2022
Utilization Management
Program Description

2022 Utilization Management Program

Signature Page

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- **<u>Changes in UM Program Description from 2021 Version</u>**
    - **Grammatical corrections**
    - **Pagination corrections**
    - **Addition/correction of relevant regulatory references**
    - **Addition of CalAIM Initiatives**
    - **Pharmacy change to Medi-CalRx**
    - **Updated Recommendations for 2022**

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Introduction

Alameda Alliance for Health (the Alliance) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to lower-income people of Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents.

The Alliance provides health care coverage to over 250,000 children and adults through the Medi-Cal and Alliance Group Care programs. Alliance members choose from a network of over 1,700 doctors, 17 hospitals, 68 community health centers, and more than 200 pharmacies throughout Alameda County. The Alliance cares about the health of our community and reflects the community's cultural and linguistic diversity in the health plan's structure, operations, and services. In addition, many of the Alliance providers, employees, and Board of Governors (BOG) live in areas that we serve. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is always our priority.

The Alliance's Utilization Management (UM) Program was established to provide basic and complex care management structures and key processes that enable the health plan to improve the health and health care of its members. The UM Program is a supportive and dynamic tool that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, and regulatory and accrediting organizations. The UM Program is compliant with Health and Safety Code Sections 1363.5, 1367.01, 1368.1, 1374.16, 1374.72 and Title 28, CCR, Sections 1300.1300.67.2, 1300.70(b)(2)(H) & (c).

The UM Program Description includes a discussion of program objectives, structure, scope, and processes.

The annual evaluation of the effectiveness of UM processes was conducted and the recommendations were documented in the 2021 UM Program Evaluation. Based on those recommendations, the Alliance will focus on the following areas for 2022:

- Monitor the existing UM infrastructure to ensure that it meets the needs of the members, providers, and the organization.
- Continue to optimize opportunities to enhance the existing clinical information system reporting capabilities to focus on the improvement of monitoring operational activities, i.e. Turn-around Time monitoring, referral types.
- Focus on strategies and tactics to reduce readmissions.
- Improve monitoring of network utilization (over/under), including out of network and specialty referrals.
- Enhance reporting and analysis of member and provider complaint data related to UM decision making to improve experiences with UM process.
- Implementing activities to improve member experience with UM, targeting CAHPs measures for "getting needed care" and "getting care quickly" as it relates to primary and specialty care.

- 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.
- Provide leadership in collaboration with Case Management to enhance service coordination for members being managed by CCS.
- Strengthen internal oversight of UM processes.
- Strengthen oversight of delegates; and
- Continue to focus on activities to mitigate regulatory audit deficiencies related to UM activities.
- Secure staffing and resourcing to support these initiatives.

Section I. Program Objectives & Principles

The purpose of the Alliance UM Program is to objectively monitor and evaluate the appropriateness of utilization management services delivered to members of the Alliance. The UM Program serves Alliance members through the following objectives:

- Ensure that appropriate processes are used to review and approve the provision of medically necessary covered services.
- Provide continuity of care and coordination of medical services.
- Improve health outcomes; and
- Assure the effectiveness and efficiency of healthcare services.

The Alameda Alliance for Health adheres to the following operating principles for the UM Program:

- Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria.
- UM decisions are made on appropriateness of care and service, as well as existence of benefit coverage.
- Appropriate processes are used to review and approve provision of medically necessary covered services.
- Prior authorization requirements are not applied to emergency, family planning, preventive, or basic prenatal care, and sexually transmitted disease or HIV testing services.
- The Alliance does not financially reward clinicians or other individuals for issuing denials of coverage, care, or service.
- The Alliance does not encourage UM decisions that result in under-utilization of care to members.
- Members have the right to:
    - Participate with providers in making decisions about their individual health care, including the right to refuse treatment.
    - Discuss candidly with providers the appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

- Receive written notification of a decision to deny, defer, or modify requests for prior authorization.
- Request a second opinion from a qualified health professional at no cost to the member.
- Voice grievances or appeals, either verbally or in writing, about the organization of the care received.
- Request a Medi-Cal state hearing, including information on the circumstances under which an expedited fair hearing is possible.
- Have access to, and where legally appropriate, receive copies of, amend or correct their medical record; and
- Receive information about how to access State resources for investigation and resolution of member complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and its toll-free number, and the DMHC, Health Maintenance Organization (HMO) Consumer Service and its toll-free number

Section II. Program Structure

A. Program Authority and Accountability

1. Board of Governors

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 Alliance programs and is responsible for approving the Quality Improvement and UM Programs. The Board of Governors delegates oversight of Quality and UM functions to the Alliance Chief Medical Officer (CMO) and the Health Care Quality Committee (HCQC) and provides the authority, direction, guidance and resources to enable Alliance staff to carry out the UM Program. UM oversight is the responsibility of the HCQC. UM activities are the responsibility of the Alliance Medical Services staff under the direction of the Medical Director for Utilization Management and the Senior Director, Health Care Services in collaboration with the Alliance CMO.

2. 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 Alliance staff to carry out the Quality Improvement and UM Programs. Committee membership is made up of provider representatives from Alliance contracted networks and the community including those who provide health care services to Seniors and Persons with Disabilities (SPD) and chronic conditions.

Alliance committees meet on a regular basis and in accordance with Alliance Bylaws. Alliance Board meetings are open to the public, except for peer review activities, contracting issues, and other proprietary matters of business, which are held in closed

session.

The HCQC Committee provides oversight, direction and makes recommendations, and final approval of the UM Program. Committee meeting minutes are maintained summarizing committee activities as well decisions and are signed and dated. A full description of the HCQC Committee responsibilities can be found in the most recent Quality Improvement Program.

The HCQC provides the external physician involvement to oversee the Alliance QI and UM Programs. The HCQA includes a minimum of four (4) practicing physician representatives. The UM Committee include in their membership physicians with active unrestricted licenses to practice in the State of California. The composition includes a practicing Medical Director Behavioral Health and/or a Behavioral Health Practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed.

The HCQC functional responsibilities for the UM Program include:

- Annual review and approval of the UM Program Description.
  Oversight and monitoring of the UM Program, including:
    - Recommend policy decisions.
    - Oversight of interventions to address over and under-utilization of health services.
    - Oversight of the integration of medical and behavioral health activities
    - Guide studies and improvement activities.
    - Review results of improvement activities, HEDIS measures, other studies and profiles and the results of audits; and
    - Recommend necessary actions.

B. Utilization Management Committee

The Utilization Management Committee (UMC) is a sub-committee of HCQC. The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The sub-committee is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

1. UM Committee Structure

As a sub-committee of the HCQC which reports to the full Board of Governors, the HCQA supports the activities of the UM Committee and reviews and approves the UM activities and program annually. Reporting through the HCQC

integrates UM activities into the Quality Improvement system.

2. Authority and Responsibility

The HCQC is responsible for the overall direction and development of strategies to manage the UM program including but not limited to reviewing all recommendations and actions taken by the UM Committee.

The HCQC has delegated authority of the following functions to the UM Committee:

- Annual review and approval of the effectiveness of the UM Program
- Annual review and approval of the UM Program
- UM Policies/Procedures,
- UM Criteria, and
- Other pertinent UM documents such as the UM Delegation Oversight Plan, UM Notice of Action Templates, and
- Case/ Care Management Program and Policies/ Procedures.

3. UM Committee Membership

The UMC is chaired by the Chief Medical Officer.

Members of the UM Committee include:

- The Alliance Chief Analytics Officer
- The Alliance Medical Directors, UM
- The Alliance Medical Director, CM
- The Alliance Medical Director, Quality Improvement
- The Alliance Senior Director, Quality Improvement
- The Alliance Senior Director, Pharmacy & Formulary
- The Alliance Senior Director, Health Care Services
- The Alliance Director, Compliance
- The Alliance Director, Member Services
- The Alliance Director of Provider Relations and Provider Contracting
- The Alliance Director, Quality Assurance
- The Alliance Director, Social Determinants of Health
- The Alliance Manager, Healthcare Analytics
- The Alliance Managers, Case Management
- The Alliance Managers, Utilization Management
- The Alliance Manager, Grievance & Appeals

4. UMC Voting Privileges

For the purposes of voting at the UM Committee, only physician and Director level members of the UM committee may vote.

5. UMC Quorum

A quorum is established when fifty one percent (51%) of voting members are

present.

6. UMC Meetings

The UMC meets at least quarterly but as frequently as necessary. The meeting dates are established and published each year.

7. UMC Minutes

All meetings of the UM Committee are formally documented in transcribed minutes which include discussion of each agenda topic, follow-up requirements, and recommendations to the HCQC. All minutes are considered confidential. Draft minutes of prior meetings are reviewed and approved by the UMC with noted corrections. These minutes are then submitted to the HCQC for review and approval.

8. UM Committee Functions

The UM Committee is a forum for facilitating clinical oversight and direction. The UMC purpose is to:

- Improve quality of care for the Alliance members.
- Evaluate and trend utilization data for medical and behavioral health services provided to Alliance members and benchmarks for over/under utilization. This includes in- network and out-of-network utilization data review to ensure services are accessible and available timely to members.
- Provide a feedback mechanism to drive quality improvement efforts in UM.
- Increase cross functional collaboration and provide accountability across all departments in Medical Services.
- Provide mechanism for oversight of delegated UM functions, including review and trend authorization and utilization reports for delegated entities to identify improvement opportunities.
- Identify behaviors, practices patterns and processes that may contribute to fraud, waste, and abuse with a goal to support the financial stability of our providers and network.

