regulatory, contractual and NCQA standards as well as submitted regular utilization reports, i.e. quarterly, semi-annual, and annual, to assess the delegate's performance on services provided to Alliance members. The Alliance has adopted the Industry Collaborative Efforts UM Reporting Templates as an acceptable format of reporting Results of the annual evaluation and any audit results are reviewed by the Compliance and Delegation Oversight Committee. The UM Department performs oversight audits of UM outpatient and inpatient activities as well

as works with delegates on operational issues to ensure that members receive services from delegates that are in line with the Alliance's established policies and procedures.

The Alliance shares the performance of UM activities with several delegates. The Alliance's UM delegates, as of the date of this document, are the following:

Figure 4 – 2021 The Alliance Delegated Network

Delegate	NCQA Accreditation or Certification	Provider Type	Delegated Activity -UM	Delegated Activity – Grievance and Appeals
Kaiser	Yes	HMO	X	X
CHCN	No	Medical Group	X	
CFMG	No	Medical Group	X	
Beacon/College Health IPA (CHIPA)	Yes	MBHO	X	

Overall, the network was sufficient to meet the needs of the Alliance membership and provider network throughout 2021. The organization clarifies issues related to delegated activities and responsibilities as needed. The issues have led to additional clarification in contractual documents as well as additional training to delegates on roles and expectations. In 2021, Joint Operation Meetings (JOMs) facilitated communication and operational alignment. These JOMs, which are collaborative meetings between the Alliance and Delegates/Vendors to address operations and performance outcomes are also used to identify joint opportunities for improvement. For 2022, there will continue to be opportunities to continue to improve the level of oversight, monitoring, reporting, and training of delegates. Additionally, through quarterly delegate audits, UM will continue to analyze opportunities to further identify denial patterns and begin to monitor approval type patterns to further ensure the appropriateness of decision making.

UM Program Structure

The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of the Alliance health care delivery network. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect entities and multiple disciplines within the organization. The UM Program is evaluated on an on-going basis for efficacy and appropriateness of content by the Alliance staff and oversight committees.

Responsibility, Authority and Accountability/ Governing Committee

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 12-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of the Alliance programs and is responsible for approving the Quality Improvement and Utilization Management Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to the Alliance Chief Medical Officer (CMO) and the Health Care Quality Committee (HCQC). The CMO and the HCQC provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management Program. Utilization Management activities are the responsibility of the Alliance Medical Services staff under the guidance of the Medical Director for Utilization Management and the Senior Director of Health Care Services, under the direction of the Alliance Chief Medical Officer.

Committee Structure

The Board of Governors appoints and oversees the HCQC, the Peer Review and Credentialing Committee (PRCC) and

the Pharmacy and Therapeutics Committee (P&TC) which, in turn, provide the authority, direction, guidance, and resources to enable the Alliance staff to carry out the Quality Improvement, Utilization Management and Case Management Programs. Committee membership is made up of provider representatives from the Alliance contracted networks and the community including those who provide health care services to Seniors and Persons with Disabilities (SPD) and Chronic Conditions.

The HCQC Committee provides oversight, direction, recommendations, and final approval of the UM Program. Committee meeting minutes are maintained summarizing committee activities and decisions and are signed and dated.

HCQC charters a sub-committee, the Utilization Management Committee (UMC) which meets at least quarterly every year, serving as a forum for the Alliance to evaluate current UM activities, processes, and metrics. The UMC also evaluates the impact of UM programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes. HCQC assumes responsibility for oversight of the UMC activities and monitoring its areas of accountability as needed. The structure of the committee meetings is designed to promote engagement from all participants.

In 2021 the HCQC approved the UM Department 2021 Evaluation, 2021 Description, and UM 2021 Workplan on March 18, 2021, for Board of Directors approval. The committee was chaired by the Chief Medical Officer with support of the Senior Director of Quality Management, external physicians, and key organizational staff. The UM Committee had eight meetings in 2021.

In 2022 the UM Subcommittee of HCQC will continue to support the focus on UM activities, oversight for delegated UM activities, case management/care coordination, population health, CalAIM implementation, integration of behavioral health and medical as well as regulatory compliance.

Evaluation of the level of involvement of senior-level Physician and Behavioral healthcare practitioners

The Alliance CMO acts as the senior level physician involved in the UM program to:

- Set UM policy
- Supervise program operations.
- Review of UM Cases/Appealed Cases as needed.
- Participate on the UM Committee and the HCQC committee.
- Evaluate the overall effectiveness of the UM Program.
- Delegate senior level physician involvement to provide clinical expertise and guidance to program development.

Behavioral healthcare involvement in UM has been performed in partnership by two entities, Beacon Health Strategies and Alameda County Behavioral Health. The behavioral health practitioner involvement reflects the behavioral health benefit administered by the Alliance. Behavioral health representation is provided by both entities to participate in UM Program development and oversight. Each entity provides committee participation in the role of a behavioral health practitioner:

- Alameda County Behavioral Health System (ACBHS) - For MediCal beneficiaries, the management of severe and persistent behavioral health conditions is managed by the County Mental health Program, ACBHS.
- Beacon Health Strategies (Beacon) - For mild to moderate behavioral health conditions and behavioral health management for IHSS enrollees, the Alliance contracts with Beacon Health Strategies

The behavioral health entities have provided senior level behavioral health practitioner involvement in the UM Program by:

- Setting UM behavioral healthcare policies
- Reviewing UM behavioral healthcare cases, as needed
- Participating in the various UM Committees
- Evaluation of the overall effectiveness of the UM Program (Beacon)

Program Scope and Structure

The Alliance UM Program encompasses the management and evaluation of care across the scope of UM. This includes prior authorization, concurrent and retrospective review of institutional care, acute care, behavioral health and chemical dependency, rehabilitation, skilled nursing, pharmaceuticals, ambulatory services. The UM Program involves the medical and behavioral management of all members at the most appropriate site and level of care. (For behavioral health activities, refer to the Managed Behavioral Health Organization's [Beacon Health Strategies] UM Program for a description of delegated behavioral health UM activities.

UM Program activities include the following but are not limited to:

- Prior authorization of services and pre-admission education
- Admission and concurrent review
- Discharge planning: pre-admission, concurrent, and post hospital discharge follow-up/referrals with the member
- Retrospective review
- Quality improvement projects within the UM Program
- Integration of medical and behavioral health in collaboration with the behavioral health vendor and ACBHS
- Continuity and coordination of care for members when a provider is terminated from the network.
- Continuity and coordination of care for members newly eligible for Alliance coverage who are receiving active care and treatment from a non-Alliance provider.
- Evaluate and refer for members needing care coordination, (ex. EPSDT, CCS, ECM, etc.)
- Ensuring that denials related to utilization issues are handled efficiently according to UM timeliness standards.
- Review of overturned PA Appeals
- Monitoring and auditing delegated entities UM activities for compliance to contractual requirements with implementation of corrective action plans as appropriate
- Internal monitoring and auditing for compliance to DHCS, DMHC, and NCQA requirements
- Departmental policies, procedures, and processes with implementation of corrective action plans as appropriate

Utilization Management Resources

The Alliance UM Department is staffed with physicians, nurses and non-clinical support staff including clerical support and clinical support coordinators. A full description of staff roles and responsibilities is provided in the 2021 UM Program Description.

The assignment of work to the team, whether working on site or remotely, for both clinical and non-clinical activities, does not change the team member's job responsibilities or job description. In 2020, in response to the Covid 19

pandemic and public health requirements, the UM department transitioned to fully working from home, and this continued through all of 2021. Staff were provided equipment, remote connectivity, and policies to follow to successfully work from home while maintaining full functionality and meeting regulatory requirements. The job descriptions with assigned tasks and responsibilities remained the same regardless of the geographical location of the team member.

In 2021, based on the established staffing ratios and roles, the UM Department hired for department roles. Budgeting for a Clinical Supervisor for Outpatient UM and an RN for Major Organ Transplant was done in 2021, and hiring is expected to occur in Q1 of 2022. With the onboarding of new staff, the Health Care Services Department teams reviewed the current organization goals and restructured some clinical assignments in the Department to achieve those goals.

Delegated Utilization Management

As described in the section above for Delegated Activities, the Alliance provides health services to our members through a delegated network. UM activities for members enrolled to the HMO products are performed predominantly by the delegated health provider networks.

The Alliance has several levels of UM delegation: For Knox Keene licensed Health Plans, UM may be fully delegated. For certain medical groups, UM decision making is a shared risk; the Medical Groups are delegated for the performance of outpatient referral management and UM decision making while the Alliance UM Department maintains responsibility for certain outpatient services and inpatient care. All delegates perform levels of UM decision making based on their contracts and performance. The Alliance maintains responsibility for UM decision making associated with transportation, MLTSS, and pharmacy. The resolution of clinical grievance and appeals are only delegated to the Alliance's Knox Keene licensed Health Plan (Kaiser.) For care management and complex case management, the Alliance delegates basic care management and care coordination to network providers. Currently, the Alliance delegates complex case management to Kaiser and Beacon. For Delegates unable to fulfill the delegated activities, the entity is subject to remediation activities up to and including revocation of delegation.

Behavioral health UM activities are delegated to and managed by the contracted managed behavioral health organization (MBHO), Beacon Health Strategies.

The Compliance Department is responsible for the overall performance of the internal and external audits of delegates. UM Department staff are responsible for the review and reporting of the UM components of the annual process which includes standards and file review. The Compliance Department is responsible for finalizing the audit findings and issuing required corrective actions if needed. All audit findings are reported into the Compliance Department and the HCQC.

In 2021, the UM staff conducted annual audits on the four (4) delegates. The threshold for UM audit compliance is 90%. For entities that do not meet the threshold, the UM staff may require a corrective action plan which is tracked for compliance with the resolution of the deficiency. Entity audit results for 2021 were:

- Four groups did not pass UM audit ($\geq$ 90.0%), and corrective actions were required.

Figure #5 The Alliance Network – 2021 Annual Audit Score

Delegate	Provider Type	Delegated Activity-UM	2021 Audit Results	Corrective Action Required
Kaiser	HMO	X	Deficiencies found, Corrective Action Plan Required	Yes or No: TBD Final audit report has not been issued; issue date is TBD

Delegate	Provider Type	Delegated Activity- UM	2021 Audit Results	Corrective Action Required
CHCN	Medical Group	X	Deficiencies found, Corrective Action Plan Required	Yes or No: TBD Final Audit report to be issued on 5/6/22
CFMG	Medical Group	X	Deficiencies found, Corrective Action Plan Required	Yes or No: Yes UM decision not made within required timeframe NOA letters did not provide specific reason for denial, did not provide a reference to the benefit, guideline or similar criteria on which decision was made, did not provide notification that expediated external review can occur currently with internal appeal process
Beacon/College Health IPA (CHIPA)	MBHO	X	Deficiencies found, Corrective Action Plan Required	Yes or No: TBD Final audit report to be issued on May 6, 2022

Additionally, the UM team is responsible for ongoing monitoring activities including review of the delegated entities annual work plans/evaluations, and semi- annual reporting.

For 2021, the current UM delegates continued to meet the program's scope of activities. The individual issues of compliance to delegation requirements are addressed with the delegate through the Compliance Department. The UM team works collaboratively with the Compliance Department on identifying potential process improvement activities and monitoring corrective action plans. In 2021, the team continued to collaborate with Senior Health Care Services Leadership and Compliance staff to resolve on-going corrective actions identified during regulatory audits.

Recommend Actions/Next Steps

For 2021, there will be additional opportunities to improve the oversight of delegated UM activities. The UM Department leadership is continuing the development of a robust level of delegate oversight, performance monitoring and engagement with operational processes. The activities include dedicated staff monitoring activities, quarterly chart audits, performance management, delegate feedback and UM training.

Utilization Management Processes and Information Sources

Utilization Management Decision Making

Decision and screening criteria are designed to assist UM staff and delegates in assessing the appropriateness of care for clinical and behavioral health situations encountered in the clinical setting. Application of the criteria is not absolute but based upon the individual health care needs of the member, medical risk factors, and social determinants of health, and in accordance with the member's specific benefits plan and capacity of the health care delivery systems. The decision criteria are made available to the member, providers or public upon request by contacting the UM Department. A full description of the criteria utilized for UM decision making is available in the 2021 UM Program Description.

For 2021, the Alliance UM Department utilized the clinical criteria as defined in the UM Program. In 2021, the Alliance used the Milliman's CareWebQI® interactive software tools which integrate the MCG® guidelines into the core information system, TruCare, using the 24th Edition MCG® criteria. The 25th Edition MCG® criteria was released in 2021, but the updated MCG® criteria software was unable to embed into the UM platform TruCare (TC) due to TC upgrade delays into 2022, which led to the UM department continuing to use the 24th Edition MCG® criteria . Upon review of member needs and the requirement to use alternative criteria as appropriate, there were no changes to the clinical criteria informed by the UM Medical Necessity hierarchy, applying first and foremost the DHCS Provider Manual guidelines, then MCG®, followed by the MCP's Policies, and other evidenced based clinical criteria including UpToDate®. In 2021 there were no requests from members, and no requests from providers for copies of the decision-making clinical criteria.

In 2021 the Alliance UM staff collaborated with Senior Leadership to ensure that Transportation processes continued to match the benefits defined in APL 17-010 for Non-Emergency Medical and Non-Medical Transportation and the requirement to provide non-medical transportation for Medi-Cal services that are not covered under the MCP contract. The Alliance monitors the performance of ModivCare's (formerly Logisticare) provision of this benefit by conducting operational meetings and JOMs, regular review of G&As, and performance metrics.

Consistency in Application of Criteria

The Alliance UM Department assesses the consistency with which physicians, pharmacist, UM nurses, Retrospective Review nurses and non-physician reviewers apply criteria to evaluate inter-rater reliability (IRR). A full description of the testing methodology is available in the UM Program and Health Care Services policy for IRR. UM has set the overall IRR passing threshold as noted in Figure 6.

Figure #6 Inter-rater Reliability Thresholds

Score	Action
High – 90%-100%	No action required
Medium – 61%-89%	Increased training and focus by Supervisors/ Managers
Low – Below 60%	Additional training provided on clinical decision-making. If staff fails the IRR test for the second time, a Corrective Action Plan is required with reports to the Senior Director of Health Services and the CMO. If staff fails to pass the IRR test a third time, the case will be escalated to Human Resources which may result in possible further disciplinary action.

The IRR process uses hypothetical but realistic UM cases. IRRs included a combination of acute and/or outpatient IRR modules offered by MCG® specifically designed for staff training, educational, and IRR purposes. To maintain a high level of consistency in the performance of UM, the threshold to pass IRR was increased to 90%, and 5 cases were increased to 10 for UM staff.

All new hire staff will train and participate in the IRR process upon completion of their training. Results are tallied as they complete the process, appropriate feedback and follow-up education are provided, and corrective actions implemented

as needed. When opportunities for improving the consistency in applying criteria, UM staff addresses corrective actions through requiring global or individualized training or completing additional IRR case reviews (see Figure #6).

UM Clinical Group	2021 Overall Passing Rate
OP Nursing	100%
IP Nursing	90%
G&A Nurse	100%
MDs	100%

For 2021, IRR testing was performed in Q3 for UM clinical staff and non-clinical staff to establish consistency in practice and outcomes for members, using 10 cases.

OP Performance

- The overall passing rate meeting the minimum threshold was met by 100% of the OP nurses.

IP Performance

- The overall passing rate meeting the minimum threshold was met by 90% of the nurses, however 1 nurse failed all modules after 3 attempts.

G&A

- The overall passing rate meeting the minimum threshold was met by the G&A nurse.

MDs

- The overall passing rate meeting the minimum threshold was met by 100% of the MDs.