UM Committee responsibilities are to:

- Maintain the annual review and approval of the UM Program, UM Policies/Procedures, UM Criteria, and other pertinent UM documents such as the UM Delegation Oversight Plan, UM Notice of Action Templates, and Case/ Care Management Program and Policies/ Procedures.
- Participate in the utilization management/ continuing care programs aligned with the Program's quality agenda.
- Assist in monitoring for potential areas of over and underutilization and recommend appropriate actions when indicated.
- Review and analysis of utilization data for the identification of trends
- Recommend actions to the Quality Oversight Committee when opportunities for improvement are identified from review of utilization data including, but not limited to, Ambulatory Visits, Emergency Visits, Hospital Utilization Rates, Hospital Admission Rates, Average Length of Stay Rates,

and Discharge Rates.
- Review information about New Medical Technologies from the Pharmacy & Therapeutics Committee including new applications of existing technologies for potential addition as a new medical benefit for Members.

Based on the decision of the UM Committee and recommendations through the appropriate Quality Committees, the approval of a new technology or new application of an existing technology by the HCQC shall be deemed to be the Alliance policy on coverage, and where the Alliance does not have the authority to modify the benefit package, the Chief Medical Officer shall notify, in writing, each payer for whom the Alliance manages benefits of its recommendation.

The UMC reports to the HCQC and serves as a forum for the Alliance to evaluate current UM activities, processes, and metrics. The UM committee 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.

C. Program Oversight and Staff Responsibility

The Alliance Health Care Services Department is responsible for management and coordination of programs including the UM Program. The UM Department staff administer the UM Program. Non-clinical staff may receive and log utilization review requests to ensure adequate information is present.

Appropriately qualified and trained clinical staff use approved criteria to conduct utilization reviews and make UM determinations relevant to their positions, e.g. Non- physician staff may only approve services; qualified non-clinical staff may make non- medical necessity denial decisions (example: not eligible); potential denials are referred to physician reviewers. The CMO, Medical Director, or licensed MD staff review requests that require additional clinical interpretation or are potential denials. A qualified physician reviews all denials made, whole or in part, based on medical necessity. The CMO or a Medical Director makes medical necessity denial decisions for medical and pharmacy service requests. The Alliance Pharmacist, a licensed Pharm. D., may approve, defer, modify, or deny prior authorization requests for pharmaceutical services.

1. Chief Medical Officer

The Chief Medical Officer is a designated board-certified physician with responsibility for development, oversight, and implementation of the UM Program. The CMO holds a current unrestricted license to practice medicine in California. The CMO serves as the chair of the HCQC and UMC, and makes periodic reports of committee activities, UM Program activities and the annual program evaluation to the BOG. The CMO works collaboratively with Alliance network physicians to continuously improve the services that the UM Program provides to members and providers.

Any changes in the status of the CMO shall be reported to Department of Health Care

Services (DHCS) and Department of Managed Health Care (DMHC) within the required timeframe.

2. Medical Directors

The Medical Directors are licensed physicians with authority and responsibility for providing professional judgment and decision-making regarding matters of UM. The Medical Directors hold current unrestricted license to practice medicine in California. Medical Directors responsibilities include but are not limited to the following:

- Ensure that medical decisions are rendered by and are not influenced by fiscal or administrative management considerations.
- The decision to deny services based on medical necessity is made only by Medical Directors.
- Ensure that the medical care provided meets the standards for acceptable medical care.
- Ensure that medical protocols and rules of conduct for plan medical personnel are followed.
- The initial reviewer must not review any appeal cases in which they were the decision maker for the authorization.
- Develop and implement medical policy.

The Alliance may also use external specialized physicians to provide specific expertise in conducting reviews. These physicians are currently licensed, and many have board certification in specific areas of medical expertise. The CMO is responsible for managing access and use of specialized physicians.

3. Senior Director, Health Care Services

The Senior Director, Health Care Services is a Licensed Clinical Social Worker and is responsible for overall UM Department operations, staff training, and coordination of services between departments. The Director's management responsibilities include:

- Develop and maintain the UM Program in collaboration with the CMO.
- Coordinate UM activities with the Quality Department and other Alliance units.
- Maintain compliance with the regulatory standards.
- Monitor utilization data for over and under-utilization.
- Coordinate interventions with the CMO to address under and over utilization concerns when appropriate.
- Monitor utilization data and activities for clinical and utilization studies; and maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans, sharing information about requirements and successful evaluation strategies.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Available for UM staff on site or by telephone.

4. Pharmacy Services Senior Director

The Pharmacy Services Senior Director is a licensed pharmacist (Pharm.D.) responsible for coordinating daily operations and reviewing and managing pharmacy utilization reports to identify trends and patterns. The Director provides clinical expertise relative to the Pharmacy, Quality and UM components of Alliance plan management including Member and Provider Services and Claims operations. The scope of responsibilities of the Pharmacy Services Director includes:

- Render pharmaceutical service decisions (approve, defer, modify, or deny) pursuant to criteria established for specific line of business by the CMO and the Alliance Pharmacy and Therapeutics Committee.
- Assure that the Alliance maintains a sound pharmacy benefits program.
- Manage the Alliance Medication Formulary on an ongoing basis.
- Manage the Drug Utilization Review program.
- Monitor compliance with delegation requirements and the performance of the Pharmacy Benefits Management and other pharmacy vendor firm's services.
- Provide clinical expertise and advice for the on-going development of pharmacy benefits.
- Review medication utilization reports to identify trends and patterns in medication utilization.
- Develop and manage provider and client education programs to improve medication prescribing patterns and to increase patient compliance.
- Ensure compliance with Federal and State regulatory agencies; and
- Manage the contract with, and delegated activities of, the pharmacy benefits management organization.

5. Utilization Review Clinicians

UM Review Clinicians with a current unrestricted California nursing license, California Physician Assistant license, and/or California Nurse Practitioner are responsible for the review and determinations of medical necessity coverage decisions. Clinicians may approve prospective, concurrent, and retrospective inpatient or outpatient medical necessity coverage determinations using established and approved evidenced-based.

medical criteria, tools, and references as well as their own clinical training and education. UM Review Clinicians, who are qualified clinical non-physician staff, may approve non-medical necessity benefit denial decisions. (Example: not eligible.). Licensed Vocational Nurses, (LVNs) Nurse Reviewers are under the supervision of a Registered Nurse, (RN,) and do not make clinical approval or denial decisions. Utilization Review Clinicians also work collaboratively with case managers and assist with member transition of care and discharge planning. For cases that do not satisfy medical necessity guidelines for approval, the UM Review Clinicians are referred to a Medical Director for final determination. The CMO or Medical Directors are available to the nurses for consultation and to make medical necessity denials. All clinical staff involved in the authorization review process must identify and refer any potential quality issues appropriately for further investigation.

6. UM Coordinators

The UM Coordinators are non-clinical staff responsible for performing basic administrative and operational UM functions. Clinical staff provides oversight to the non-clinical staff.

Roles and responsibilities include:

- Outpatient UM Coordinators
  - Ensure appropriate UM referral entries into the information system.
  - Process UM referrals approvals for selected requests identified as Auto Authorizations or Authorization in their Scope of Work that do not require clinical interpretation.
  - Complete intake functions with the use of established scripted guidelines and
  - Manage and complete UM Member and Provider communications.
  - Complete administrative denials for non-eligibility, as defined in UM Policy 057 – Authorization Requests.
- Inpatient UM Coordinators:
  - monitor and collect facility admissions census data.
  - Complete data entry of initial cases.
  - Maintain member and provider communications.
  - Assist in requesting additional information as needed
  - Review of hospital referral to ensure appropriate case closure.
  - Approve inpatients services as defined in UM Policy UM-057 Authorization Requests.
- Ensuring the efficient processing for the authorization process and maintain documentation in support of the on-site and telephonic UM nurse staff.

Section III. Program Scope, Processes & Information Sources

The UM Program consists of comprehensive and systematic functions, services, and processes that provide care management to members and include medical necessity determinations regarding the appropriateness of health care services in accordance with definitions contained in the member evidence of coverage. The UM Program also encompasses delegated utilization management functions, activities and processes for behavioral health and pharmacy services.

A. Utilization Management Activities

Referral Management includes Prior Authorization Review, Concurrent Review, and Post Service Review of requests for authorization:

- Services exempt from Prior Authorization means services for which the health plan cannot require advance approval.
- Pre-service Review means a formal process requiring a requesting health care provider to obtain advance approval to provide specific services or procedures.

Preauthorization, Prior Authorization, and Pre-Certification are terms also used to describe Pre-service Review.

- Concurrent Review means a review for an extension of a previously approved, ongoing course of treatment over a period or number of treatments. Concurrent reviews are typically associated with inpatient care, residential behavioral care, intensive outpatient behavioral health care, and ongoing ambulatory care.
- Post Service Review means the assessment of the appropriateness of medical services after the services have been provided. This is also called Retrospective Review.
- After Hours and Emergency Care

Emergency health care services are available and accessible within the service area 24 hours a day, seven days a week. The Alliance provides 24-hour access for members and providers to obtain timely authorization for medically necessary care, for circumstances where the member has received emergency services and care and is stabilized, but the treating provider believes that the member may not be discharged safely. A Physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

Emergency health care services are covered without prior approval:

- to screen and stabilize the member where a prudent layperson, acting reasonably, would have believed an emergency medical condition existed.
- when there is an imminent and serious threat to health including, but not limited to, the potential loss of life, limb, or other major bodily function.
- when a delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function.
- If an authorized representative, acting for the Alliance, has authorized the provision of emergency services.

A "Prudent Layperson" is a person who is without medical training, and who draws on his/her practical experience when deciding whether emergency medical treatment is needed. A Prudent layperson is considered to have acted reasonably if other similarly situated laypersons would have believed that emergency medical treatment was necessary.

Other Alliance representatives who may direct members to emergency services include the Nurse Advice Line staff, and the Alliance nurse case manager or disease manager, an Alliance Member Services Representative or after-hours call answering service, or a contracted specialist. The Alliance will honor health plan coverage for services when directed by any Alliance staff member or delegated representative.

B. Communication Services for UM Process with Members and Providers

The Alliance members, providers, and the public may contact the UM department to discuss any aspect of the UM program. Members contact the Member Services Department at 510-747-4567 and may be warm transferred to an UM Manager or Director. Providers contact the UM Department directly at 510.747.4540. UM staff are available at least 8 hours per normal business day (excludes weekends and holidays). During scheduled business hours, the Alliance provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. After hours calls are answered by a contracted vendor and non-emergency calls are returned the following business day. After Hour calls requiring clinical decision-making are transferred to the Alliance on-call nurse for assistance. Staff identify themselves by name, title and as representatives of the Alliance when initiating or returning calls. HIPAA protocols are followed to ensure protection of privacy. Language assistance and TDD/TTY services are available as needed for members to communicate with the Alliance regarding the UM program.

Both the UM staff voice mail phone message line for utilization review information and the computer network system are controlled by a secured password system, accessible only by the individual employee. The facsimile machines used for utilization review purposes are located within the Department to assure monitoring of confidential medical record information by the Alliance's UM staff.

C. Decision Support Tools

The appropriate use of criteria and guidelines require strong clinical assessment skills, sound professional medical judgment, and application of individual case information and local geographical practice patterns. Licensed nursing review staff apply professional judgment during all phases of decision-making regarding the Alliance members.

"Decision Support Tools" are intended for use by qualified licensed nursing review staff as references, resources, screening criteria, and guidelines with respect to the decisions regarding medical necessity of health care services, and not as a substitute for important professional judgment. The Medical Director evaluates cases that do not meet review criteria/guidelines and is responsible for authorization/denial determinations.

UM staff clearly document the Review Criteria/Guidelines utilized to assist with authorization decisions. If a provider questions a medical necessity/appropriateness determination, any criteria, standards, or guidelines applied to the individual case supporting the determination is provided to the provider for reference.

The following describes the approved Department "Decision Support Tools" that have been implemented and are evaluated and updated at least annually.

D. UM Review Criteria, Guidelines and Standards

The Alliance, Provider Groups and Vendors delegated for UM functions must utilize evidenced based nationally recognized criteria for UM decision making. UM criteria are used to determine medical necessity in the Authorization Request review process.

Standards, criteria, and guidelines are the foundation of an effective UM Program. The tools are utilized to assist during evaluation of individual cases to determine the following:

- Services are medically necessary.
- Services are rendered at the appropriate level of care.
- Quality of care meets professionally recognized industry standards.
- UM decision-making is consistent.

The following standards, criteria, and guidelines are utilized by UM staff and Medical Directors as resources during the decision-making process:

- Regulations and Guidelines
- UM Medical necessity review criteria and guidelines.
- Length of stay criteria and guidelines
- Clinical Practice Guidelines
- Referral Guidelines
- Policies and Procedures

Examples of regulations and guidelines are as follows:

- Regulations:
  - Code of Federal Regulations
  - California Health and Safety Code.
  - California Code of Regulations Title 22.
  - California Code of Regulations Title 28.
  - California Welfare and Institution Code

- Guidelines:
  - Medi-Cal Guidelines (Medi-Cal Provider Manuals)

1. Application of UM Criteria

The Alliance requires that UM criteria be applied in a consistent and appropriate manner by physician and non-physician UM staff based on available medical information and the needs of individual Members. For use in determining the appropriateness of UM determinations at the Alliance Plan level for the direct requests for authorization, the Alliance adopts and maintains approved criteria with current versions of the following UMC approved UM Criteria hierarchy:

- Regulatory contractual requirements, such as DHCS regulations, Provider Manuals, All Plan Letters.
- Evidence based guidelines, such as MCG®, InterQual, and UpToDate. Alliance specific guidelines
    - UM Auto Authorization List as approved by the UM Committee.
    - Other Utilization Management Committee Approved Criteria
    - Pharmacy Therapeutics Committee Approved Criteria
    - When none of the above criteria are applicable, consider the following and two (2) or more of the following criteria are applicable, then MCG® criteria are to be used as the first choice.
        - MCG® Guidelines
        - UpToDate.com
- National medical association guidelines, such as American Commission of Obstetrics and Gynecology (ACOG), American Association of Pediatrics (AAP), American Diabetes Association (ADA), World Professional Association for Transgender Health (WPATH).
- Definition of Medical Necessity (Product Line specific when the above criteria do not apply to a specific request for an UM decision).
- Other resources

Due to the dynamic state of medical/health care practices, each medical decision must be case specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition, or the need for a referral.

2. Clinical Review Criteria

Utilization review determinations to approve, defer, modify, or deny requested services are made based on a consistently applied, systematic evaluation of utilization management decision criteria. The criteria adopted by the Alliance are reviewed and discussed by the UMC. They are selected based on nationally recognized and evidence-based standards of practice for medical services and are applied based on individual need. Primary criteria used for utilization review decisions are from MCG® Care Guidelines. Other applicable publicly available clinical guidelines from recognized medical authorities are referenced when indicated. Also, when applicable, government manuals, statutes and laws are referenced in the medical necessity decision making process. The UMC annually reviews the MCG® Care Guideline criteria and applicable government and clinical guidelines for changes and updates.

Additionally, the Alliance has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion

in benefit plans to keep pace with changes and to ensure that members have equitable access to safe and effective care. The UMC reviews and approves all new coverage policies before implementation.

For the Medi-Cal line of business, the term “Medically Necessary” will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. {Title 22, CCR, Section 51303(a)}. When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, “Medical Necessity” is expanded to include the standards set forth in Title 22, CCR, Section 51340 and 51340.1.

The above definition of medically necessary applies to any line of business without a product specific definition.

The Alliance is accredited by the National Committee for Quality Assurance (NCQA) and adheres to the latest NCQA Standards and Guidelines.

NCQA defines medical necessity review as a process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the member’s circumstances, relative to appropriate clinical criteria and the organization’s policies.

3. Access to and Disclosure of UM Criteria and UM Procedures and Processes

UM Criteria and UM Procedures and Processes are available to the Alliance practitioners, providers, members, and the public upon request in accordance with established regulatory and contractual requirements.

If criteria are requested, the organization makes them available:

- In person, at the Alliance
- By telephone, mail, fax, or email.

E. Benefits

The Alliance administers health care benefits for members, as defined by contracts. Benefit coverage for requested service is verified by the UM staff during the authorization process as follows:

- Medi-Cal member benefits are developed by the State of California, DHCS and DHCS mandated benefits for Medi-Cal Members. DHCS benefits, available on the DHCS Web site, defined by, but not limited to:
  - Service requests for Medi-Cal beneficiaries.

- Medi-Cal Manual of Criteria
- Medi-Cal DME.
- Medi-Cal Hospice
- Medi-Cal Waivers.
- Medi-Cal Linked and Carve Out Programs
- Medi-Cal Enhanced Care Management (ECM)

- IHSS benefits are developed by Public Authority of Alameda County

Benefit resource guides for all Product Lines are maintained by Member Services Department. Benefits resource guides describe in detail the covered and non-covered services, procedures, and medical equipment for the line of business. These guides are aligned with the applicable product line benefits.

1. Benefit Exclusions

Based on the specific contract requirements and applicable laws, some services are explicitly excluded from coverage. Per contract requirements, specific services may not be covered benefits, unless clinical indicators support medical necessity, as determined by the Medical Directors, in which case the medically needed services will be provided. Every attempt is made by the UM staff to identify additional community programs to provide wrap-around services to enhance the Alliance benefit package.

2. Transition to Other Care when Benefits End

The Alliance assists with, and/or ensures that practitioners assist with, a member's transition to other care, if necessary, when benefits end.

3. New Medical Technology Evaluation Assessment

The Alliance maintains a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in its benefits plan to keep pace with changes and to ensure that members have equitable access to safe and effective care. Evaluation of new technology is applied for medical and behavioral health procedures, pharmaceuticals, and devices. The UM Committee is responsible for evaluating and recommending coverage status for a new technology to the UM Committee or the Pharmacy and Therapeutics Committee, and to the Health Care Quality Committee. This includes evaluation of medical and behavioral health procedures, pharmaceuticals, and devices. Requests for evaluation of a new technology or a new application of an existing technology may come from a member, practitioner, organization, the Alliance's physician reviewers, or other staff.