Qualitative Analysis

Overall, the overall scoring showed all team members except one nurse passed the IRR modules for their respective areas.

Opportunities for Improvement

1. Share collective information with clinical staff for team education.
2. Continued evaluation by managers of individual staff and MDs by UM Medical Director to ascertain the issues that required multiple attempts, and when re-education is needed.
3. Initiate IRR testing and MCG support for new and temporary hires.
4. Continued staff education on appropriate use of system for MCG IRR modules.

Management of non-delegated medical determinations – Prior Authorization/ Concurrent Review/Post-Service

The monitoring of referral management activities performed by delegates is reported in the annual UM Program Evaluation. Services provided by full risk providers are reported through the Compliance Department and HCQC. Services normally assigned through the shared risk contracts, and managed by delegate include:

- Professional services, in-network
- Laboratory services in clinic
- In-office medications/injectable medications

The Alliance UM Department retains responsibility for UM determinations of non-delegated services or activities for non-delegated providers, e.g. Transportation Vendor and DME Vendor. Services that are the responsibility of the Alliance and are not delegated to Medical Groups include:

- Hospital services, including acute, long-term acute and acute rehabilitation.
- Skilled Nursing Facilities services
- Sub-Acute Facility services
- Durable Medical Equipment
- Prosthetics/Orthotics/Medical Supplies
- Outpatient Facility Based Services (i.e. specialized radiology or diagnostic procedures, dialysis, etc.)
- Hospice
- Out of Network, Tertiary
- Out of Area Services (Per Contract)
- Managed Long Term Services and Support/Community Based Adult Services (CBAS)
- Long Term Care, month of admission plus the following month
- Transgender Services
- Transportation
- Major Organ Transplant Services
- Acupuncture
- Home Health
- Medications covered under the pharmacy benefit - i.e., non-formulary, some self- injectable medications.
- Experimental/investigational procedure/services determination
- Cancer clinical trial determinations

1. Kindred long-term acute admissions had denied services at some time during the stay. Findings were that the appropriate criteria were used, and the cases were adjudicated appropriately using the criteria. There were findings about opportunities for improved communication and frequency of reviewing once denials were issued, improved support provided to the facility around difficulty placements, and evaluation for alternative placement options to lower levels of care. Administrative day level was added to the Kindred LTACH contract when medical necessity was not met and there was no safe discharge to a lower level of care.

Opportunities for Improvement

1. Develop schedule for continued stay review of the UM decision making for delegated services.
2. Improved oversight of active discharge planning
3. Continued placement searches and escalation for difficult placement hospitalizations
4. Continued administrative day monitoring for acute change in status and medical necessity
5. Share collective information with delegate's clinical staff for education.

UM Information Systems

The Alliance maintains a core information system, TruCare®, that is utilized by both UM and case management and Pharmacy staff. UM and CM staff have identified opportunities to enhance the functionality of the system to assist in managing UM referrals and case management functions, and in 2019 a major initiative to optimize the TruCare® platform was launched. It was completed in 2021 and resulted in both optimization of the software itself and upgrade to version 8.0 in December 2021. These optimization and upgrades included staff training to ensure standard workflows are in use and staff is competent in the use of the software. Continued information system optimization through education sessions are planned for staff into 2022.

UM DETERMINATIONS

The Alliance is responsible for the referral management responsibilities performed for non-delegated entities or for non-delegated services. This includes reviews for pre-authorization, concurrent, post-service, and retrospective claims review.

The Alliance referrals are tracked and monitored for compliance of both regulatory requirements; timeliness of decision-making (turn-around times), usage of specialty referrals and the rates for services denied as not meeting medical necessity or benefit (denial rate).

The Alliance maintains a list of non-delegated services that require prior authorization and a process for UM staff to evaluate referrals for specified services or procedures.

Referrals are tracked and reported by:

- Total Number of referrals
- Total Number approved
- Total Number denied
- Total Number partially denied

Denials are reported in relationship to:

- the total number of referrals to total number of denied services or "denial rates".
- The established threshold for UM denials at 5%.

Referrals are also monitored to ensure staff process requests within the required timeframes or Turn-Around Times (TAT).

- The performance goal for TAT is 95% for routine and urgent authorizations.

Quality of NOA letters regarding all types of authorization requests are monitored to ensure clear and concise language, reading literacy to the 6th grade level, and that they are containing all regulatorily required content and references. In 2019 AAH received regulatory findings of deficits in outpatient NOA content and continues to employ multiple strategies in 2021 to maintain the improved performance in this area. This includes NOA template standardization, concurrent (before sending out,) retrospective review of the quality of the NOAs, annual and focused audits, feedback to all staff and MDs involved in the production of NOAs, ongoing training of all staff and MDs as indicated, active workgroup attention to new and expanding NOA needs, and ongoing quality monitoring of the NOA letters. Additionally, expanded language translation was added to larger sections of the NOA and approval letters in the key threshold languages in accordance with APL 21-004 that took effect in 2021. Language translation is provided by an external vendor, AvantPage.

Usage of specialty referrals are monitored to ensure members have access to specialty services within or outside of the network to support continuity of care, timely access, and specialty and/ or tertiary/ quaternary care that is not available within the network.

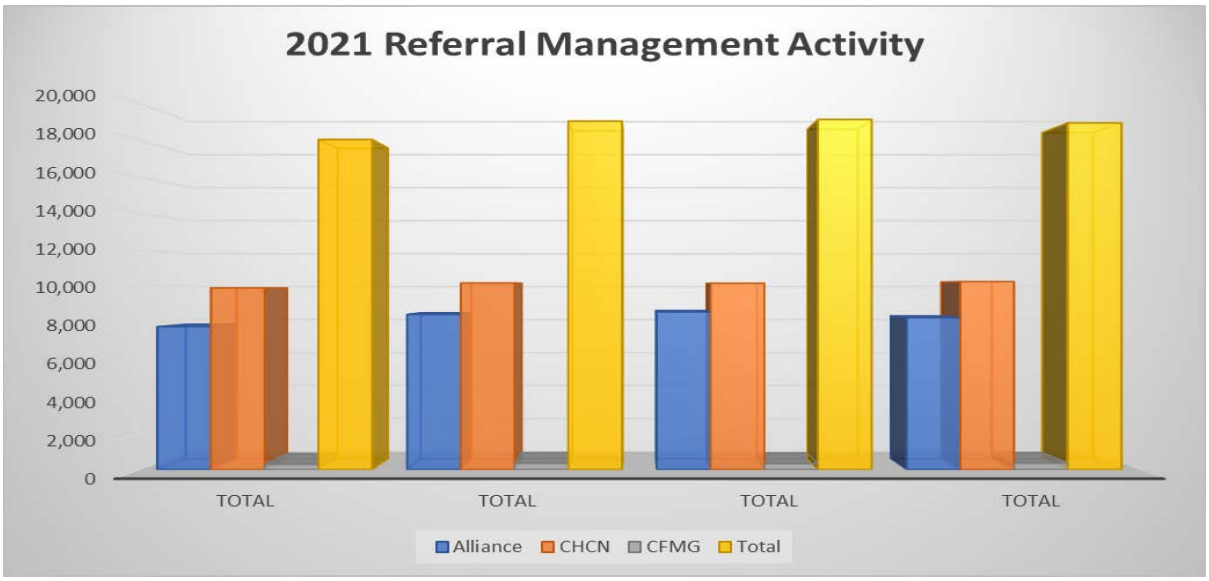
As discussed in a previous section, the Alliance manages two products, Medi-Cal and Commercial (Group Care). For the purpose of data analysis, because the commercial network, IHSS, represents only 2% of the total membership and 4% of the referral activities, the data is aggregated for reporting. In key areas where the activities are specific to a network, the report will note the differences.

Utilization Management Referral Management Data

Quantitative Analysis

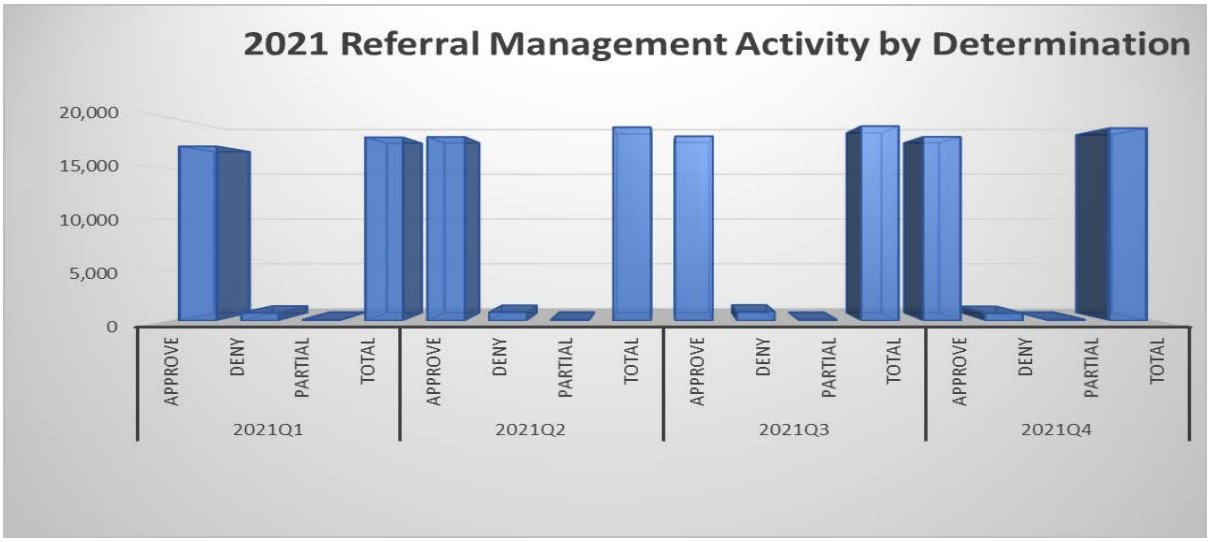
The data presented in Figures 7 – 11 represents key UM referral management functions by provider group, product, and UM determination.

Figure #7 2021 Referral Management Activity



Outpatient Referral Management data by quarter based on number of authorizations managed by the Alliance by date of service; Reporting period is January 1 through December 31, 2021 for all Delegates and all products. Totally referral volume decreased from 2020, due to decreases in referral volume by Alliance, increases by CHCN, and marginal increases from CFMG networks compared to 2020.

Figure #9 2021 Referral Management Activity by Determination



Outpatient Referral Management data using the final determination, reported by quarter, based on number of authorizations managed by the Alliance by date of service; Reporting period is January 1 through December 31, 2021 for all Delegates and all products. Relative approval, denial, partial denial, and total rates were similar to 2020, with incremental increases from the early quarters compared to the later quarters in 2021.

Figure #10 Comparisons of 2020 and 2021 Outpatient Referral Denial Rate

OP Denial Rates	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
2020	4.9%	4.6%	3.9%	3.9%	3.5%	3.8%	4.4%	4.4%	4.4%	3.7%	3.7%	3.3%	4.1%
2021	4.9%	5.3%	4.7%	4.9%	5.1%	5.3%	5.3%	5.5%	5.0%	4.8%	4.8%	4.6%	5.0%

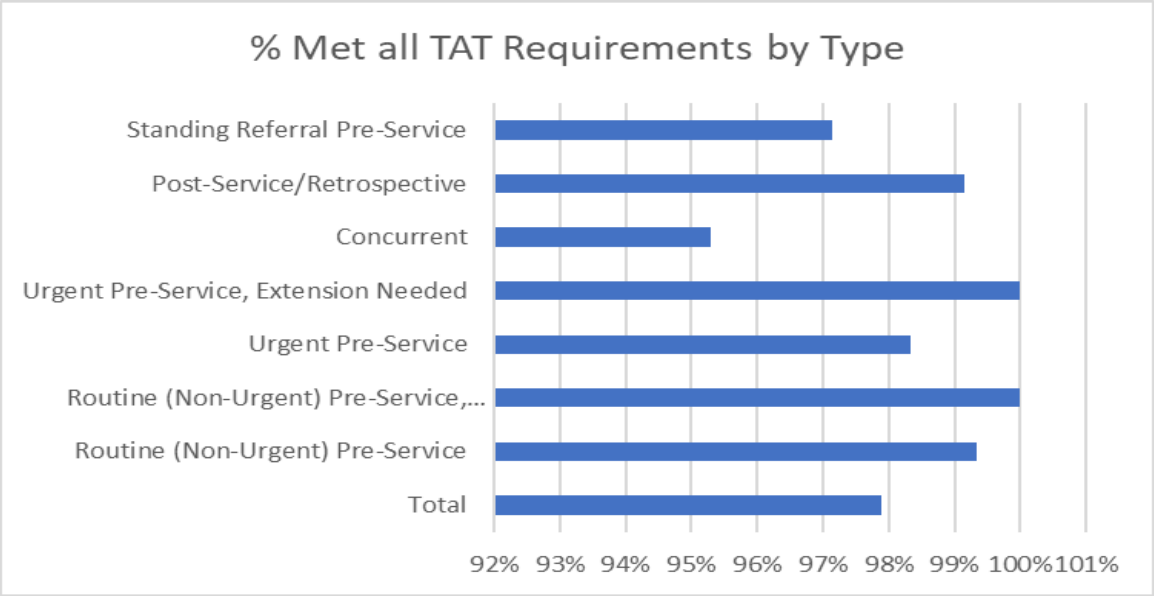
Outpatient Referral Management Denial Rate by month is based on number of authorizations by date of service through December 31, 2021 for all Delegates. The 2021 Year to Date (YTD) denial rate was 5.0%, which is an increase of 0.9 percentage points from 2020 and is in the range of an expected rate.

Referrals are also monitored to ensure staff process requests within the required timeframes or Turn-Around Times (TAT). The Compliance Department monitors turn-around time performance and reports it to the HCQA. The performance goal for TAT is 95%. For 2021, TAT performance maintained an overall TAT of 98%, MediCal TAT of 98%, and Group TAT of 99%.

Figure #11a 2021 Referral Management TAT Reports

2021 Performance Referral Management TAT						
	Q1	Q2	Q3	Q4	YTD	Goal
Overall	98%	98%	97%	98%	**98%**	**95%**
MediCal	98%	98%	97%	98%	**98%**	**95%**
Group	99%	99%	99%	98%	**99%**	**95%**

Figure#11b 2021 Referral Management TAT Reports



The percent of all TAT requirements by referral type were measured to the performance threshold of 95%. Overall % Met TAT was almost 98%. The higher percent met TAT was for Urgent pre-service, extended needed (100%) and Routine (non-urgent) pre-service (100%), followed by Routine (non-urgent) pre-service (>99%), Post-service/ Retrospective (>99%), Urgent Pre-service (>98%), and Standing Referral Pre-service (>97%). The lowest percent type was for Concurrent however, it still met the 95% performance threshold. Identification of incorrect IT design methodologies for Inpatient TAT helped identify this lower performing referral type in the 2021 quarters and will be a focus for process improvement for 2022.

Qualitative Analysis

The overall referral volume managed by the network recovered in 2021 from the abrupt and sustained decrease during Covid 19 pandemic in 2020. The volume of referrals by network provider aligns with the volume of enrollment, with CHCN having the highest volume of referrals and the largest membership which includes adults, MCE and SPD members; CFMG having the lowest referrals and lowest membership, which includes primarily children and adolescents.

The 2021 Year to Date (YTD) denial rate of 5.0% is in line the established performance threshold of 5%. In 2021, a review of custodial SNF authorizations was undertaken for Q3 and Q4, revealing opportunities for enhanced UM clinical review processes and improved nurse-MD communications for dual members. Deep dives were undertaken in Q3 to understand patterns for Catastrophic inpatient stays, readmission risk factors for medically complex members, and root causes of facility service avoidable delays and/ or difficult placement search or delays. UM will continue to analyze opportunities to further identify denial patterns and begin to monitor approval type patterns to further ensure the appropriateness of decision making.