The following are evaluated when considering new technology:

- Organizational reviews from appropriate government regulatory bodies, such as FDA or CMS.

- Relevant scientific information from peer-review literature, professional societies, and/or specialists and professionals who have expertise in the technology.

Based on the decision of the UM Committee, P&T Committee and recommendations through the appropriate Quality Committees, the approval of a new technology or new application of an existing technology by the Quality BOG Committee shall be deemed to be the Alliance's policy on coverage. When the Alliance does not have the authority to modify the benefit package, the Chief Medical Officer shall notify, in writing, each payer for whom the Alliance manages benefits of its recommendation. A full description of the process is defined in UM policy and procedure.

4. Member Eligibility Verification

Authorization is based on member eligibility at the time of service and is verified by the UM staff at the time of the request. Medi-Cal eligibility is on a month-to-month basis. The Alliance Direct members may become eligible retrospectively, in which case their claims would be subject to retrospective review**.**

5. Determination Information Sources

UM clinical staff collects relevant clinical information from health care providers to make prospective, concurrent, and retrospective utilization review for medical necessity and health plan benefit coverage determinations. Clinical information is provided to the appropriate clinical reviewers to support the determination review process. Examples of relevant sources of patient clinical data and information used by clinical reviewers to make medical necessity and health plan benefit coverage determinations include the following:

- History and physical examinations.
- Clinical examinations.
- Treatment plans and progress notes.
- Diagnostic and laboratory testing results.
- Consultations and evaluations from other practitioners or providers.
- Office and hospital records.
- Physical therapy notes.
- On-site, telephonic and fax concurrent reviews from inpatient facilities.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from responsible family members; and
- Independent, unbiased, and evidenced based analyses of new, emerging, and controversial healthcare technologies.

F. UM Determinations

Qualified health professionals supervise review decisions, including service reductions.

UM decisions based on medical necessity to deny or authorize an amount, duration, or scope that is less than requested shall be made by qualified physicians or appropriate health care professionals, who have appropriate clinical expertise in treating the condition and disease. Appropriate health care professionals at the Alliance are qualified physicians, qualified doctoral level behavioral health care professionals, and qualified pharmacists. The timeliness of UM decisions shall be commensurate with the seriousness and urgency of the request, whether the request is routine or expedited, and made in a timely manner and not unduly delayed for medical conditions requiring time sensitive services. Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria. In addition to guidelines and criterion, patient records and conversations with appropriate practitioners are used in the decision-making process. Qualified health care professionals also supervise utilization review decisions. Under the supervision of a licensed medical professional, non-clinical staff collect administrative data or structured clinical data to administratively authorize cases that do not require clinical review.

Only a Medical Director, with a current license to practice without restriction in California, makes medical necessity denial determinations. A Medical Director is available to discuss UM denial determinations with providers. Providers are notified how to contact the Medical Director about determination processes in the denial letter.

In accordance with the DHCS contract, only qualified health care professionals supervise review decisions, including service reductions. A qualified physician will review all denials that are made based on medical necessity. Additionally, a qualified physician or pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan Medical Director in collaboration with the Plan Pharmacy and Therapeutics committee (P&T Committee) or its equivalent.

UM decisions are not based on the outcome of individual authorization decisions or the number and type of non-authorization decisions rendered. UM staff involved in clinical and health plan benefit coverage determination processes are compensated solely based on overall performance and contracted salary and are not financially incentivized by the Alliance based on the outcome of clinical determinations.

Board certified physician advisors are available to the UM Program for consultation on clinical issues as well as consultation for potential denials. The UM Program maintains a list of board-certified physician specialists identified for consultation and documents their involvement in member authorization and appeal records when appropriate.

Decisions affecting care are communicated in writing to the provider and member in a timely manner, in accordance with regulatory guidelines for timeliness, and are not unduly delayed for medical conditions that require time-sensitive services. Reasons for decisions are clearly documented in the member/provider correspondence in easily understandable language. Notification must reference the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion

on which the denial decision was based, upon request, must be included in the notification.

Providers are informed how to contact and speak with the Medical Director who made the decision. Notification communication includes appeal rights and procedures. Member notifications comply with appropriate contractual and regulatory guidance for each member's line of business. Member correspondence about authorization decisions includes a statement in each Alliance threshold language instructing the member how to obtain correspondence in their preferred language. Notice of Action Letters are sent in the Members' preferred language for those members whose preferred language is an identified threshold language, following the requirements of APL-21-004. Records, including Notice of Action letters, meet contractual retention requirements. Members are informed that they may request copies of their medical records.

G. UM Referral Management and UM Review Processes

The scope of medical management services and activities includes utilization review determinations, referral management, discharge planning, complex case management, and UM documents.

1. Services Exempt from Prior Authorization

Exemptions from Prior Authorization services for members differ by product line and are listed in the member's benefit handbook, online at www.alamedaalliance.org and in the specific provider manuals. Exemptions include:

- Emergency Services, whether in or out of Alameda County; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
- Urgent care, whether in or out of network
- Primary Care Visits
- Preventative Services
- Mental Health Care and Substance Use treatment
- Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
- Basic prenatal care – a woman can go directly to any network provider for basic pre-natal care.
- Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention.
- HIV testing and counseling
- Initial Mental Health Assessments
- Early and Periodic Screening, Diagnostic and Treatment

2. Auto-Authorization

- Services approved on the most recent copy of the Medical Management Auto Authorization Matrix.
- Direct - Services for which UM requests are not required, include but are not limited to:
  - Specialty visits, direct network
  - Preventive health diagnostic services, i.e. mammogram, colonoscopy

3. Services Requiring Prior Authorization

The Alliance develops, reviews, and approves at least annually, lists of auto authorizations. Any procedure, treatment, or service not on these lists requires prior authorization. The Alliance communicates to all contracted health care practitioners the procedures, treatments, and services that require prior authorization and the procedures and timeframes necessary to obtain such prior authorization.

Authorization requirements for medical services are listed on the website, at www.alamedaalliance.org. Providers can also review the approved drug formulary at this website.

The services that currently require prior authorization include, but are not limited to:

- Non-emergency out of area care, outside of Alameda County
- Out of network care, for services not provided by a contracted network doctor.
- Inpatient Admissions, non-emergency/elective
- Inpatient Admission to Skilled Nursing Facility or Nursing Home
- Outpatient hospital services/surgery
- Outpatient facilities, non-hospital based, such as surgeries or sleep studies.
- Outpatient diagnostic and radiology services, minimally invasive or invasive such as CT Scans, MRIs, cardiac catheterization, PET
- Durable Medical Equipment, standard or customized; rental or purchased.
- Medical Supplies
- Prosthetics and Orthotics
- Podiatry services
- Home Health Care, including skilled nursing, nursing aides, rehabilitation therapies, and social workers.
- Transportation
- Transplant Services
- Experimental or Investigational Services
- Cancer Clinical Trials
- Medications not on the Alliance Approved Drug List and/or exceeding the monthly medication limit.
- All admissions to LTSS services - CBAS and Long-Term Care (LTC) facilities
- Acupuncture, greater than 4 visits per month.
- Chiropractic Services- See Prior Authorization grid for detail.
- Radiology Services (i.e. CT, MRI, PET)
- Second Opinions

- Select behavioral health services.

The Alliance also routinely analyzes past utilization patterns to determine whether it would be in the member's best interests to remove any of the listed services from the prior authorization requirement or add additional requirements. The Alliance makes any adjustments to this list by amending the Prior Authorization Policies, as appropriate.

4. Medical Director Responsibilities

The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and health services.

The CMO and Medical Directors, with support of the UM Committee, have the authority, accountability, and responsibility for denial determinations. Physician review and determination is required for all final denial decisions based on medical necessity for requested medical services. The review of the denial of a pharmacy prior authorization for medical necessity, however, may be carried out by a qualified Physician or Pharmacist. For those contracted entities that are delegated UM responsibilities, the entity's Medical Director has the sole responsibility and authority to deny coverage; the Medical Director may also provide clarification of policy and procedure issues, and communicate with entity practitioners regarding referral issues, policies and procedures, etc.

5. Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. Only physicians, pharmacist, or doctoral level behavioral health specialists can make decisions/determinations for denial or modification of care based on medical necessity.

6. Timeliness Standards

The Alliance maintains established timeliness standards for UM determinations for routine and urgent Authorization Requests in compliance with Regulatory Standards for each Product Line as described in corresponding Policies/Procedures. The timeliness of UM decisions shall be commensurate with the seriousness and urgency of the request whether the request is routine or expedited. Time sensitive requests cannot be delayed waiting for medical information. Response to requests must meet required regulatory timeframes.

7. Utilization Review Processes

The UM Program includes the following utilization review processes:

Prospective Review

Prospective (pre-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted prior to the delivery of a health care service or supply to a member. A prospective review decision is based on the collection of medical information

available to the health care provider prior to the time the service or supply is provided.

Concurrent Review

Concurrent review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted during a member's ongoing stay in a facility or course of outpatient treatment. The frequency of review is based on the member's medical condition with respect to applicable care guidelines.

Retrospective Review

Retrospective (post-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted after the health care service or supply is provided to a member.

Submissions received within 30 days from the date of service will be reviewed for medical necessity. Submissions received after 30 days from the date of service will be denied for not obtaining prior authorization. Exceptions include member eligibility issues, if the services were emergent/urgent, or inpatient services where the facility is unable to confirm enrollment with the Alliance. If the exceptions are met, then the submission will be reviewed for medical necessity regardless of when it was received.

The Alliance maintains instructions for the authorization process on the website and provider training which is available to contracted and non-contracted providers. For non-contracted facilities, the Alliance maintains a 24-hour UM contact notification process on the California DMHC website. The Alliance maintains a full list of conditions eligible for retrospective review by the Department and is reviewed annually for any changes.

8. Outpatient Referral Management

Alliance network physicians are the primary care managers for member healthcare services. Based on the member's assignment, referrals may be managed by the Alliance or a delegated Provider Group.

Network Primary Care Physicians (PCPs) may process in-network specialist and facility referrals directly to members as "direct referrals" without administrative pre-authorization from the UM Program or the Provider Group. These referrals are primarily for routine outpatient and diagnostic services and are tracked by the UM Program using claim and encounter data. For services identified as requiring prior authorization, PCPs must submit and coordinate prior authorization for several services that require prior authorization, such as DME, home health and certain radiology services. All elective inpatient surgeries and non-contracted provider referrals require prior authorization.

The UM Program clinical information system tracks all authorized, denied, deferred, and modified service requests and includes timeliness records. These processes are outlined in the Provider Manual and in internal policies and procedures.

Practitioners and providers send referrals and requests for prior authorization of services to the UM Department by mail, fax and/or telephone, based on the urgency of the requested service. Request must include the following information for the requested service:

- Member demographic information (name, date of birth, etc.)
- Provider demographic information (Referring and Referred to)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (ICD-10 Code and description)
- Pertinent medical history and treatment
- Location where service(s) will be performed.
- Clinical indications necessitating service or referral *(See Section: Minimum Clinical Information for Review of UM Requests for Authorization)*

Requests for services are reviewed in accordance with approved UM criteria and the member's benefit structure. When decisions on coverage are based on medical necessity, relevant clinical information is obtained and consultation with the treating practitioner occurs, as necessary.

Requests for Authorization determinations related to Medi-Cal and IHSS Product Lines are defined differently as follows**:**

- Pre-Service Determinations for Medi-Cal and IHSS are defined in the following terms:
    - Approval - the determination to provide a service.
    - Modification – the determination to either approve less than what was requested or to approve something else in place of what was requested.
    - Denial - a determination to not provide the request service.
    - Delay – when a determination cannot be made, and additional time is required to obtain relevant clinical information.
    - Termination- to not extend an extension of a previously authorized service (e.g. PT visits, SNF days, etc.) (NOTE: must give 10 calendar days' notice of terminations)

UM staff receive requests for authorization of outpatient services and elective procedures prior to admission to ensure that admission to a healthcare facility is appropriate/medically necessary. Non-Clinical UM staff may approve services which can be auto-authorized, within their scope when the specific elements of the policy are met. Clinical UM staff will review services that require prior authorization based on medical necessity. The medical necessity clinical review is based on the severity and complexity of the individual case, unless there are questions regarding the medical necessity of services.

Should the UM staff question the medical necessity of services to be rendered, or appropriateness of the level of care for service based on review criteria and guidelines, the Medical Director will be consulted for case review. The Medical Director, or physician designee, will contact the attending physician to discuss the case, if necessary.

Should the Medical Director or physician designee determine that proposed services are not medically necessary or indicated, a denial determination may be made by the Medical Director. Denial notification and communication will be made in accordance with current regulatory timeliness standards and denial notification requirements, as established by regulators, including the DHCS and Department of Managed Health Care (DMHC) and national accrediting organizations, such as NCQA.

9. Second Opinion

The Alliance members may request a second opinion from any qualified primary care provider or specialist within the same medical group. If a qualified specialist is not available within medical group, a referral is provided within the Alliance's network. If the qualified specialist is not available in the Alliance network, staff will assist the medical group to identify an out-of-network specialist. The second opinion from a qualified health professional will be provided at no cost to the member. The Alliance provides a second opinion from a qualified health care professional when a member or a practitioner requests it for reasons that include, but are not limited to, the following:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and requests consultation, or the member requests an additional diagnosis.
- The treatment plan in progress is not improving the medical condition of the member within an appropriate period given the diagnosis and plans of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the practitioner's advice or consulted with the initial practitioner concerning serious concerns about the diagnosis or plan of care.

The Alliance educates its members and practitioners of the availability of second opinions in annual member publications. Policies regarding second opinions are available to the public upon request. Member rights related to second opinions include:

- To be provided with the names of two physicians who are qualified to give a second opinion.
- To obtain a second opinion within 30 calendar days, or if the medical need is emergent or urgent, to obtain an opinion within a timeframe that is appropriate to the member's condition and that does not exceed 72 hours

- To see the second opinion report

10. Standing Referrals

The Alliance maintains process to provide enrollees a standing referral to a specialist. The procedure shall provide for a standing referral if the PCP, in consultation with both the specialist, if any, and the Alliance Medical Director (or designee), determines that the enrollee has a condition or disease that requires continuing specialized medical care from the specialist or Specialty Care Center, (SCC).

The Alliance may require the PCP to submit a treatment plan during care or prior to the referral from the enrollee as determined by the Medical Director:

- If a treatment plan is necessary during care and is approved by the Alliance, in consultation with the PCP, specialist, and enrollee, a standing referral shall be made in accordance with the treatment plan.
- A treatment plan may be deemed unnecessary if the Alliance approves a current standing referral to a specialist.
- The treatment plan may limit the number of visits to the specialist, limit the period of time during which visits are authorized, or required that the specialist provide the PCP with regular reports on the care and treatment provided to the enrollee.

The Alliance maintains guidelines for standing referral requests for enrollees that required specialized medical care over a period and who have a life-threatening, degenerative, or disabling condition, to a specialist or SCC that has expertise in treating the condition or disease for having specialist coordinate he enrollee's health care. Standing referral to a specialist or SCC are provided within the Alliance's network to participating providers, unless there is no specialist or SCC within the Alliance's network that is appropriate to provide treatment to enrollee, as determined by the PCP in consultation with the Medical Director and as documented in the treatment plan.

11. Concurrent/Continued Stay Review (Acute, Skilled, Rehabilitation)

The Alliance provides telephonic UM services and on-site UM at a sub-set of network hospitals. Appropriate inpatient medical management is ensured through consistent and coordinated Concurrent Review of members, irrespective of the presence or utilization of a contracted hospitalist. Concurrent/Continued Stay Review is a process coordinated by the UM staff during a member's course of hospitalization, which may include acute hospital, skilled nursing, and acute rehabilitation facilities, to assess the medical necessity and appropriateness of continuation at the requested level of care. Concurrent/Continued Stay review also involves the telephonic or on-site medical record review that occurs after admission if no pre-admission review has occurred.

Additional objectives of continued stay review are to:

- Ensure that services are provided in a timely and efficient manner.
- Ensure that established standards of quality care are met.
- Implement timely and efficient transfer to lower levels of care when clinically

indicated and appropriate.
- Implement effective and safe discharge planning.
- Identify cases appropriate for Case Management and Transitions of Care Services

The Concurrent Review Procedure shall be followed throughout the member's hospitalization, utilizing approved criteria and guidelines. Telephonic, facsimile reviews or on-site are coordinated by the UM staff daily, or on cyclic intervals based on individual case requirements. In the event a scheduled review date falls on a weekend or holiday, the UM staff will coordinate a Concurrent Review on the work day prior to the scheduled review date, or not later than the first work day after the holiday or weekend.

Continued hospital care and/or ancillary services that do not meet continued stay criteria are referred to the Medical Director, or physician designee, to evaluate and consult with the attending physician, as appropriate. When the Medical Director decides that the case does not meet criteria for continued stay based on medical necessity or appropriateness, the attending physician will be contacted, and discharge planning discussed. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter may be issued immediately by fax or via overnight Certified Mail to the attending physician, hospital and the member, if the member disagrees with the discharge plan.

12. Transition of Care and Discharge Planning

Transition of Care and Discharge Planning management are components of the UM process that assess necessary services and resources available to facilitate member discharge and/or transition to the appropriate level of care. Discharge Planning refers to activities related to planning the discharge of a member out of an inpatient medical facility. Transition of Care refers to activities related to movement of a member from a clinical setting to a home or community setting.

Discharge planning begins as early as possible during an inpatient admission, and is designed to identify and initiate cost effective, quality-driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physicians, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential need for post-hospital intervention
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member’s care.
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources.

- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge Planning staff, and UM staff.
- Referral to Transitions of Care programs or Home Health Programs within or outside of AAH programs.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director, as previously noted in the Concurrent Review Process.

UM Review Clinicians work with facility discharge planners, attending physicians and ancillary and community service providers to assist in making necessary arrangements for member post- discharge needs. The UM Review Clinicians integrate with the Case Management Population Health driven initiatives by identifying, referring, communicating, and making recommendations that will help meet members' needs and address medical and psychosocial issues that result in hospitalization.