Overall authorization Turnaround Time for 2021 for both Medi-Cal (98%) and Group Care (99%) met the established goal.

Quality of NOA letters has improved and continues to remain an area of focus to ensure compliance with all regulatory requirements, as well as addressing APL releases and CAP. Close monitoring of UM processes for PAs enables the department leadership to ensure that TATs are met.

While the volume of referrals is reported in terms of product, ancillary network and determination, there is an additional opportunity to further assess the types of services by requested services and by type of authorizations, auto approved or clinical review. Attention will be placed on Rehabilitation Services, Major Organ Transplant, Tertiary-Quaternary level of care, Out of Network, Catastrophic stay reason capture, Administrative Day Inpatient Approvals, and Concurrent Inpatient utilization for the next year. Additionally, steps were taken to improve data capture of medical necessity for both approval and denials, as well as the reasons for these final determinations. In 2022, the program will analyze opportunities to increase the number of requests that may appropriately be automatically authorized, thus improving throughput for members' care. This will also assist in validating an appropriate staffing ratio for the department. Lastly, efforts will be explored for standardizing documentation of medical decision making by Medical Directors for referrals.

Tracking of Unused Authorizations

The Alliance monitors the use of authorizations to ensure Members are accessing approved services and to identify potential specialty access concerns. An unused authorization report is run mid-cycle during the authorization period. A letter is sent out to members to remind them to use their approved authorization. Since the unused authorizations are based on claims sent in, there is a lag in knowing whether a given authorization was actually used or not. In Q3, Unused Authorization data was reviewed in UMC and identified the most commonly unused service types were in Hand Therapy and Podiatry office visits. Emphasis was placed on the population of diabetics who commonly require standing referrals for specialty Podiatry care and who missed this service visit.

Tracking of Specialty Care Authorizations

Tracking of Specialty Care Authorizations captures the full picture of specialty authorizations, and it is analyzed and reported regularly at UMC. It includes all Specialty Referrals that require authorization, by service type, in or out of network, approved/partially approved/denied, by determination reason, by network, by Provider, with TAT:

Qualitative Analysis

In reviewing the tracking outcomes for Specialty Referrals, it is noted that there may be some underutilization of the Palliative Care benefit, as there are relatively few referrals. At the end of 2020, the Alliance began an engagement with a network partner, AHS, to enhance and extend the use of this benefit by our seriously ill members, and this will continue into 2022. Due to the 2022 carve in of major organ transplants, transplant evaluations will increase, beyond the previous corneal and renal transplant referrals. There was a notable rise in chiropractic referrals in the 2nd and 3rd quarter with proportionally corresponding denials.

Recommendations/Next Steps for 2022:

Continue to improve the quality oversight of the current UM processes. This will be accomplished by continued internal monitoring of UM files on a periodic basis and interventions as indicated. Training of staff will be aimed at maintaining standard processes across the UM reviewers. This also includes reviewing and revising the standardized reports focused on referral management. This will continue to include the trending of out of network utilization to identify potential inappropriate use or access to care issues related to lack of providers or services in key areas. In particular there is opportunity to explore referral patterns for chronic pain management.

TRANSPORTATION

The Alliance is responsible for the provision of transportation services to enrollees based on their benefit package with the defined regulatory body. Each product benefit package is different, and therefore requires specific procedures to managing the services.

The Alliance maintains a contract with a specialty vendor, ModivCare, (formerly called Logisticare,) to provide the necessary transportation services, which includes the determination of the necessity for the services, the mode and the benefits associated with the transportation.

Benefits are administered based on the program guidance. The Alliance does not delegate UM decision making to the Logisticare. All UM determinations related to transportation for non-full risk provider groups is managed by the Alliance UM Department.

Currently, the Alliance maintains four types of transportation:

- Emergency – all products, no authorization required.
- Non-emergency Medically Necessary Transportation (NEMT) - Medi-Cal, medically necessity required,
- Non-Medical Transportation (NMT) – Medi-Cal/EPSDT services

The Medi-Cal benefit includes NEMT for services deemed to be 1) to access medically necessary services and 2) member cannot be transported safely in other means of public transportation, or only NMT for access to EPSDT services.

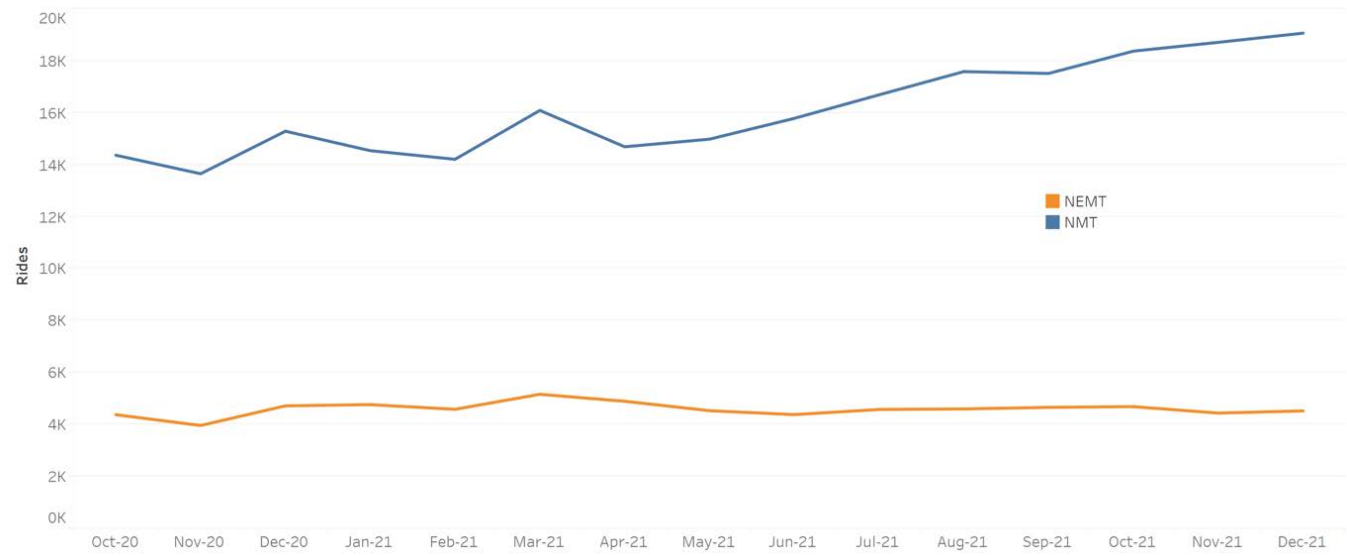
QUANTITATIVE ANALYSIS

Figure#12 – 2021 Transportation Utilization

	Description		1st QTR Total	1st QTR Average	% of Total	2nd QTR Total	2nd QTR Average	% of Total	3rd QTR Total	3rd QTR Average	% of Total	4th QTR Total	4th QTR Average	% of Total	YTD	YTD Totals
Members	Members Served	Number of unique members utilizing transportation		1,818			1,891			1,931			2,008		1,912	1,912
Utilization	Gross Reservations	All Reservations taken including cancelled trips	59,140	19,713	100.0%	59,005	19,668	100.0%	65,439	21,813	100.0%	69,537	23,179	100.0%	253,121	253,121
	Utilization Rate	Transportation utilization rate (completed trips/total enrollment)		5.7%			5.6%			6.0%			6.1%		5.87%	
Call Center	Calls Received	Measures number of Reservations calls received	9,152	3,051		9,241	3,080		7,652	2,551		9,575	3,192		2,968	35,620
	Average Hold Time	Average hold time should be less than 3 min for 90% of calls		00:43			01:06			01:09			01:08		01:01	
	Service Level	Goal: 80% of calls answered within 30 seconds		87.1%			69.6%			70.2%			81.8%		77.2%	
Quality Mgmt	Complaints - Total	Measures the number of valid complaints Goal: 1% or less	92	31	0.2%	152	51	0.3%	225	75	0.3%	229	77	0.3%	698	698
	Complaint Percentage	Total complaint percentage based on gross reservations		0.16%			0.26%			0.34%			0.33%		0.3%	
Timeliness	On Time Performance*	Goal: 90% on time for all legs		82.4%			82.1%			81.1%			75.3%		80.2%	
	Will Call On Time	Goal: 90% on time for Will Call Legs		96.9%			96.8%			96.3%			95.5%		96.4%	

NMT vs NEMT

NMT/NEMT	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
NEMT	4,377	3,962	4,718	4,765	4,584	5,163	4,894	4,531	4,381	4,578	4,599	4,659	4,687	4,439	4,524
	23.36%	22.50%	23.58%	24.69%	24.40%	24.30%	24.99%	23.22%	21.73%	21.53%	20.73%	21.02%	20.33%	19.18%	19.18%
NMT	14,363	13,650	15,287	14,538	14,206	16,087	14,688	14,980	15,780	16,687	17,581	17,510	18,369	18,707	19,060
	76.64%	77.50%	76.42%	75.31%	75.60%	75.70%	75.01%	76.78%	78.27%	78.47%	79.27%	78.98%	79.67%	80.82%	80.82%



QUALITATIVE ANALYSIS

In 2021, the Alliance continued to ensure the provision of the transportation benefits, using ModivCare as the provider. ModivCare quality outcomes show that they are meeting the performance metrics for request response times and have a low rate of complaints. Complaints are monitored through the G&A process and reported at UMC for review and action as needed.

The amount of Ambulatory transport has a sustained increase since 2019, reflecting the increased use of the NMT benefit. However, the Covid 19 pandemic affected the use of the NEMT benefit starting in March of 2020 due to social distancing but have been normalizing into 2021. The NMT transports remained steady over the two years. The majority

of the NMT trips are for Dialysis, which is an ongoing clinical need, even during a pandemic. Work continued over the course of 2021 to ensure that members who needed transportation after leaving hospitals had timely responses, and improvement was made during the year. Of note, there was a DHCS finding of not having PCS forms completed before taking NEMT, and the Alliance worked with ModivCare to educate them and develop a process to ensure that the correct level of care was provided.

Recommendations/Next Steps for 2022:
The Alliance UM Department will continue to monitor provision of the transportation benefit using criteria to allow appropriate members in need of non-medical transportation to access the transportation benefits and ensure timely responses to requests. AAH will ensure that vulnerable members receive transportation services to get to needed care. This includes the process to ensure that PCS forms are obtained for NEMT trips.

Monitoring of Over/Under Utilization

The Over/Under Utilization Report is a collaborative report with the Quality Management and Utilization Management Department.

The Utilization Management Department monitors over- and under-utilization for selected activities using UM measures to identify issues that may indicate barriers to accessibility for routine health care services. Monitoring activities were further developed to include a special focus for monitoring for potential under-utilization of out of network services and Primary/Preventive Care in the capitated setting.

The Alliance UM Department monitors, analyzes, and annually evaluates network performance against several relevant data types for each product line, Medi-Cal and Commercial. The UMC reviews quantitative and qualitative analysis of potential areas of under and over – utilization, identifying opportunities for improvement and implementation of a corrective action plan if necessary.

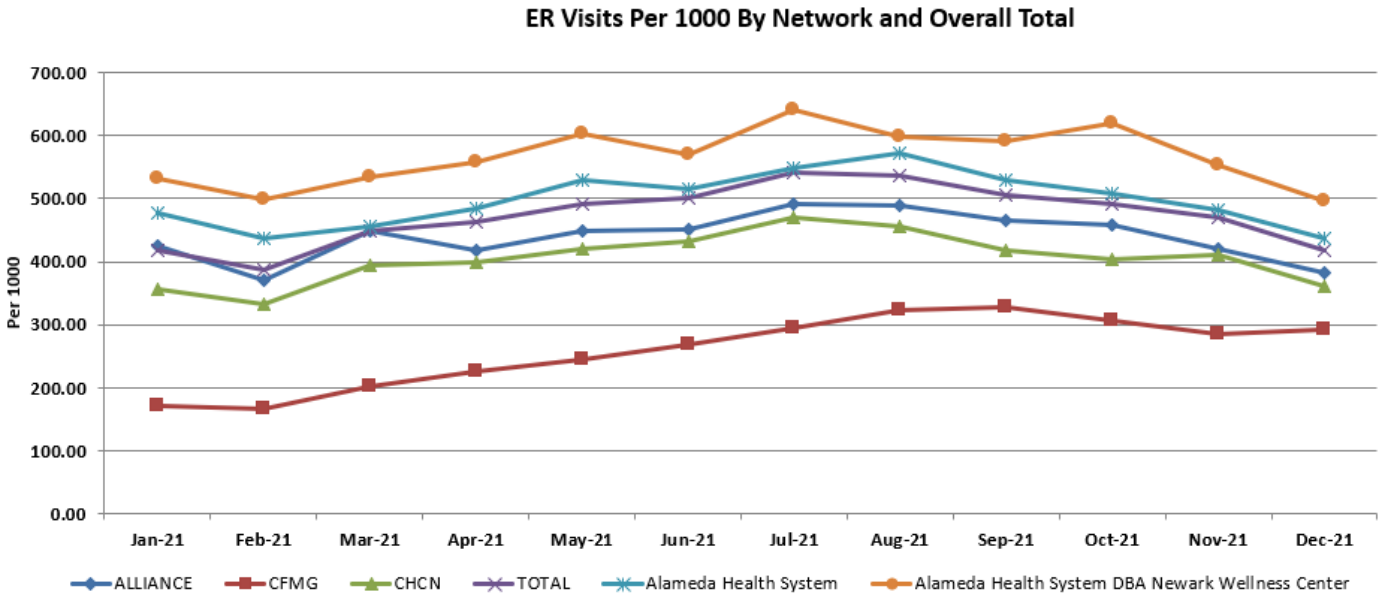
The UM Department has established monitoring activities to include:

- Acute hospitalization (Emergency Room, bed days, average length of stay and discharges, readmissions)
- Ambulatory services (primary care visits, specialist services, preventive health care services, emergency room visits)
- Out of network activities, both medical and behavioral health
- Behavioral Health utilization data
- Pharmacy utilization, (e.g., antibiotics, opioid use, medication management.)
- HEDIS use of service metrics.