For SPD members, UM Review Clinicians are responsible for ensuring discharge planning is in place ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for discharge planning activities includes:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received.
B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD beneficiary as applicable, physical, and mental function, financial resources, and social supports.
C. Services needed after discharge, type of placement preferred by the SPD beneficiary/representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary/representative of the SPD beneficiary, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD beneficiary/representative of the SPD beneficiary, and pre-discharge counseling recommended.
D. Summary of the nature and outcome SPD beneficiary/representative of the SPD beneficiary involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action

contemplated by the hospital/institution.

13. Denial Notifications

Adverse Benefit Determination letters or/and Notice of Action (NOA) letters for denials are provided to members and their practitioners in compliance with the member's regulatory appeal requirements. All potential denials and/or modifications of service are discussed with the appropriate Medical Director, who makes the final determination.

Services that are denied, modified, delayed shall contain the following elements:

- Clear, concise, and easily understandable explanation of the reason for denial in the Notice of Action (NOA) or adverse determination letter
- Reference to the specific benefit, guideline, protocol, or other similar criterion on which the denial decision is based.
- Statement that members can obtain a copy of the actual benefit, guideline, protocol, or other similar criterion on which the decision was based.
- Member Rights
- Appeal Rights and Process

In addition to the above for ongoing services that are terminated for all members, the NOA shall include:

- Agreement to an alternative treatment plan by attending practitioner for hospital concurrent decisions and by the PCP for Ambulatory Concurrent decisions
- In addition to the above for Medi-Cal members:
- Citation to the criteria used to support the decision (Medi-Cal only)
- Information about the member's State Hearing rights and process
- "Aid Paid Pending" process, as applicable for Medi-Cal, must also be included.

In addition, All UM NOA correspondences for pre-service and concurrent denials, modifications, and adverse decisions sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer to allow for the Requesting Practitioner to request a reconsider of the UM Determination

14. Peer to Peer Review (Discussing a Denial with a Peer Reviewer)

All UM Notice of Action correspondences for pre-service and concurrent denials, (including modifications, terminations, and adverse decisions) sent to the Requesting Practitioner shall include a name and phone number for contacting the Peer Reviewer to allow the Requesting Practitioner the opportunity to discuss issues or concerns regarding the decision. If a denial is being considered by the Peer Reviewer, a practitioner can discuss the decision by calling or writing to supply additional information for discussion with the Peer Reviewer. The Peer Reviewer will make himself/herself available for discussion of the denial decision within one business day of the receipt of the provider telephone call or written request. If the discussion does not result in a fully reversed denial determination, the practitioner can initiate an expedited or standard appeal, as

appropriate.

15. Required Internal Reporting for UM Staff

- Potentially fraudulent or abusive practices identified to The Compliance Department
- Potential under and over utilization to the UM Manager
- Coordination of care for results or facilitation to the UM Manager
- Opportunities for improvement to the UM Manager
- Breaches of adherence to confidentiality and HIPAA policies to the Alliance's designated Compliance staff member
- Potential quality issues identified through UM activities to the Quality Improvement Department
- Barriers to accessibility and availability of UM services to their UM Manager

16. UM Documents

In addition to this program description, other documents important in communicating UM policies and procedures include:

- The Provider Manual, available on the Alliance web site and on a CD, provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's UM Program, referral and tracking procedures, processes, and timeframes necessary to obtain prior authorization are included in the manual. In addition, the Provider Manual describes how providers may obtain a copy of the clinical guidelines used to make medical determinations.

- The Provider Bulletin is a periodic newsletter distributed to all contracted provider sites and delegated groups on topics relevant to the provider community and may include UM policies, procedures, and activities.
- The Member Alert is a periodic newsletter distributed to members in all lines of business. Each issue covers different topics of interest and importance to members about their health may include information about UM policies and procedures.

- Evidence of Coverage (EOC) documents are distributed to members based on their product line. Members have the right to submit a complaint or grievance about any plan action. The Evidence of Coverage document directs members to call the Member Service phone number to initiate complaints or grievances involving UM issues and actions. Member complaints or grievances are documented in the data system and forwarded to the UM unit for follow-up response. The Alliance Grievance and Appeal unit coordinates with the UM unit on appropriate responses to member complaints or grievances.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the UM Program information is available on the Alliance website.

H. Continuity of Care for Medical and Behavioral Health Services

Continuity of care can be defined as the lack of interruption in the care provided to members when circumstances dictate a change in the member's insurance coverage, geographic location, entity, or provider assignment.

The Alliance must provide continuity of care with an out-of-network provider when:

- The Alliance can determine that the beneficiary has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider).
  - An existing relationship means the beneficiary has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment in the Alliance for a non-emergency visit, unless otherwise specified by regulation.
- The provider is willing to accept the higher of the Alliance's contract rates or Medi-Cal FFS rates.
- The provider meets the applicable professional standards and has no disqualifying quality of care issues (a quality of care issue means the Alliance can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other MediCal beneficiaries);
- The provider is a California State Plan approved provider; and
- The provider supplies the Alliance with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, if it is allowable under federal and state privacy laws and regulations.

The Alliance is not required to provide continuity of care for services not covered by Medi-Cal. In addition, provider continuity of care protections does not extend to the following providers: durable medical equipment, transportation, other ancillary services, and carved-out services.

The UM staff works with the member and the member's current treating physician and/or PCP to assist the member in continuity of care. Every effort is made to maintain continuity of care for the member during the transition process. If the current treating physician is not affiliated with any of the existing Provider Groups, (PGs,) or with the member's PG selection, the UM staff works with the PGs to make arrangements with the physician to continue care of the member until the treatment is completed or the member can be safely transitioned to a physician within the PG. The UM staff notifies each PG of its membership qualifying for continuity of care assistance.

When members are identified as possibly benefiting from coordination of care, both within and outside of the network, the case is referred to Case Management for further intervention. The Case Management actively engages in activity that monitors and assesses continuity and coordination of clinical care. Individual registered nurses work closely with the Member,

the physicians and any other associated healthcare delivery organization involved in the case, to provide timely, quality-based care meeting the needs of the individual member.

Continuity of care is also evaluated when members are referred from primary care physicians and specialists, including behavioral health specialists, or when a member is transferred or admitted to another level of care, such as a transfer or admittance to a skilled nursing facility (SNF), rehabilitation, chemical dependency, or mental health facility, where member follow through is a risk.

The Alliance documents all requests for assistance with continuity of care and is responsible for monitoring and oversight of the activities. A full description of the various programs is listed in the applicable policies and procedures.

1. ***New Enrollees***

The Alliance recognizes that a strong doctor-patient relationship, particularly for members with serious medical conditions, may enhance the healing process. Maintaining continuity of care as new enrollees change physicians and health plans are an important aspect of this relationship. Each newly enrolled Medi-Cal member are placed in a transition group for up to 30 days, during which time they select their Alliance, PG, and PCP.

For a newly enrolled SPD members, the Alliance must honor any active MediCal FFS Treatment Authorization Requests (TARs) for up to 60 days or until a new assessment is completed by the Alliance. A new assessment is considered completed by the Alliance if the beneficiary has been seen by an Alliance -contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The FFS TAR must be honored as outlined above without a request by the beneficiary or the Provider.

2. ***Terminated Practitioners (Both PCPs and Specialists)***

The Alliance's contracts with delegates establish a mechanism to continue appropriate and timely care for members whose physicians are terminating from the PG. This process includes notification from practitioners of intent to terminate, in accordance with the laws applicable to the line of business. Members under current care, and those with approved prior authorizations, not yet utilized, are identified, so that their care can be managed and coordinated with the receiving entity or with the Alliance physicians. Members, such as those undergoing cancer treatments of chemotherapy or radiation therapy, that are dialysis-dependent, awaiting transplants, in late-term pregnancies, have pending surgeries, or those awaiting transfer or admittance to a skilled nursing facility (SNF), rehabilitation, chemical dependency, or mental health facility, and any other members who might have their ongoing care negatively impacted by the termination of the group are identified.

The Alliance will notify members affected by the termination of a practitioner or practice group in general, family, or internal medicine of pediatrics, at least 30 calendar days prior

to the effective termination date, and help them select a new practitioner.

For members undergoing active treatment for a chronic or acute medical condition, care may be continued through the current period of active treatment or up to 90 calendar days, whichever is less.

3. ***Pregnant and Post- Partum Members***

Pregnant and post-partum Medi-Cal beneficiaries who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into the Alliance have the right to request out-of-network provider continuity of care for up to 12 months in accordance with the Alliance contracts and the general requirements listed in the regulatory guidance. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of regulatory guidance.

For Alliance Group Care, continuation of care extends through the postpartum period for members in their second or third trimester of pregnancy.

4. *Medical Exemption Requests*

A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into the Alliance only until the Medi-Cal beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer to an Alliance provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from the Alliance enrollment that only applies to beneficiaries transitioning from Medi-Cal FFS to the Alliance. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above in this paragraph. The Alliance is required to consider MERs that have been denied as an automatic continuity of care request to allow the beneficiary to complete a course of treatment with a Medi-Cal FFS provider in accordance with the most recent regulatory guidance.

5. *Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder*

The Alliance is responsible for providing Early and Periodic Screening, Diagnosis, and Treatment services for beneficiaries ages 0 to 21. The services include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of beneficiaries diagnosed with Autism Spectrum Disorder (ASD). In accordance with the requirements listed in the most recent DHCS All Plan Letter, the Alliance must provide continued access to out-of-network BHT providers (continuity of care) for up to 12 months.