Acute Hospitalization

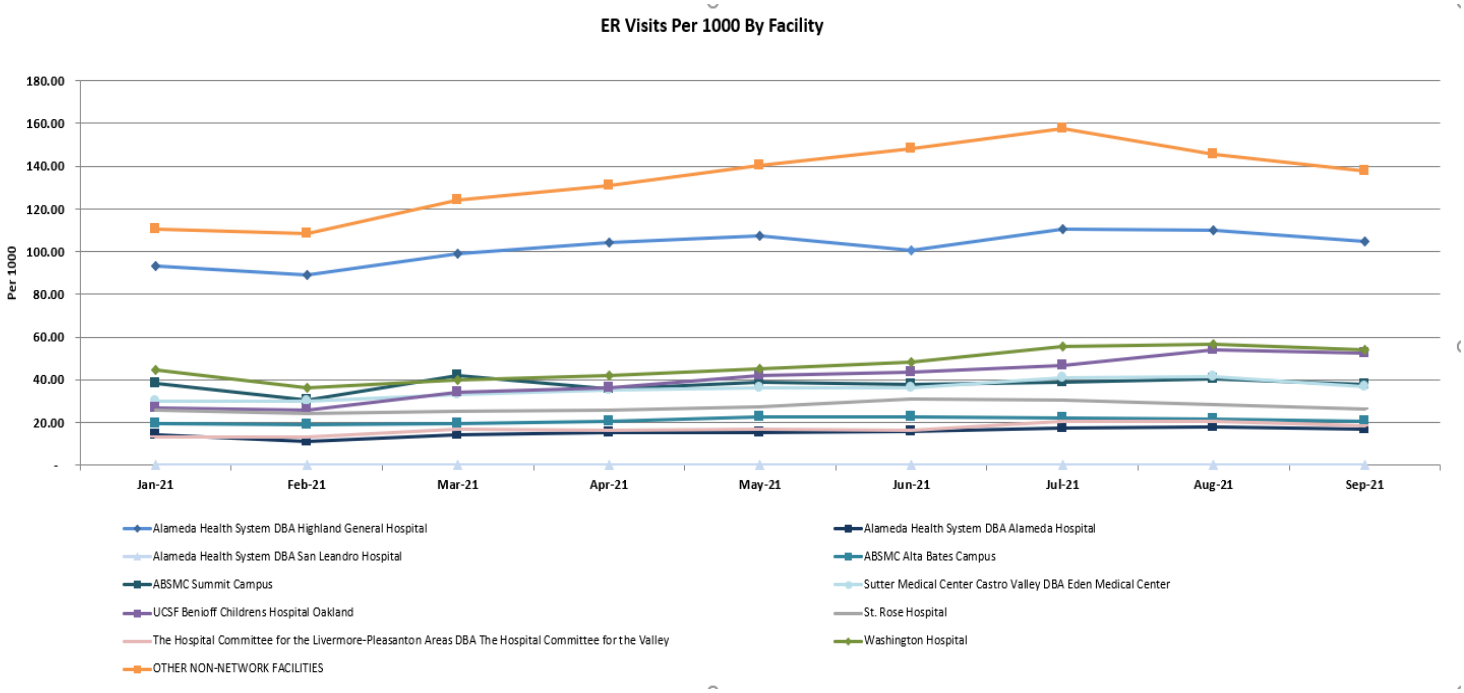
Emergency Room

Figure #13 depicts ER utilization by product from January to December 2021.



The data in Figure 13 show ER utilization across all products. There had been a precipitous drop in ER visits in March/April of 2020, coinciding with the onset of the Covid 19 pandemic. There was a slow increase in volume over the next months, and the numbers stabilized at about 100 visits per 1000 less than before the pandemic, across the entire network.

Figure 14 depicts ER Utilization by Facility for 2021



The data in Figure 14 show ER utilization across ER facilities/hospitals across time, with increase from the drop in the spring of 2020 that coincided with the onset of the pandemic, and a progressive rise in the following months.

Qualitative Analysis

The 2021 ER visit volume stabilized at about 100 visits/1000 fewer than the pattern seen before the onset of the Covid-19 pandemic in 2020. This pattern was seen in the number of visits by network, at all hospitals, and additionally at OON hospitals. Prior to the pandemic, the reporting data appeared to run parallel to the seasonality of ER utilization. In reviewing the CDC FluView Interactive for the 2021-2022 Flu Season, Influenza activity in the California was at maximum in late December 2021 and tapered down until February 2022, so is not coinciding or likely contributing to higher ED visits.

In reviewing ER visits by facilities, the top three centers for ER visits are 1) Non-network ERs, 2) Highland General (Alameda Health Systems), and 3) Washington Hospital. This is a different pattern than 2020. There were also notable peaks in ER use during Covid-19 surges and during the periods of time following these Covid-19 variant surges. Vaccinations were also increasing over this time, and it is possible that members traveled more, and been more likely to sustain injuries with increased outside activity compared to previously sheltering in place.

Hospitalization Measures

Concurrent/continued stay review for acute hospitalization focuses on:

- Facilitating timely and efficient provision of services
- Promoting adherence to established UM and Discharge Planning standards of care
- Identification of any Quality of Care needs or delayed services rendered while hospitalized
- Coordinating timely and efficient transfer to the most appropriate level of care
- Implementing proactive and effective discharge planning
- Identification of ongoing case management needs in the ambulatory setting

The Alliance UM Department is responsible for providing clinical oversight of the inpatient concurrent review process. The UM team is also responsible for discharge planning designed to identify and coordinate quality, cost efficient post-hospital care at the point of admission, (or the first day UM is notified of an admission) by:

- Identifying a member's medical/psycho-social issues with potential need for post-hospital intervention
- Communicating to the attending physician, specialists, and member regarding covered benefits for services needed post-discharge or upon transfer to a lower level of care.
- Assisting with locating appropriate placement for members with complex medical or psychosocial barriers to discharge.
- Referral to the Case Management department for coordination of care and follow up for the members.
    - Identification of any Disease Management condition prioritized by the Case Management Department
    - Identification of Community Resources or Enhanced Care Management needs
    - Assessment for Readmission risk and facilitating referrals and/or support to mitigate

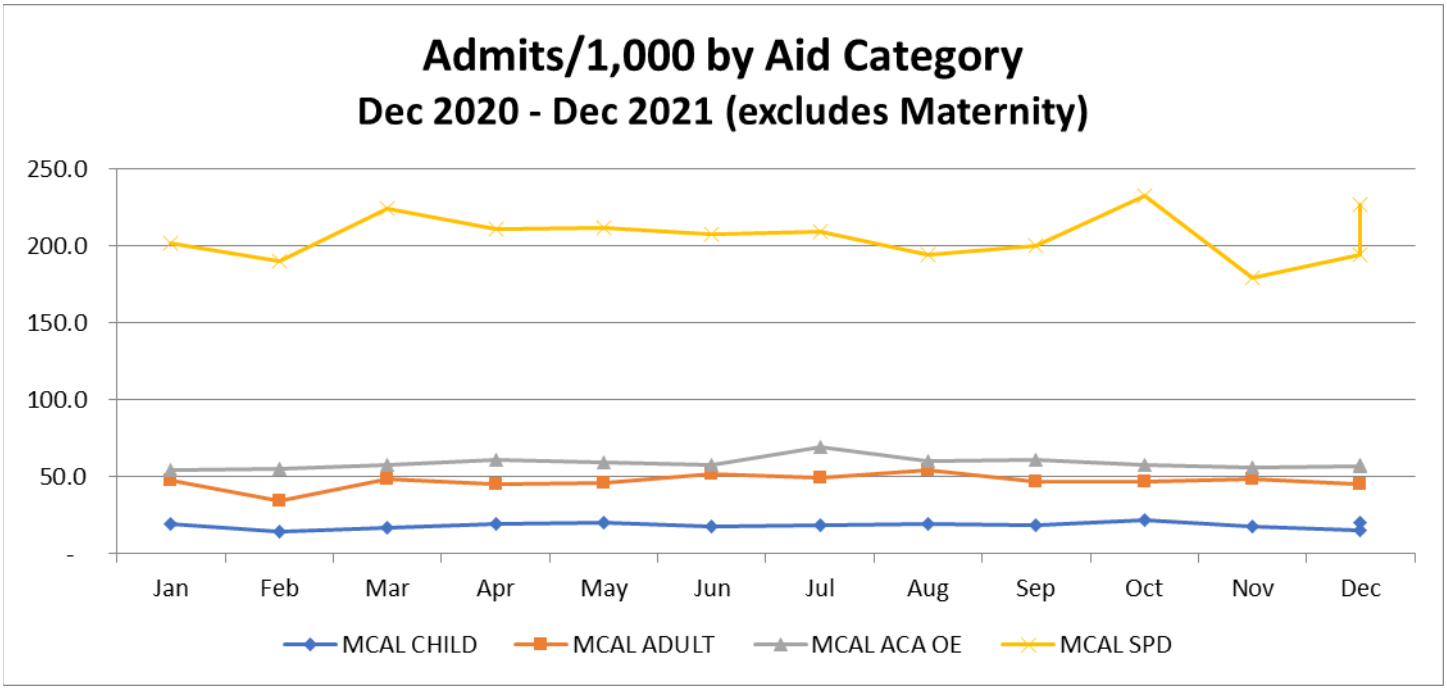
Quantitative Analysis

The Alliance has established benchmarks for inpatient admissions:

Figure #15– 2021 Hospitalization Targets

Inpatient Barometer All Products	
Metric	Target
Admits/1000	60
Bed Days/1000	297
Average Length of Stay (ALOS)	5.2

Figure #16 2021 Hospitalization admits per thousand by Aid Category.



The data above represents the 2021 performance for all lines of business in inpatient management by admits per thousand. Medi-Cal SPDs continue to have the highest admits per 1000 members while all other member aid categories remain relatively flat. This is as expected for the SPD population, who often have higher complex medical needs and more frequent utilization. Admits have stabilized to normal levels after the pandemic associated dip in 2020 By Network, the Alliance has the highest volume of admits/ 1000: 76.9, followed by AHS 65.5, then CHCN 56.6, and CFMG 10.1. AHS members are preomdinantly hospitalized at AHS Highland, and Alliance members are hospitalized predominantly at Washington Hospital. CHCN member are distributed across 2 main facilities: Alta Bates Summitt and AHS Highland. CFMG members are predominantly hospitalized at UCSF Benioff-Childrens Hospital. The facilities with the highest admits/ 1000 in decreasing order are: AHS Highland (9.9), Alta Bates Summitt (9.3), Washignton Hospital (6.2), Out of Network (5.9), Eden Medical Center (5.4), and St Rose (3.4).

Figure #17 **2021 Hospital bed days per thousand by Aid category**

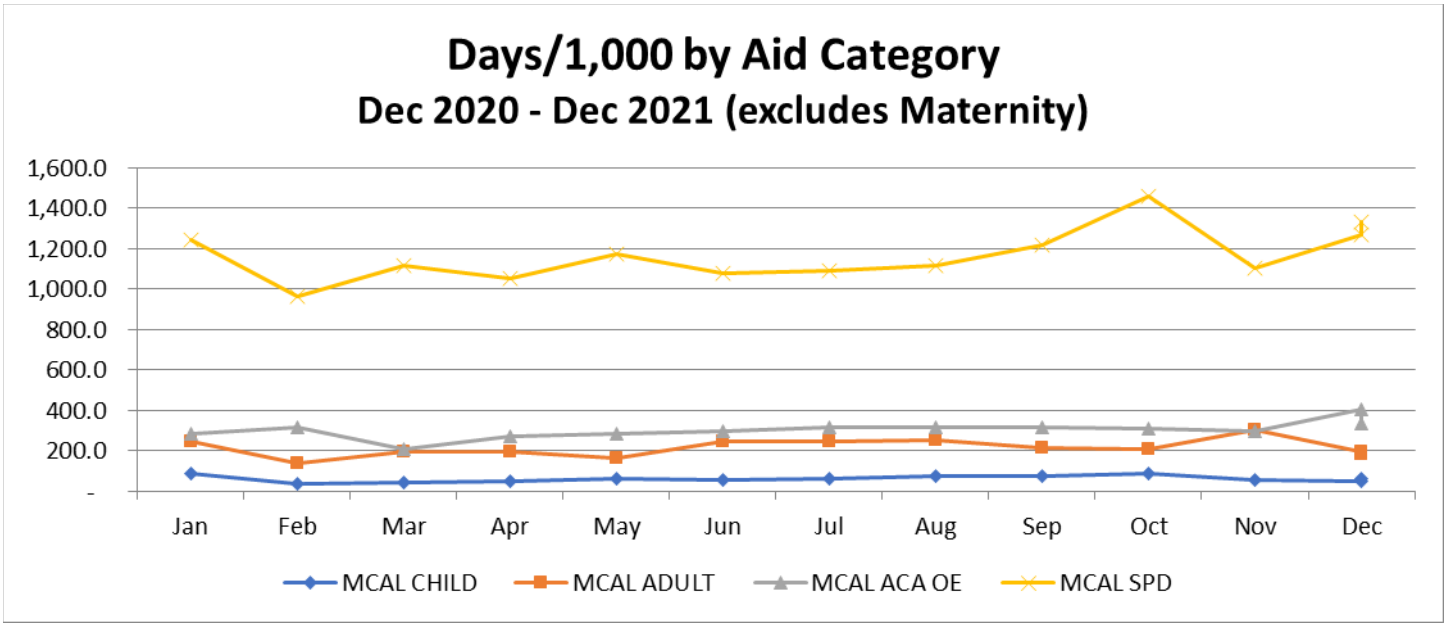
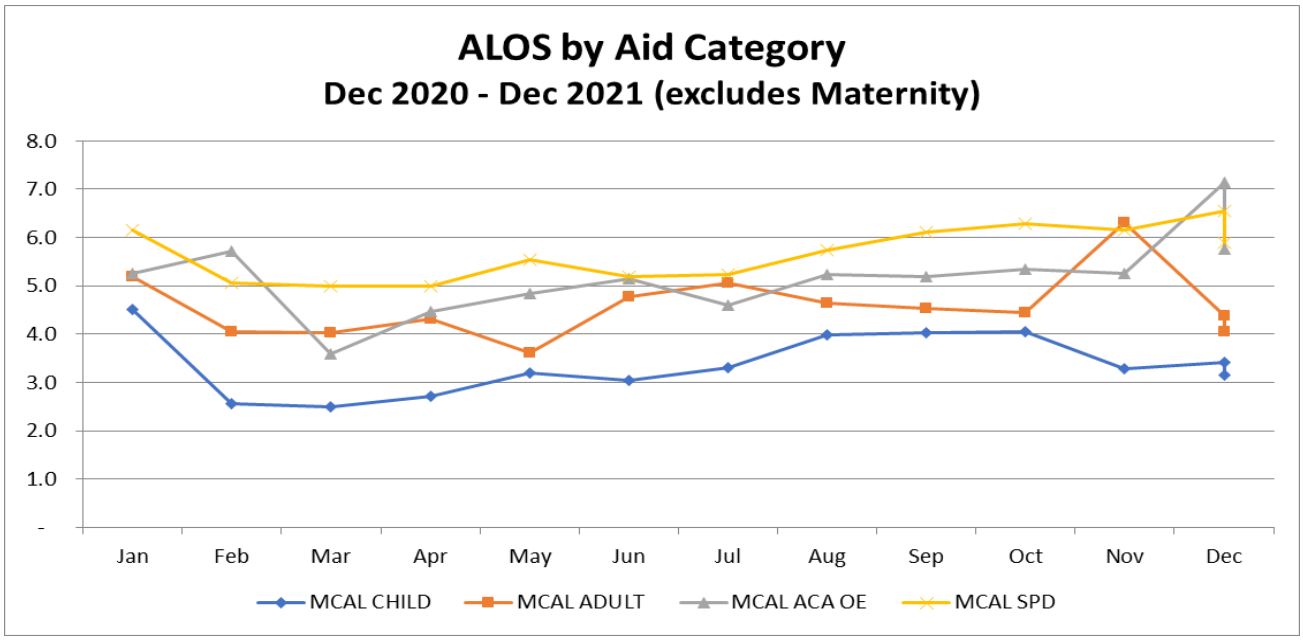


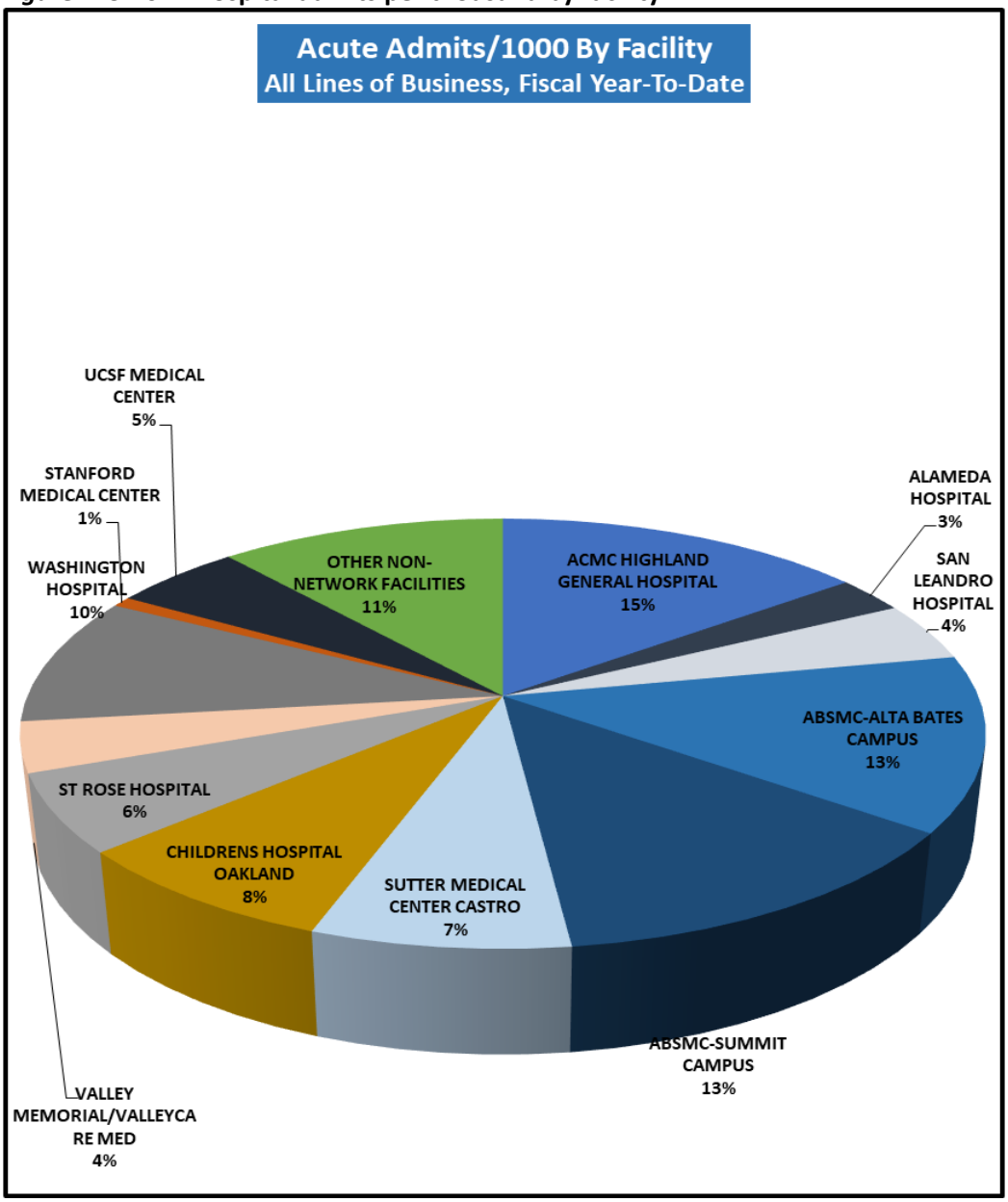
Figure #17 represents the 2021 performance for all lines of business in inpatient management by bed days per thousand. The data above again shows Medi-Cal SPDs as having the highest bed days per 1000 members while all other member aid categories remain relatively flat. However, Medi-Cal Expansion membership bed days per thousand began to rise in December 2021. Two networks decreased their days/ 1000 in 2021 compared to 2020 with CHCN 303.7 days/1000 (-6.7) and CFMG was 18.2 days/1000 (-0.4). While the following networks increased their days/ 1000: Alliance 452.2 (+27.7) and AHS 330.1 (+1.5). By facility, AHS Highland has the highest days/ 1000: 52.4 (-4.7), following by Alta Bates Summitt 46 (-0.6). Washingon Hospital increased their days/ 1000: 39.5 (+3.1). UCSF also increased their days/ 1000: 20.2 (+6.4). For the LTACHs, Kindred had 13.3 days/ 1000 (+3.0) and Kentfield 2.5 (+1.5).

Figure #18 **2021 Hospital average length of stay per thousand by Aid Category.**



The data above shows considerable variability, but Medi-Cal SPD and Medi-Cal Expansion (MCE) have the longest stays for inpatient hospitalizations, as expected for these medical complex populations. The aid categories that increased the most from 2020 to 2021 were Medi-Cal SPD (+0.2) and Adult (+0.1). Those that decreased from 2020 to 2021 were IHSS (-1.0), MCE (-0.6), and Child (-0.5). The overall ALOS (5.2) in 2021 was affected by patients admitted with Covid, and staffing shortages across the health system that negatively impacted efficient progression of care and placement availability. During variant surges there were local covid-19 outbreaks in the hospital and skilled nursing settings impacting patients and staff that created barriers to hospital discharge due to county-imposed lockdowns, and decreased bed availability to accommodate isolation protocols. Initially the patients admitted with Covid had long ALOS, but that LOS came down over the course of the year. However, it is notable that overall ALOS (5.2) has not returned to pre-pandemic metrics (4.8 in 2019).

Figure #19 **2021 Hospital admits per thousand by facility.**



There was a slight decrease in % of admissions to Sutter facilities (-2%) and a slight increase in % of admissions to Alameda Health System facilities (+1%) between 2020 and 2021. LTACH all had the highest ALOS with Kentfield (49.5) and Kindred (35.6), and followed by Tertiary/ Quartenary facilities: Stanford Health Care 3.1 ALOS (+0.3 from prior year), and UCSF had 6.6 (0.0 from prior year).. Washington Hospital had a 6.2 ALOS (+0.2) which is an outlier compared to other network community hospitals which all fall well below 6 ALOS. A comparable hospital with similar admits/1000 is Eden Hospital which has 4.6 ALOS (+0.1). Even out of network hospitals where AAH UM team has more difficulty in assisting with out of area discharges, has 5.6 ALOS.

Qualitative Analysis

The Alliance evaluates inpatient utilization per 1000 members and Emergency Room (ER) visits per 1000 members as key utilization performance measures, by network. The Seniors and Persons with Disabilities and Medi-Cal Expansion membership is evaluated separately due to the significantly different clinical demand of SPD members compared to MCE members as reflected in the target rates. Duals are excluded because the Alliance is the secondary coverage and therefore don't render UM determinations for hospital care. The rates shown are based on claims and encounter data. Medi-Cal performance is compared to the DHCS rate targets.

As seen across the Medi-Cal beneficiary data, the SPD population continues to be the highest utilizers across all hospital categories. The Medi-Cal Expansion is slightly higher in average length of stay (ALOS) as well as admits and bed-days.

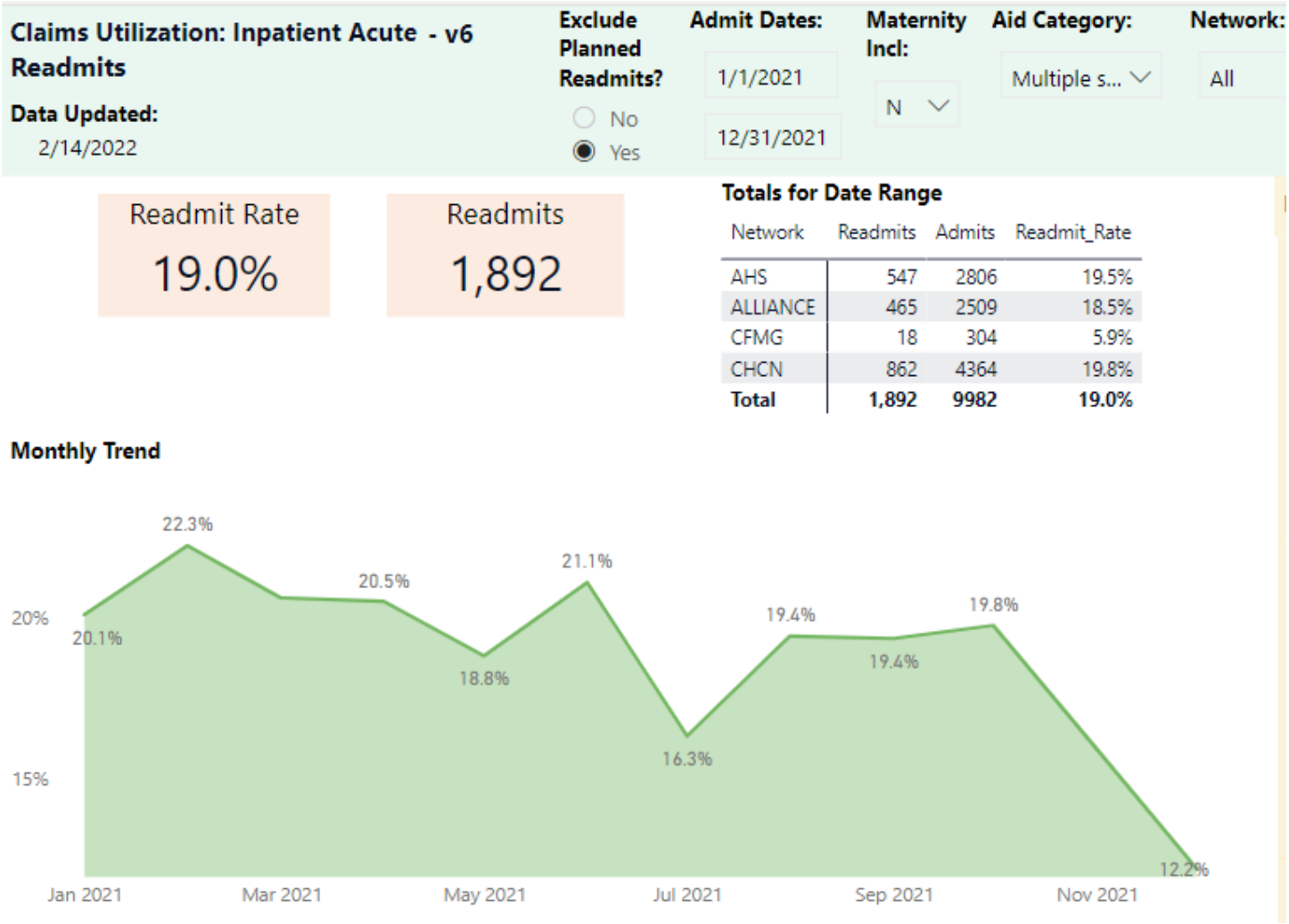
Data provided to assess admissions by facilities, the top three hospitals are 1) ABSMC Facilities (Summit, Alta Bates, and Eden), 2) Highland Hospital, and 3) Washington Hospital. Two of the three hospitals also align with the ER utilization data by facilities as highly utilized facilities. Given the high number of admissions to Sutter facilities and Alameda Health System facilities, in 2021 the Alliance engaged both Sutter and Highland leadership and staff to develop strategies to support throughput and appropriate care transition program for Alliance members. Joint initiatives related to throughput, discharge options, and care coordination occurred throughout 2021. Of note, members who were enrolled with the Health Homes program showed decreases in both ED visit volume and ALOS when hospitalized. This metric will continue to be tracked as the Health Homes program transitions to the Enhanced Care Management (ECM) benefit in 2022. Due to the outlier performance for Washington Hospital, attention will be placed to increased oversight for hospital stays, to exploring new strategic coordination between the facilities and to initiate discussion about potential hospitalist management for AAH members.

Readmissions

All Cause Readmission rate, defined as readmission within 30 days of discharge, is trending above goal of 18%. Relevant activities should include early interventions prior to discharge and co-management with Case Management. Readmissions rates have remained relatively unchanged despite these interventions hovering between 20-19% for 2021. For 2021, the overall network readmission rate was 19%, and note that November data below is incomplete due to delayed claims processing.

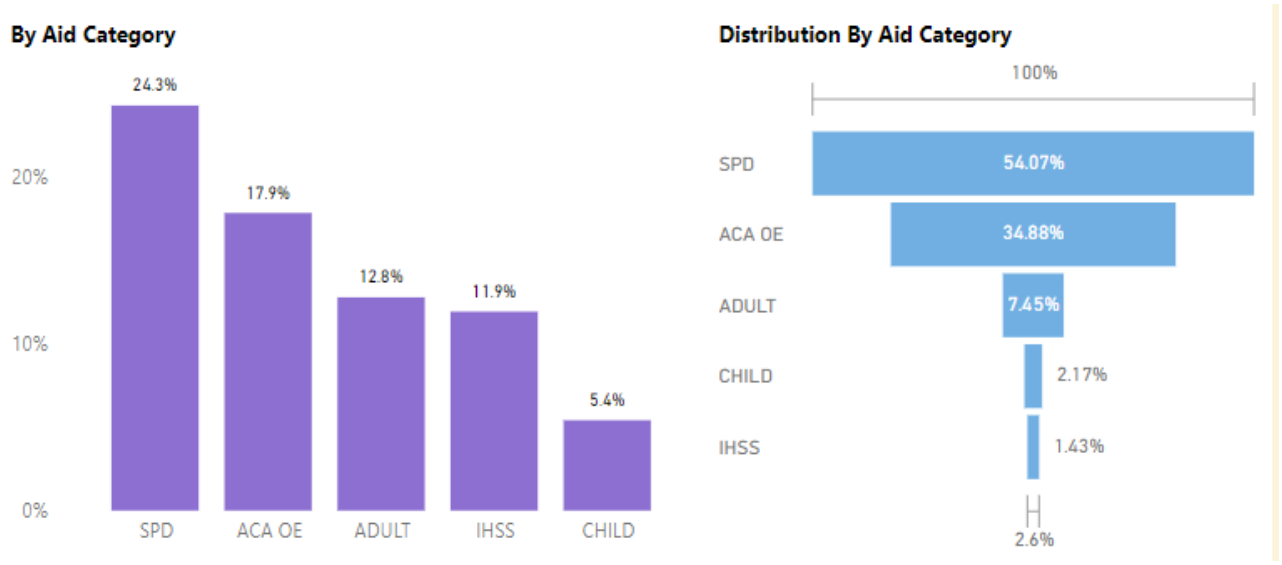
Quantitative Analysis

***Figure #20* - 2021 Hospital Readmission Overall and by Network**



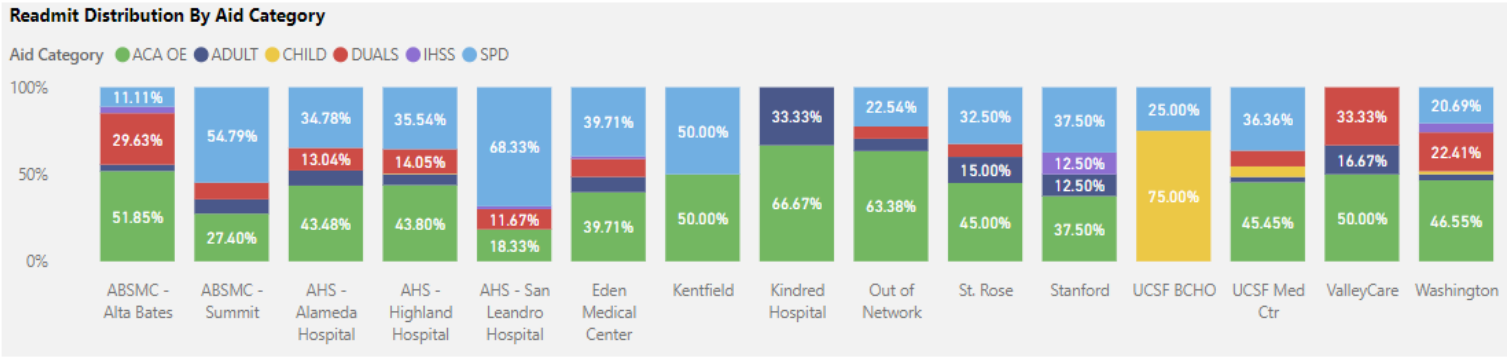
Data identified in Figure 20 notes the overall readmission rates, and the rates per Network. The overall readmission rate represented by Health Plan total (19%) is above the goal of 18%, and the highest readmit rate is at AHS at 20.3%. There has been no significant reduction in overall readmission rates from 2020. November is incomplete due to the delay in claims processing.