I. Behavioral Health Management

The provision of behavioral health and substance use services are applied to Alliance

members according to their benefit. Group Care members receive a comprehensive benefit for all behavioral health services. In 2021, the Alliance implemented the requirements of All Plan Letter (APL) 21-002 – Implementation of SB 855, Mental Health and Substance Use Disorder Coverage for the Group Care Line of Business. Medi-Cal members receive services for mild to moderate behavioral health services. The provision of treatment for moderate to severe behavioral health services for Medi-Cal members is managed under a Memorandum of Understanding with Alameda County Behavioral Health Care Services, as described below.

The Alliance ensures services are provided in a culturally and linguistically appropriate manner.

1. Alameda County Behavioral Health Care Services (ACBHCS)

Specialty behavioral health services for Medi-Cal members excluded from the Alliance contract with DHCS are coordinated under a Memorandum of Understanding executed with ACBHCS. This is a carve-out arrangement for specialty behavioral health management with the State of California directly overseeing and reimbursing the behavioral health services provided to Medi-Cal members.

The referral procedure for Alliance members includes:

- Alliance Primary Care Providers (PCPs) render outpatient behavioral health and substance abuse services within their scope of practice.
- PCPs refer the members to ACBHCS for evaluation and coordination of medically necessary specialty behavioral health services by the Access Team, including inpatient psychiatric care.
- PCPs refer members to qualified Medi-Cal providers for the provision of services not covered by ACBHCS.

2. Behavioral Health

The Alliance contracts with a Managed Behavioral Health Organization (MBHO) NCQA accredited delegate for the provision of behavioral health and substance abuse services not covered through ACBHCS, and for behavioral health and substance abuse services benefits for of all other lines of business. The Alliance delegates behavioral health utilization management activities and the maintenance of the provider network for behavioral health and substance abuse services.

All services are based on a member's benefit plan and the functions delegated to the MBHO by the Alliance. The scope of the program covers behavioral health treatment that may be beyond the customary scope of practice of a primary care physician. Care settings include home and office bases services, free-standing and hospital-based programs, residential treatment programs and facility based acute care treatment units. The MBHO uses information provided by the Alliance to determine member-specific benefit coverage, including plan-specific Evidence of Coverage documents, web-based member eligibility verification systems and direct download of member eligibility information via 834 files exchanges. Medical necessity is determined by applying level of care criteria, while the clinical appropriateness of services are evaluated using

Clinical Practice Guidelines. Member specific clinical information is obtained from the member and/or family member or other legal representative, behavioral health medical providers (through verbal case review and/or submission of medical records). Program processes include triage and referral; prospective; concurrent; post-service review and care coordination. Services include education to members and providers, coordination of care with primary care physicians, linkage and coordination with state and community agencies.

The Alliance reviews and approves the MBHO's LOC criteria through the HCQC. The Alliance reviews the criteria to ensure its clinical criteria for both medical and behavioral health services are aligned. MBHO's Level of Care criteria (LOC), as adopted by the UMC, were developed from the comparison of national, scientific and evidence-based criteria sets, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM.)

The MBHO uses the LOC criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, and treatment history in determining the best placement for a member. LOC criteria are applied to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular LOC. However, the individual's needs and characteristics of the local service delivery system are taken into consideration prior to the making of UM decisions.

3. Alameda Alliance Triage and Referral

The Alliance arranges for triage and screening services available by telephone to members 24 hours per day, 7 days per week. The Alliance ensures that the telephone triage or screening services are provided in a timely manner appropriate for the requesting member's condition.

The Alliance is contingent on its contracted provider network to provide triage services to its members. Primary care providers and mental health care providers provide triage and screening services 24 hours a day, 7 days a week for medical and behavioral health care services.

For cases when the providers are unable to meet the time-elapsed standards, the Plan provides members the Plan's nurse advice line to call as an alternative triage and screening service arrangement. Providers who are unable to provide triage and screening services are required to inform members about the Alliance's nurse advice line information.

4. Monitoring Over and Under Utilization of Medical and Behavioral Health Services

The CMO or its physician designee monitors patterns of over and under-utilization.

Data is reviewed at the UMC and HCQC and when a pattern of under or over utilization is identified an analysis of barriers is conducted and potential interventions are identified. Data is then re-evaluated to determine the efficacy of the interventions.

When a concern over potential over or under-utilization for a specific member is identified, the clinical team including the Primary Care Physician, under the direction of the UM Medical Director, develops a plan to address the utilization issue which may include referral to Behavioral Health Case Management and/or the Alliance's Case Management or Disease Management programs, physician peer to peer with the inpatient attending physician, referral to the Alameda county mental health authority for additional services and supports.

5. Behavioral Health Integration

Members may contact their appropriate behavioral health organization directly or be referred by the PCP and/or health care professional. The Alliance maintains procedures for providers to coordinate care and services for members in need of behavioral health services including, but not limited to, all medical necessary services across the behavioral health provider network.

The Alliance uses a variety of mechanisms that ensure behavioral health services and management processes are actively integrated into the UM Program and include:

- A behavioral healthcare practitioner, who is a behavioral healthcare physician or a doctoral-level behavioral health practitioner, is involved in quarterly HCQC meetings to support, advise, and coordinate behavioral healthcare aspects into UM Program policies, procedures and processes.
- There are regular care coordination rounds, in which the staff attending rounds evaluates topics such as access, availability, health management systems, practice guidelines, clinical and service quality improvement activities, member satisfaction, continuity and coordination of care and member's rights and responsibilities.
- The Alliance routinely receives clinical reports from its Behavioral Health provider network which are reviewed by the Chief Medical Officer, the Senior Director of Health Care Services, the Senior Director of Quality Improvement, and the Director, Compliance, or designees.
- The Alliance participates in quarterly operational meetings with the Behavioral Health provider network delegate to review and coordinate administrative, clinical, and operational activities.

J. Pharmacy Management

Starting in 2022, much of the pharmacy benefit for MediCal members is carved out to the DHCS Medi-Cal Rx program. For those pharmacy benefits not carved out and for the commercial LOB, the Alliance ensures the provision of pharmacy management to a

pharmacy benefit manager (PBM), PerformRx. The PBM possesses service level guarantees that manages pharmacy services under the delegated arrangement and maintains clinical policies and procedures that are revised at least annually. The Alliance delegates some of its pharmacy utilization management activities to the pharmacy benefit management company. The PBM supports full prior authorization review services, including confirmation of denials for weekends/holidays/emergency. The PBM provides support to the Alliance's Pharmacy and Therapeutic Committee activities including formulary management, guideline development and trend reviews related to pharmacy services. The Pharmacy and Therapeutics Committee meets quarterly and provides oversight for evidence-based, clinically appropriate pharmacy guideline criteria. Guidelines are developed in conjunction with review of peer-reviewed literature and with consideration for such factors as safety, efficacy, and cost effectiveness, with the input and evaluation of external clinical specialists appropriate to the subject matter.

The PBM receives and processes medication prior authorization requests for medications filled through network retail and specialty pharmacies. The PBM's Prior Authorization Department is comprised of certified technicians and clinical pharmacists who conduct reviews and approve requests that meet prior authorization criteria. All requests that the PBM cannot approve per their protocol are forwarded to Alliance for the final determination. All pharmacy PA requests must be processed, and a decision rendered within the regulatory requirement. Pharmacy UM decision monitoring is reported through the UM Committee.

K. Linked and Carved Out Services

For linked and carved out services the Alliance provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits. These linkages are established through special programs, such as the Alliance Community Liaisons, and specific program Memoranda of Understanding (MOU) with other community agencies and programs, such as the California Children's Services, Alameda County Behavioral Health Care Services, and the Regional Center of the East Bay (RCEB). The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The UM Department coordinates activities with the Case Management Department to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

A full description of program the identification and referral process as well as the care coordination activities is maintained in the UM department policies and procedures.

Section IV. Special Programs

A. Transplant Programs

The Alliance provides an appropriate level of care and services within the member's benefits for transplants according to product line requirements, whether MediCal or Group Care. All patients are monitored according to contractual requirements on an inpatient and outpatient basis, and the member, physician, and facilities are assisted to assure timely, efficient, and coordinated access.
Medi-Cal Members are covered for all medically necessary organ transplants:

a) As of 2022, the Alliance is responsible for all Major Organ Transplants/Bone Marrow Transplants. (MOT/BMT,) in addition to the kidney and corneal transplants previously covered.

b) For members under 21 years of age, organ transplant coverage is provided by California Children Services (CCS). The Alliance refers members under 21 to CCS for evaluation of potential organ transplant. CCS will refer the CCS-eligible member to the transplant Special Care Center, (SCC.) for adjudication of the request and follow-up.

c) Major Organ transplant evaluations are referred to one of the MediCal facilities noted as Center of Excellence (CoE) on the most recent DHCS CoE list of facilities for evaluation. The Alliance will authorize the request for the transplant after the transplant program confirms the transplant candidacy of the member. Once the transplant program confirms that the member is a suitable transplant candidate, the Alliance will authorize the request for the transplant.

d) Kidney and corneal transplants are provided through Alliance-approved practitioners.

e) Kidney transplants, along with related care such as dialysis, evaluation of potential donors, and nephrectomy from living or cadaver donors, continue to be covered benefits.