Figure #21 2021 **Hospital readmission rates by Aid Category and Distribution of Aid Category**



SPD contributes to the highest rates of readmission across the MCP and delegate networks, followed by Medi-Cal Expansion membership.

Figure #22 2021 **Readmit Distribution by Aid Category and Hospital by Facility**



Data in Figures 21 notes readmission rates by Aid category. As expected, the SPD members have both the highest readmit rate, and are the majority of all members readmitted. The overall health plan rate for SPD also exceeds the readmission goal rate of 18%. Members identified as non-SPD are consistently below the threshold rate. Figure 22 notes readmissions at facility/ hospitals, by Aid Category. During a review of all catastrphoic cases in Q3 and Q4 in 2021, SPD members made up a significant portion of these hospital stays. A non-specialty hospital, AHS San Leandro Hospital has the highest proportion of SDP members. In that same catastrophic stay review, there were notable opportunities to address progress of care and discharge planning delays that would benefit from increased UM oversight in 2022.

Reduction in readmissions is the focus of the Transitions of Care (TOC) program. The TOC program had started in 2020 as a pilot with Alameda Health Systems, reflecting both inpatient and outpatient coordination of services. The volume of TOC cases has steadily increased over 2021, and now includes members discharging

out of AHS facilities and members discharging with a Covid 19 diagnosis. The Alliance has also been working with the Health Homes program and CHCN to standardize the elements of an effective TOC process.

Continuity of Care

Following the requirements to provide Continuity of Care (CoC), Alliance members with pre-existing provider relationships who made a continuity of care request to the Alliance were given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider who agreed to the terms and conditions used by the Alliance.

A member transitioning from MediCal Fee-for-Service (FFS) into the Alliance may request to complete a course of treatment with an existing FFS or non-participating health plan provider.

a. The Alliance treated every exemption on the MER report as an automatic CoC request for the identified beneficiary. That included CoC requests for PCP, Specialty Care, or mental health. Additionally, special consideration for CoC was applied for medical exception for designated type of problem or condition (i.e. Acute conditions, serious chronic condition, pregnancy, terminal illness, care of a child under 5 years old, previously scheduled surgery/ procedure, or behavior health services that includes acute, serious, or chronic services).
b. Very few denials for CoC requests were seen in 2021.

Out of Network Services

Out of the network services are defined as any service provided by non-participating practitioners or facilities. Members may access OON services either through an emergency or as a direct referral for specialty services not available within the network, timely access standards not met, continuity of care, quality of care concerns, or for continuity of treatment. The Alliance analyzes data related to OON services to address network deficiencies. This activity is focused at assessing requests for OON specialty services which may indicate the lack of availability of specific specialty types or geographic locations.

Figure 24a OON Report #01592

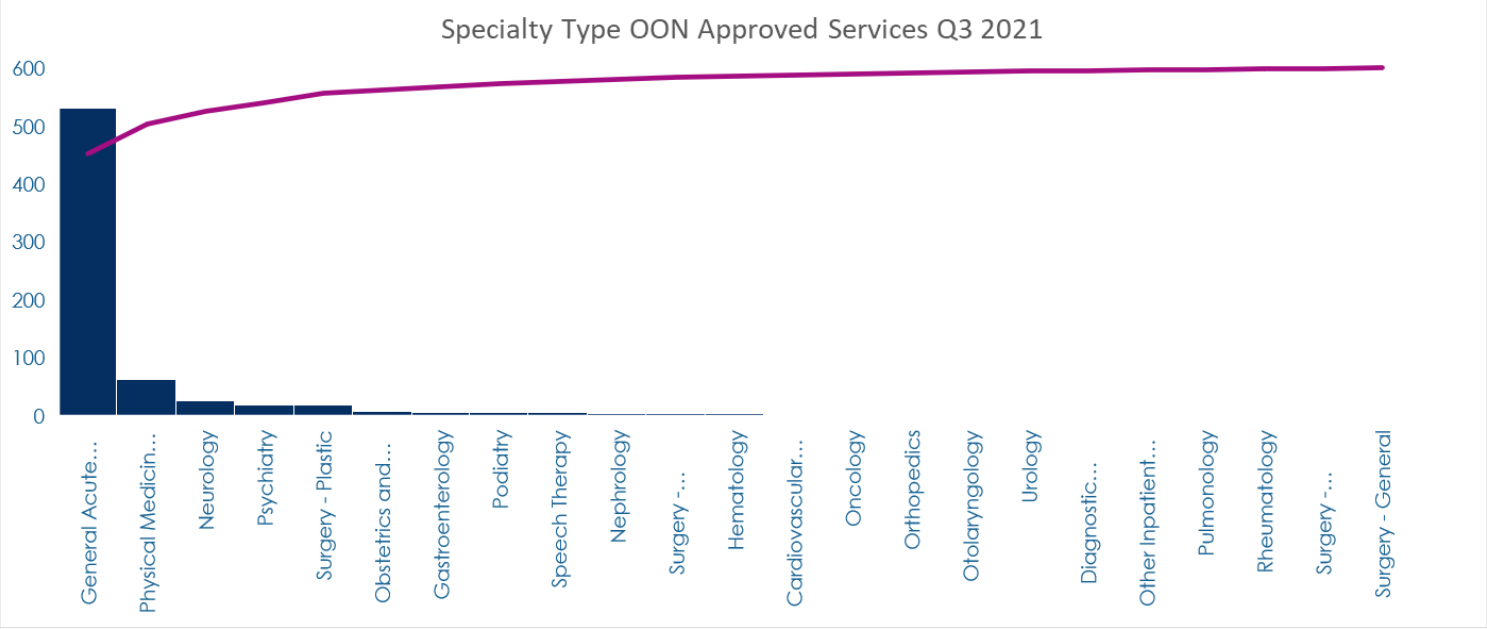
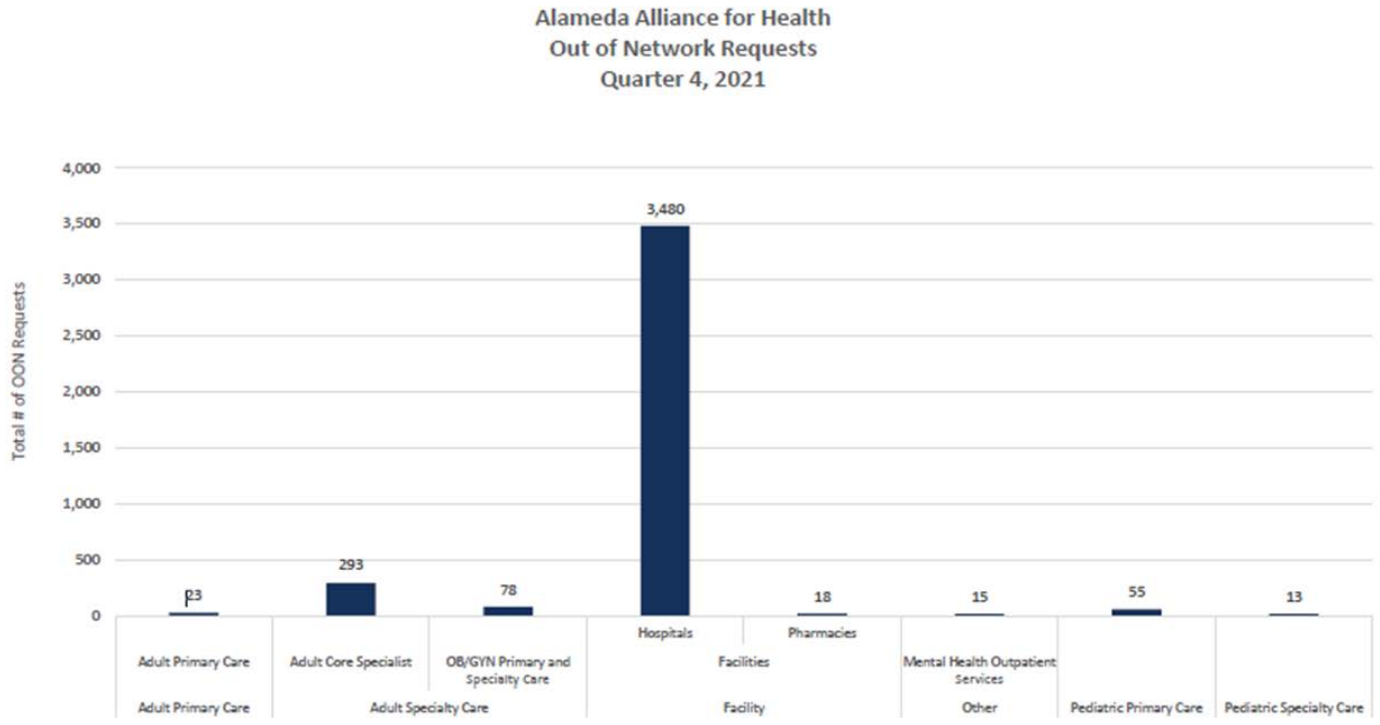


Figure 24b OON Report MCPDP



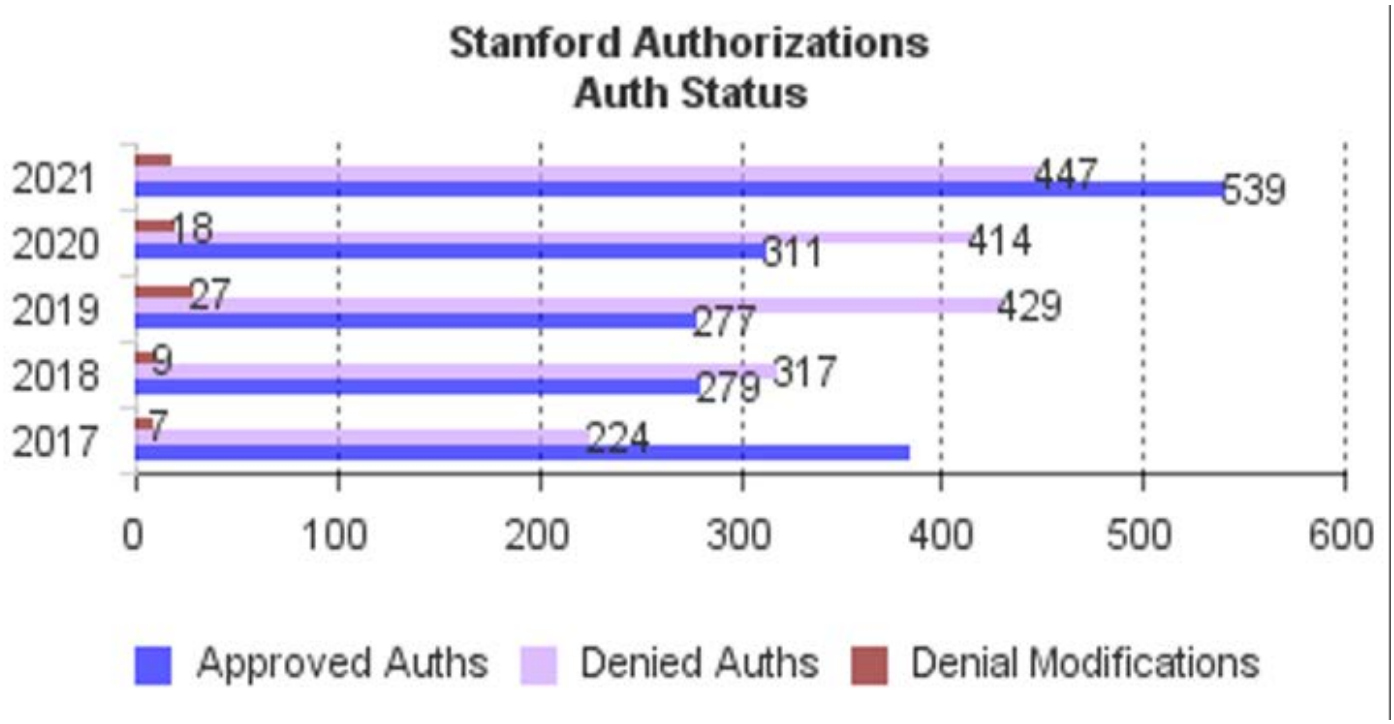
Dataset Used: Quarter 3 2021

* Provider Types are categorized by Annual Network Certification requirements, located in All-Plan Letter 21-006

In 2021, the Alliance continued to review OON requests and approvals, and in the 4th quarter recognized that there is a data discrepancy between the previous DHCS OON report and the new MCPDP OON report, shown in figures 24a and 24b. This discrepancy is being evaluated for data integration issues between delegates and the MCP, OON data validation across networks, and specialty and OON data coding and mapping issues. An example of mapping issues involves the need to distinguish LTACH, subacute, ARU, outpatient rehabilitation and home health referrals which impacted the 2nd largest category attributed to the physical medicine. Similarly, code taxonomy and data validation steps were responsible for an inaccurate report for OON pediatric primary care visits.

AAH contracts with 16 hospitals in the East Bay, and reports show acute hospital stays account for the highest volume OON category. Drivers for most OON hospital volume is admissions through ED and there was increase in OON hospitals stays during the pandemic, potentially due to member mobility for remote work, family caregiving, and pleasure travel. The top volume requested OON provider is Stanford Hospital Systems, so the additional monitoring of each Stanford OON service request for medical necessity and the appropriateness to re-direct to an in-network provider continued. AAH continued its contracting efforts with Stanford, and now includes carveouts specialty care for Oncology Services in 2021 and Major Organ Transplants in January 2022. Adult specialties make up the next significant OON category, in particular Neurology and Plastic Surgery due to Autonomic Dysfunction diagnosis and management at Stanford Health Care. Most Gender Affirmation Surgeries are conducted in Marin County through existing LOAs. OB-GYN care continues to be notable due to continuity of care for low risk pregnancies, and the network OB-GYN referrals to OON Maternal Fetal Medicine for high risk pregnancies.

Figure 24a OON UM Determinations –



Data in Figure 24a show the Authorizations requests to Stanford for services from Q1 2017 to Q4 2021, measuring the number of referrals to Stanford by the authorization determination: approved, modified, or denied. Up until 2020, the authorization requests reflected OON requests because all of Stanford was non-PAR. However, a new contracted service for Oncology services was launched in late 2020, and as a consequence approved auths for Stanford in 2021 began to reflect a rise in PAR requests, and coincidentally a rise in non-oncology related specialty referrals.
The data over time demonstrated that the number of approved auths continued to decrease and the number of denials continued to increase, until 2021. In the future, the OON requests for Stanford will need to be separated from PAR Oncology service requests and MOT requests respectively in 2022. Continued attention around oncology second opinions will also be monitored in 2022.

Quantitative Analysis

In both OON Q3 reports, hospitalizations remain the highest volume OON category, but the next highest volume categories were different. Upon review, it was recognized that there are errors in some categories of data: taxonomy codes, mapping of data element categories from some delegates, data integration between delegates and the MCP, lack of OON data validation, and incorrect NPI numbers for some providers who have more than one treatment site or different delegate or MCP networks. A team is being created to track and correct the errors in the OON data.

The chart in Figure #24a shows the continued trend of decreased approvals and increased denials at Stanford, up until the launch of the Oncology services contract in late 2020. The Alliance launched the Oncology initiative with Stanford for oncology services to be provided within the AAH network, to expand oncology services and access to clinical cancer trials for Alliance members, improved timely access, improved geographic location for the southern part of the county, and to ensure access to high quality specialty care. In 2022, Stanford will also be a Major Organ Transplant in-network Center of Excellence.

The process for denials of OON requests is accompanied by confirmation of the requested service within the Alliance network and within time and distance requirements, as well as continuity of care considerations. OON approval and denial reasons are measured. OON approval reasons are most often met for specialty care is not available in network, and due to timely access needs. The most common OON denial reason is due to existing specialty care available within the network. OON denial determinations are also routed to the AAH Case Management Department for assistance with care coordination and redirect assistance within the PAR network.

Pharmacy Utilization

The management and monitoring of Pharmacy utilization and activities is reported through the Pharmacy and Therapeutics Committee and HCQC. A full review of these activities can be found in the P&T Committee minutes. In collaboration with Pharmacy, UM undertook the initial steps to review and develop methodologies for updating the Prior Authorization for Infusion Drug list, and whose efforts will continue into 2022.

Recommendations/Next Steps for 2022:

In 2022, the Alliance UM Department identified opportunities to improve the monitoring and the reporting of over/under utilization management activities, which included:

- Enhance UM system reporting to capture required elements for over/under utilization monitoring reports, to include access to OON specialty services.
- Emergency Room
    - Use monitoring reports identify potential frequent utilizers of ER services.
    - Document CM interventions for high utilizers and high-risk members, including those on hemodialysis, including ER services.
- Hospital Utilization
    - Continue to assess drivers resulting in longer than expected length of hospital stays.
    - Full implementation of a Transition of Care Program, with a goal of expanding to all hospital discharges.
    - Implement process to support the early identification of members at risk for readmission which will include frailty scores and additional UM parameters such as medication monitoring to identify members at risk for readmission, developing targeted interventions to improve outcomes.
- Ambulatory Setting - identify measures to monitor for care in the capitated setting.
    - Specialty Care encounters per thousand
    - Primary/Preventive Care in the capitated setting with UM interventions–, i.e. flu vaccine, pneumococcal vaccine. Mammography, Colonoscopy, through the Quality Improvement department.
- For OON:
    - Data: Develop process to review detailed OON reports to include more specific providers and services to support prospective analysis. Separate the Par requests for services at Stanford. Correct errors in reporting to accurately capture OON referrals.
    - Continue efforts to attempt contracting with tertiary and limited availability service providers, particularly Stanford.
    - Continue to explore contracting options for providers who resist conventional contracting.

LONG TERM SERVICES AND SUPPORTS (LTSS)

The Alliance is responsible for ensuring Members who are eligible to receive LTSS services are identified and referred. Since 2020, the UM Department has taken responsibility for Community Based Adult Services (CBAS), to ensure that CBAS eligible members are identified, referred, and assessed appropriately and timely. The UM

department Out of Plan RN provides assessment, re-assessments, and re-authorizations of services to the members.

Figure 25 - 2021 CBAS Enrollment by Facility by Delegate

CBAS Enrollment by Facility by Delegate

Based on Active Approved Authorizations, excluding MediCal terminated members

Run Date: 1/5/2022

Number of Members					
Facility Name	**Alliance**	**IHSS**	**CHCN**	**Kaiser**	**Total**
Alzheimer Services of The East Bay	7	0	9	0	16
Berkeley Community Physical Therapy	1	0	0	0	1
Family Bridges Inc.	81	0	202	0	283
Golden Castle Adult Day Health Care Center	5	0	0	0	5
Grace Adult Day Healthcare	8	0	0	0	8
Silicon Valley Adult Day Health Care	3	0	2	0	5
Total	105	0	213	0	318

As seen in the Figure 25, there were a total of 318 members receiving services through one of the six CBAS centers. The Center with the highest volume is Family Bridges, by a considerable margin. In 2020 and into 2021, the impact of the Covid 19 pandemic was felt in the CBAS centers. The CBAS Centers continued to provide remote services and remain in telephonic communication with their members. The Alliance stayed in close contact with the centers to ensure that the services were provided, to problem solve with the CBAS Centers, and to ensure the continuous support for these vulnerable members.

BEHAVIORAL HEALTH

The Alliance provides access to mental health services for the Medi-Cal and Commercial membership in several ways:

- Basic mental health care needs are provided by Primary Care Providers
- Medi-Cal members with “mild to moderate” impairments in mental, emotional, or behavioral functioning are referred to the contracted behavioral health delegate, Beacon Health Strategies
- Medi-Cal members diagnosed with a severe persistent mental health is carved-out and managed by Alameda County Behavioral Health Care Services Department (ACBHCS).
- Commercial members access mental health benefits through the contracted BH delegate, Beacon Health Strategies.

The Alliance works closely with both ACBHCS and Beacon to identify members who may benefit from co-management of both medical and behavioral health services.

The UM Department is also responsible for maintaining the relationship with ACBHCS to ensure eligible Medi-Cal members receive services through the Linked and Carved Out mental health programs. The focus of the activities is to ensure contracted providers continue to identify and refer members with serious persistent mental health conditions to the appropriate ACBHCS programs as well as facilitate coordination activities for co-existing medical and behavioral health disorders to assist with their treatment access and follow-up care.

The Alliance contracts with Beacon to administer the applicable Medi-Cal for members with Mild/Moderate behavioral health needs and Commercial (IHSS) mental health benefits.

Beacon and College Health IPA (CHIPA) work collaboratively to perform all behavioral health plan management functions. College Health IPA (CHIPA) is the clinical arm of Beacon performing contracting and any utilization management decisions. CHIPA maintains the NCQA accreditation. The relationship and operations are coordinated on behalf of members and providers.

Figure #26– 2021 Beacon Health Strategies Agreement

Beacon – CHIPA Division of Responsibility Function	Beacon (Admin)	CHIPA (Clinical)
Contracting for Outpatient Professional services		X
Credentialing	X	
Member Services	X	
Utilization Management		X
Claims Adjudication/Payment	X	

Figure #26A 2020Q3 to 2021Q4 Beacon Screening and Referrals

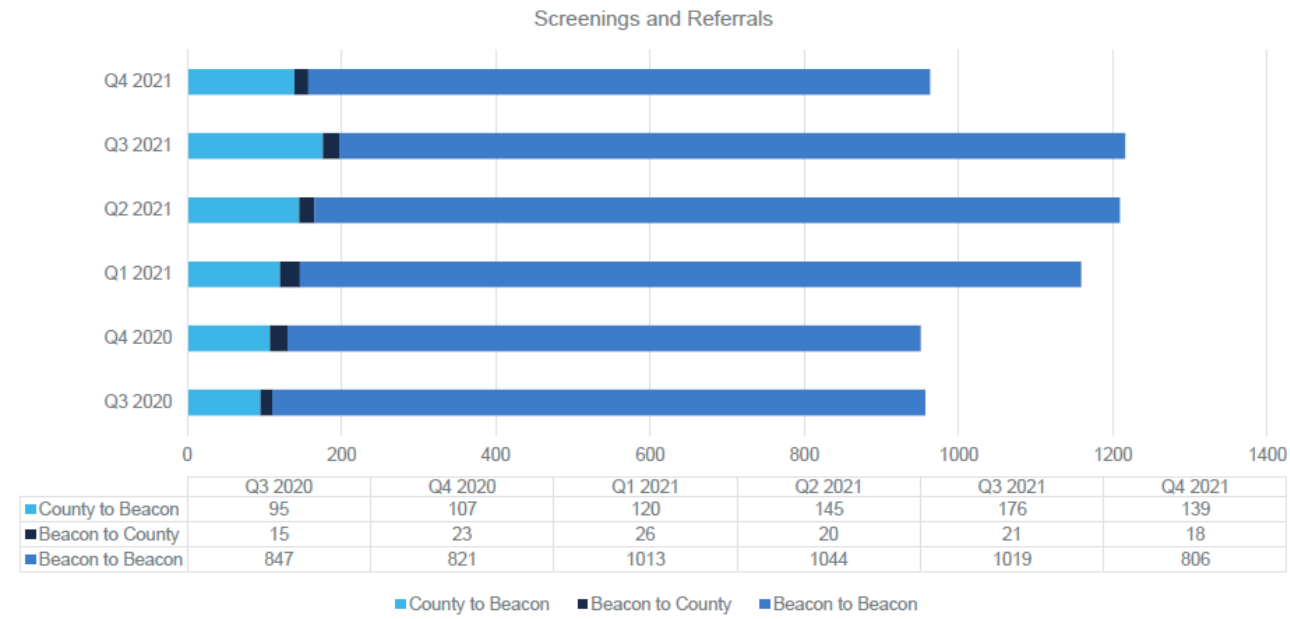


Figure 26b 2020Q2 to 2021Q4 Referrals to Beacon Care Management

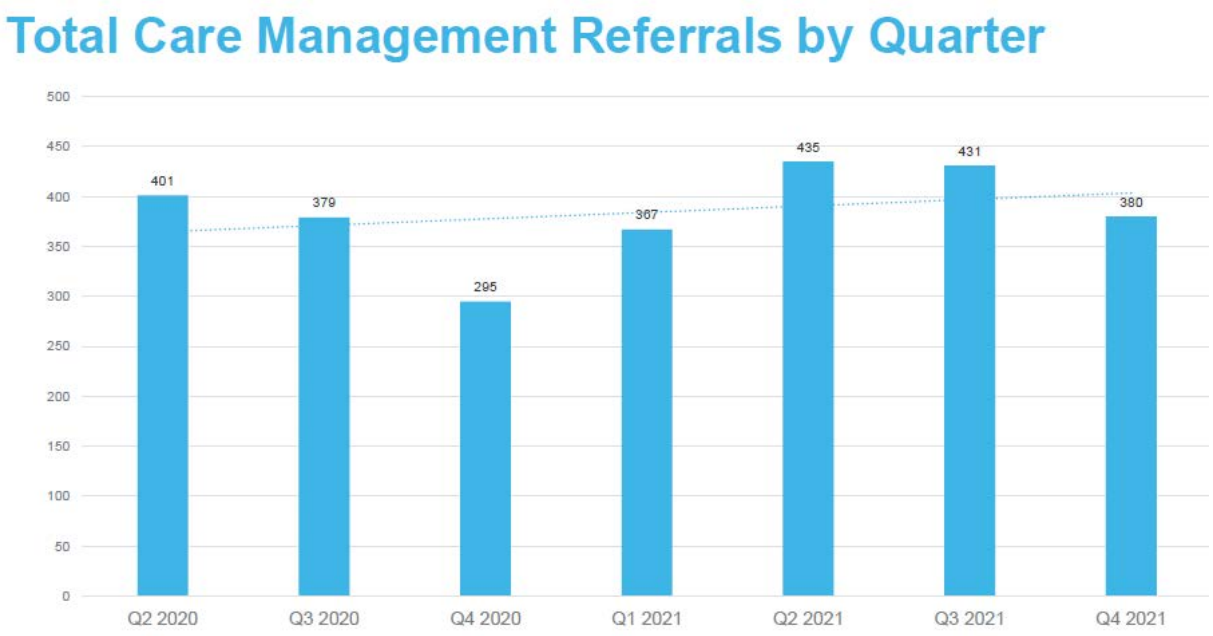


Figure 26a reflects the integration between Beacon for mild to moderate BH and the Alameda County Behavioral Health for Severe Mental Illness, showing the referrals between the entities based on member acuity. The Alliance has developed multi-disciplinary team to analyze data and identify opportunities for collaboration between medical and behavioral health. Figure 26b reflects AAH members who were referred to Beacon for additional support to access mental health treatment. About a quarter of the referrals to Beacon Care Management come from the clinical staff at AAH. A full description of the program activities is defined in the Beacon Behavioral Health Program Evaluation and UM Program Description. The Beacon BH documents are reviewed at the Alliance HCQC.

Integration with Quality Improvement/Management

The UM Department collaborates with the Quality Management on reports which impact health services. In particular, the HEDIS reports are reviewed at UMC as part of the under-utilization trend monitoring. The QM Department provides data to the UMC for analysis to use for quality improvement activities. There is opportunity for UM and Quality to continue collaboration around quality of care issues (PQI capture), and to explore identification of provider preventable conditions (PPCs) for acute hospital stays.
https://www.dhcs.ca.gov/individuals/Pages/PPC_Definitions.aspx

Assessing Members and Practitioners' Experience with the UM Process

Provider satisfaction survey that includes experience with the UM process results will be presented to HCQC in 2021. The Benchmark is a comparison of the Alliance outcomes to the other plans participating in in the 2021 SPH survey:

Figure #27 2021 Provider Satisfaction with Utilization Management

Question	2019	2020	2021	Benchmark
Access to UM Staff	46%	**49%**	43.6% (87th percentile)	30%
Obtaining Pre-Auth Info	45%	**55%**	48.0% (90th Percentile)	32%
Timeliness of Pre-Auth Info	48%	**54%**	47.4% (90th Percentile)	32%
Facilitation of Care	50%	**45%**	46.3% (93rd Percentile)	30%
Coverage of Prevention	59%	**60%**	53.8% (91st Percentile)	39%

The Provider Satisfaction Survey results for 2021 show that the overall scores from 2019 to 2021 have fluctuated somewhat for most questions. However, the 2021 scores still place AAH at or above the 87th percentile into the 90th percentiles compared to other plans for these metrics. The satisfaction rates are noted to be considerably higher than the benchmarks with other plans, hence the high percentile ranking. Provider satisfaction likely remained strong in 2021 with the implementation of the Provider Portal for online authorization requests and feedback on authorization request status. Further adoption of the Portal use by AAH Providers may improve satisfaction further.

Figure #28 2021 Member Satisfaction with Utilization Management

	Member Satisfaction with Utilization Management		
CAHPS Question	**2020**	**2021**	**Percentile Rank**
Getting Care Quickly	71.7%	72.4%	<5% Percentile
Getting Needed Care	82.6%	79.0%	15TH Percentile
Coordination of Care	80.3	83.0%	34th Percentile

Member experience with the UM process is assessed using established survey Consumer Assessment of Healthcare Providers and Hospital Systems (CAHPS) which measure patient experience across health plans, providers, and health care facilities. UM utilizes three questions to assess patient experience with UM, 1) Getting Care Quickly, 2) Getting Needed Care and 3) Coordination of Care. The results will be presented in 2022 at HCQC, and a description of the full survey can be found in the Quality Program Description.

As identified in Figure #28, the trending shows Member satisfaction with Getting Care Quickly has hovered in the low 70% between 2020 and 2021. Getting Needed Care decreased from 83% in 2020 to 79% 2021, to the 15th percentile. Member satisfaction with Coordination of Care increased from 80% in 2020 to 83% in 2021, which was at the 34th percentile. Overall, while member satisfaction shows approximately 61.3% of the surveyed members are satisfied with

getting the care from their physicians, these are lower outcomes compared to other health plans. The continued high performance in Turn Around Time for authorizations and the high rates of approved Authorization requests suggests that the dissatisfaction with these metrics are more driven by provider services than UM processes per se. Member satisfaction will need to have increased focus in the future, in collaboration with Provider Services, to assist in reminding Providers to communicate across Providers regarding members' care needs.

Recommended Interventions/Next Steps for 2022:

In 2022, there is an opportunity to ensure the UM Department participate in the analysis of the data and development of activities associated with the member and provider experience with the UM processes. While Provider Satisfaction is above the comparative benchmark and is over 50% for access to staff and auth info, and at or above 50% for care facilitation of care and preventive care coverage. However, Member experience is low compared to other health plans, and specific activities to address this will be required.

The continued lack of improvement with member satisfaction in 2022 will require a strategy with Provider Services to address this lack of improvement for Member experiences with the obtaining care.

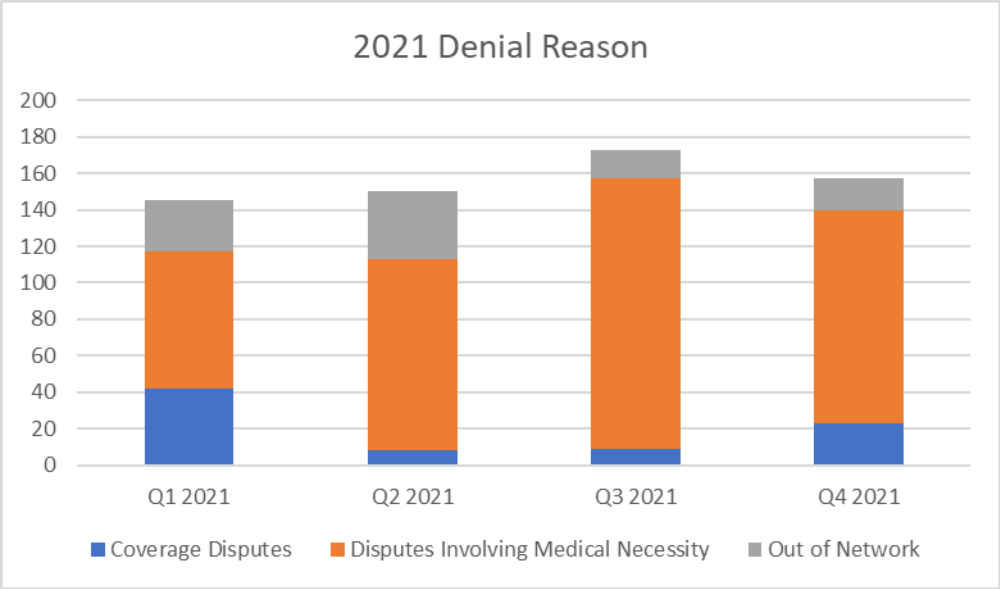
Analysis of Clinical Appeals

Quality integration activities continued with UM involvement in the analysis of member clinical appeals and overturns for medical and pharmacy services. UM participates in the analysis of clinical appeals through the UMC and HCQC. This include analyzing data by provider group responsible for the determination, by product and service type. As the Alliance only delegates the resolution of complaints and appeals to Knox Keene licensed Health Plans, the data below is inclusive of appeals of determinations made by the Alliance UM Department and all delegated provider groups except Kaiser.

Clinical Appeals are investigated to determine if the initial UM determination was appropriate. The final appeal is resolved with determinations of upheld, overturn, or partially overturned. Overturn appeal determinations are considered an opportunity to assess the UM process, and all overturned cases are reviewed monthly with Medical Directors for educational feedback, adherence to DHCS regulation, and review of UM process opportunities. The Alliance established a threshold of the overturn determination of 25%. There is opportunity to explore mapping the service and provider trends for Appeals and separately overturns to identify upstream authorization optimization and processes.

Quantitative Analysis

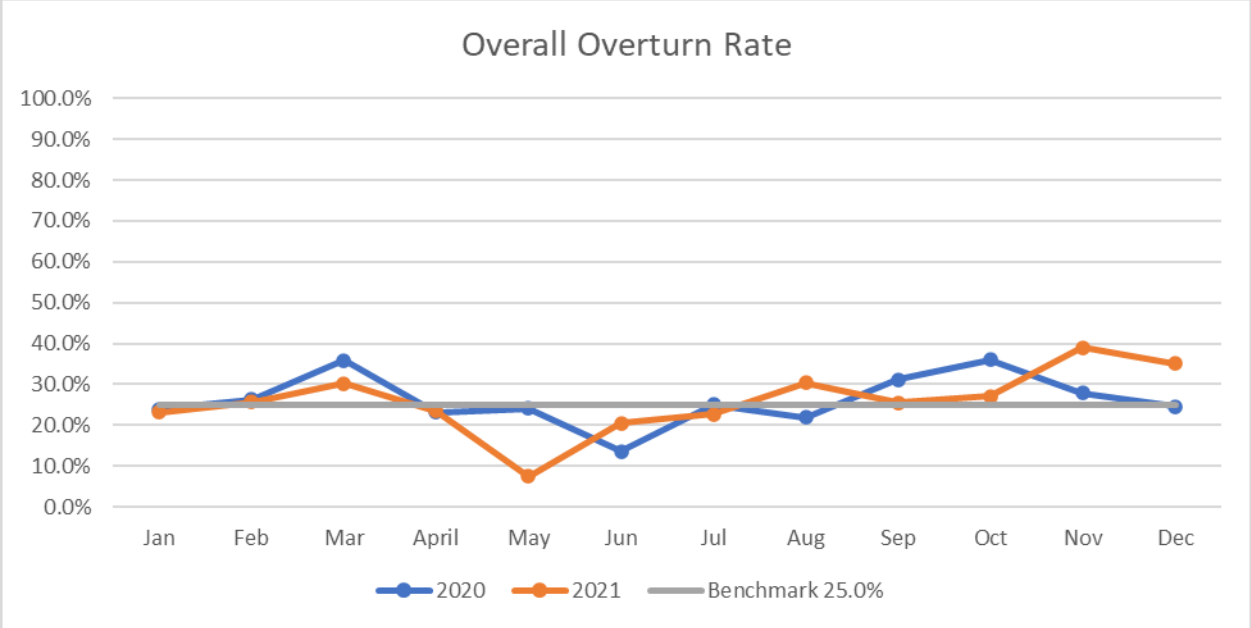
Figure #28 – 2021 Clinical Appeals



In Q4 2021, there were inconsistencies on how coverage disputes were captured, resulting in a higher number of denials based on coverage. G&A Department will research the issues and report on it in Q1 2022.

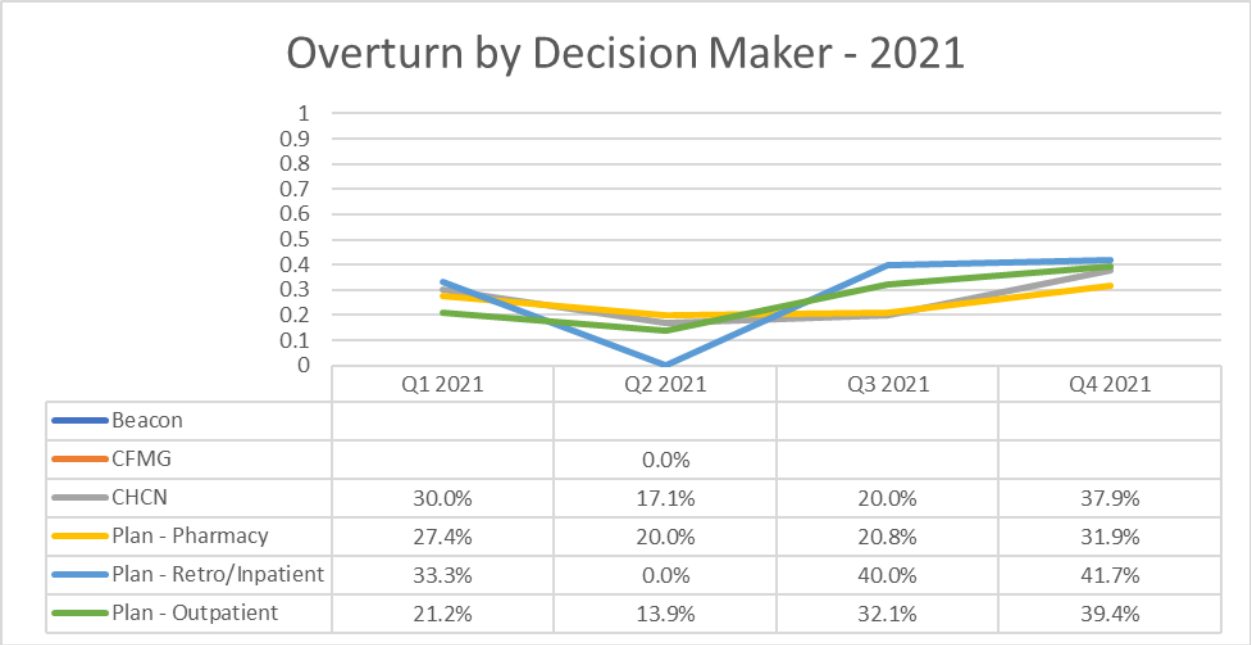
2021 Update: Pharmacy appeals were incorrectly being categorized as coverage disputes when denied based off of our MRG. In the beginning of Q2 2021, this was changed to capture them as dispute involving medical necessity, evident in the decrease of coverage disputes from Q1 2021 to Q2 2021.

Figure #29a – 2021 Clinical Appeals by Resolution/ Overturn – Threshold Compliance



The Alliance had an average overturn rate of 25.8% for 2021, just slightly over our internal benchmark of 25.0%. Most months were consistent excluding a large dip in May and an increase at the end of the year in November and December; however, with the annual overturn meeting our benchmark no interventions were identified.

Figure #29b – 2021 Clinical Appeals by Provider Group and Resolution



	Q1 2021	Q2 2021	Q3 2021	Q4 2021
Beacon				
CFMG		0.0%		
CHCN	30.0%	17.1%	20.0%	37.9%
Plan - Pharmacy	27.4%	20.0%	20.8%	31.9%
Plan - Retro/Inpatient	33.3%	0.0%	40.0%	41.7%
Plan - Outpatient	21.2%	13.9%	32.1%	39.4%

- There is not enough data to identify any trends with Beacon or CFMG.
- CHCN had experienced an increase in Q1 2021, which can be attributed to a change in process on how CHCN was reviewing care being requested at a tertiary facility. CHCN was inappropriately denying authorizations to a tertiary facility as being out of network (OON), instead of for appropriateness for the level of care. CHCN was advised to stop using denial for OON to the contracted provider. A new policy and procedure were developed to outline the appropriate process for reviewing services requested at a tertiary and quaternary facility, which was adopted by CHCN. This was put into place in Q2 2021; therefore, there was a decrease in the overturn rate.
- The Plan – Pharmacy appeals showed a decrease over the year compared to 2020, which can be attributed to weekly meetings that are being held between the Pharmacy Department and Grievance and Appeals Department to review overturned cases for quality improvement purposes.
- The Plan – Numbers were so low to identify any trends.
- The Plan – Increase in Q3 and Q4 of 2021, we continue to meet with the Medical Directors on a bi-weekly basis to review all overturns.
- There was a significant increase in Q4 2021 across all appeal types, the Grievance and appeals department will have to investigate the Q4 data to see if there are any trends.

Recommended Interventions/Next Steps for 2022:

The Pharmacy Carve Out to Medi-Cal was implemented on January 1, 2022, this change will result in a large decrease of appeals overall.

For 2022, we will continue to track the overturn rate to see if there are any trends. There was a significant increase of overturns in Q4 2021, we will compare to Q1 2022 to see if we experience a decrease closer to our benchmark or if there are any interventions to be taken based on the original decisions.

Integration of medical and behavioral health

Behavioral health is managed through delegation to the MBHO. The behavioral health practitioners are involved in key aspects of the delegate's UM program, ensuring BH focus in policies and procedures, aligning the medical necessity guidelines with medical necessity guidelines and participation in the UM committee meetings. The MBHO dedicates a clinical team to assist in the co-management of the activities.

In 2021, the teams worked on efforts crossing the medical and behavioral health services which included:

- Involvement of Behavioral Health practitioners in the HCQC.
- HEDIS activities related to behavioral health measures.
- Enhancing CCM outreach to chronically ill
- Improve coordination of care by increasing clinical oversight and co-management with the medical management teams.
- Continued efforts toward improving communication between the primary care physician and behavioral health providers.
- In 2021, planning began for the insourcing of mild to moderate BH back into the plan from the current delegate, Beacon Health Options in Q4 2022. The integration between BH and medical care is expected to be enhanced by AAH providing this service directly instead of via delegate.

A full description of the MBHO UM Program and Evaluation can be found in the HCQC minutes.

Coordination with Regulatory Compliance

The Alliance UM Department works closely with the Compliance Department in preparation for regulatory audits. In 2021, the department participated in audits from DHCS and DMHC. As a result of the reviews, several internal workgroups met to identify activities targeted at resolving the identified UM related issues. The workgroups managed these activities via ongoing work-plans. The activities identified are on target for completion within the established timeframes. The activities include mechanisms for ongoing monitoring to mitigate further regulatory deficiencies.

Recommended Interventions/Next Steps for 2022:

To ensure integrity the of the internal UM process, Alliance UM Department will conduct ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state, regulatory, contractual and accreditation standards. Alliance UM Department will implement a monitoring program for the early identification of potential compliance risks.

In addition, the program includes an opportunity to provide quality oversight of the current UM processes. This is accomplished by internal monitoring of UM authorization files on a periodic basis.

Conclusion

Overall, the 2021 UM Program was effective in maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The Covid 19 pandemic had affected volume trends in multiple areas, but as the volumes returned to normal rates, Alliance maintained the required processes within the regulatory timelines, tracked the effect of the pandemic on members, and change processes to mitigate any potentially negative effects and meet the regulatory requirements of pandemic related APLs. The UM program activities have met most of the established targets, including a reduction in regulatory findings. The UM department has provided leadership to the preparations for carving in the Major Organ Transplant services in 2022. The Alliance leadership has played an active role in the UM Program structure by participating in various committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements.

UM Program Recommendations for 2022

As a result of internal performance monitoring performed in 2021, opportunities for improvement were identified and will be incorporated into the 2022 department goals. Highlights of opportunities for improvement based on the regulatory findings include:

- Improve monitoring of network utilization (over/under), including out of network authorization requests with a continued focus on the Stanford Health Care analysis and referring providers.
- Continue monitoring of Specialty Referrals, both approved and denied
- Collaboration with the Alliance Compliance Department on the full implementation of the UM process for internal performance monitoring of UM decisions.
- Continue using the analysis of hospital data to work with hospital partners on individual hospital strategies for management of members for appropriate length of stay and timely discharge planning.
- Tighten concurrent reviews for progression of care and early discharge planning, increased internal oversight and identification of catastrophic stays, and escalating complex discharge barriers.
- Strengthen programs around oversight of clinical decision making, both internally and for Delegates.
- Provide leadership to the initiative on Major Organ Transplant carve in, including expanding staffing to manage this vulnerable population, in collaboration with all relevant Alliance departments.
- Explore Quality initiatives with the Quality Department around PQIs, HEDIS measures, and PPCs.
- Refine the ADT feed coming from contracted hospitals to enable automatic case creation in TruCare.
- Analyze the opportunity and implement the process to increase the number of authorizations that are appropriate for automatic approval.
- Continue implementation for tracking and intervening with unused Authorizations to ensure that members receive appropriate care and follow up.
- Work with AHS to improve the use of the Palliative Care benefit for members.
- Work with the Alliance Case Management Department and all relevant Alliance departments to engage on UM aspects of CalAIM for ECM and CS in 2022.
- Continue the care transition program in partnership with Highland Hospital and extend to other hospitals, with attention to readmission risk screening and disease management
- Provide leadership in collaboration with Case Management to enhance service coordination for members being managed by CCS.
- Provider leadership to the initiative for enhanced care coordination for high-risk hemodialysis members with DaVita.
- Improve reporting and analysis of grievance and appeals activities related to UM decision making and analysis for member and provider experience with UM.
- Enhanced IRR training and educational enrichment for UM staff.

- Hardwire a standard process for policy review and revision that ensures UM processes maintain operational and regulatory compliance.