Group Care (IHSS) Members are covered for all medically necessary organ transplants. This coverage is provided by Alliance-approved practitioners and facilities.

A full description of the program, including the identification and referral process as well as the care coordination activities is maintained in the department policies and procedures.

B. Transportation Services

Transportation services are covered benefits. Transportation benefits include:

- Emergency
- Non-emergency medically necessary (NEMT)
- Non-medical transportation (NMT)

Benefits are administered based on the guidance of the Alliance product line. Those products include:

- MediCal

- IHSS

For the administration of the benefit:

- For Members enrolled with Kaiser, the Alliance delegates the responsibility for the provision of transportation services to the contracted Plan Partner.

- For the administration of MediCal Direct and IHSS, the Alliance is responsible for the provision of transportation services.

The Alliance contracts with a vendor, Modivcare, (formerly called Logisticare,) to provide the various modes of transportation. The vendor's UM Department is delegated for the utilization review process to determine medical necessity when required; the vendor is not delegated for potential denials. All potential denials are referred to the Alliance UM Medical Director for final determination. Utilization review is performed using the transportation guidance for the product, and as needed, a Physician Certification Statement (PCS). A full description of the process is defined the most recent policies on transportation services.

C. Transportation Access to Early and Periodic Screening, Diagnostic and Treatment Services

The Alliance is responsible for the provision of medical and non-medical transportation to eligible children under the age of 21 to access Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The Alliance is required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation, to and from medical appointments for the medically necessary covered services. The Alliance is not responsible for providing non-medical transportation to and from the services that are carved-out, including dental services. AAH follows DHCS All Plan Letter 19-010 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment of Services for MediCal Members Under the Age of 21.

D. Long Term Services and Supports

The UM program includes oversight of the UM clinical decision-making review and authorizations for access to Long Term Service and Support benefits including Long Term Care (LTC) and Community Based Adult Services (CBAS). LTSS is responsible for the programmatic management of the LTSS programs. The Alliance administers the LTC and CBAS program elements as defined by the most recent DHCS contract, MMCD letter, or APL.

1. Long Term Care

The Long-Term Care (LTC) UM activities includes long term skilled care authorizations for the following facilities: skilled nursing, intermediate care, sub-acute care, intermediate care; developmentally disabled, intermediate care–developmentally disabled—

habilitative, and intermediate care–developmentally disabled—nursing, residential care facilities, board and care, and assisted living facilities. LTC excludes Institutes for Mental Disease and special behavioral health treatment programs. Authorizations are provided based on member's meeting criteria the eligibility and nursing facility admission criteria.

For Medi-Cal members: Long Term Care (LTC) services for eligible MediCal members. The Alliance is responsible for the provision of LTC services for the month of admission plus the following month. The UM Department is responsible for providing the following activities:

- If a Member requires LTC in the facility for longer than the regulatory timeframe for admission, the Alliance shall submit a disenrollment request for the member to DHCS, for approval.
- The Alliance shall provide all Medically Necessary Covered Services to the Member until the disenrollment is effective. For these Members, an approved disenrollment request will become effective the first day of the eligible month, provided Contractor submitted the disenrollment request at least 30 calendar days prior in the appropriate timeframe. If the Alliance submitted the disenrollment request less than 30 calendar days prior to that date, disenrollment will be effective the first day of the month that begins at least 30 calendar days after submission of the disenrollment request. Prior to the disenrollment effective date, the Alliance shall ensure the Member's orderly transfer from the Alliance's Provider to the Medi-Cal Fee-For-Service program. This includes notifying the Member and his or her family or guardian of the disenrollment; assuring the appropriate transfer of medical records or copies from the Alliance's Provider to the Medi-Cal fee-for-service provider; assuring that continuity of care is not interrupted; and, completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the Members.
- Admission to a nursing facility of a MediCal Member who has elected hospice services does not affect the Member's eligibility for Enrollment. Hospice services are Covered Services under and are not long-term care services regardless of the Member's expected or actual length of stay in a nursing facility.

2. CBAS

The Alliance administers the CBAS program elements as defined by the most recent DHCS contract, MMCD letter, or APL. The Alliance maintains procedures, processes, and mechanisms for administering assessments and re-assessments for CBAS services. For providers delegated to perform the CBAS assessments, the Alliance provides the necessary delegation oversight and monitoring activities. The Alliance develops mechanisms to generate and distribute the required reports to the identified DHCS departments.

E. Palliative Care

Palliative Care Services are provided to members per the requirements of the latest All Plan Letter Palliative care services may be delivered at the hospital, as part of the inpatient

care treatment plan, or authorized and delivered in primary care, specialty care clinics, by home health teams, or by hospice entities. The Alliance offers a network of palliative care services to its members through various provider types.

The Alliance, as part of its palliative care network development, contracts with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care. The Alliance may also contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. The Alliance utilizes qualified providers for palliative care based on setting and needs of the members if the provider complies with the existing Medi-Cal requirements.

The Alliance ensures that palliative care provided in a member's home complies with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans.

The Alliance informs and educates its providers regarding availability of the palliative care benefit through its website and education materials.

The Alliance identifies members eligible for palliative care by the following:

- Screening for palliative care eligibility in Complex Case Management referrals
- Referrals from network providers, including through case management, concurrent review, and the general authorization process.
- Analysis of member data

Palliative care services follow the general authorization process is outlined in the UM policy and procedures. Through the authorization review and decision process, the type of palliative care (including the location where palliative care services can be delivered) will be determined based on medical necessity. Referral and care coordination for palliative services will be provided to the member within the timely access standard requirements. Alliance's network providers receive instructions of the referral and authorization process for palliative care through the Alliance's provider educational materials and via the Alliance's website.

Section V. Quality Improvement Integration

The UM Program includes a wide variety of quality assurance activities to support positive member outcomes and continuous quality improvement. The CMO guides these activities in collaboration with the Senior Director of Health Care Services, the Administrative Director of Quality and the Director of Accreditation, and oversight of the HCQC. Performance results are analyzed and reviewed with opportunities for improvement identified for intervention and performance management. The following quality activities are included in the UM Program:

- Monitoring Under and Over Utilization, including Out of Network and Provider Capacity monitoring.
- Monitoring of Member Experience with the UM process.
- Monitoring UM Appeals for UM Decision Making.
- Potential quality issue referrals.
- Provider Preventable Condition identification and referral.
- Inter-rater reliability assessments.
- Delegation oversight including Corrective Action Plan completion and process improvements if audit findings occur.

The UM data sources, and information used for quality monitoring and improvement activities include the following:

- Claims and encounter data.
- Medical records.
- Medical utilization data.
- Behavioral Health utilization data.
- Pharmacy utilization data.
- Appeal, denial, and grievance information.
- Internally developed data and reports.
- Audit findings; and
- Other clinical or administrative data.

A. Monitoring Over and Under Utilization

The Alliance regularly monitors member service utilization using industry standard utilization measures. Medi-Cal contracts require that plans report rates to detect over and under-utilization. Rates for these measures vary based on the relative health of each population. For instance, usage rates for Non-SPD Medi-Cal members tend to be significantly lower than those for SPD Medi-Cal and IHSS members because the former populations are generally younger and healthier. Monitoring reports include changes in membership totals for each line of business in the last 12 months. National and regional benchmarks are not available for every line of business. In the absence of such benchmarks, the Alliance closely monitors monthly, quarterly, and annual data for significant changes and trends, reports the results quarterly to the UMC and HCQC, and acts when indicated.

UM data elements are reviewed to assess over/under utilization of services for either medical and/or behavioral health include but are not limited to the following:

- Ambulatory Services – e.g. Outpatient encounters per enrollee per year primary care visits, specialist visits, preventive health care.
- Out of Network Specialty Referrals, e.g. specialists, behavioral health care.
- Acute Hospital Services

    - Emergency room visit rates.
    - Hospital admit rates.
    - Bed days rates.
    - Length of Stay.
    - Re-admission rates.
- Behavioral health utilization data.
- Pharmacy utilization rates.
- HEDIS measures for use of services
- Complaint reports (Grievance & Appeals) that reflect barriers for access to care or delivery of care.

Because of these clinical data analyses, the Alliance identifies opportunities for improvement through root cause analysis, action plans and the continuous improvement cycle ensure the actions taken are improving performance. When appropriate, feedback is provided to both entities and individual practitioners allowing their input into the improvement activities. The Alliance continues to monitor the action plans to ensure the activities improvements in the care delivery process.

B. Experience with Utilization Management

Annually Alliance members and providers are surveyed to assess their experience with the plan's utilization management processes and services. Data is collected and analyzed to identify improvement opportunities. For identified opportunities, Alliance takes actions designed to improve the experience based on the data.

1. Member

Alliance uses survey data to assess the member experience with the UM process. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by mail to Alliance Medi-Cal members. Among the composite measures are member ratings for: 1) Getting Needed Care – member experience when attempting to get care, tests or treatments; 2) Getting Care Quickly – member experience when receiving care; and 3) Rating the Health Plan. The CAHPS summary rate results are compared to Medicaid benchmarks. The UM department participates on the member satisfaction team and develops action plans to improve member satisfaction.

2. Provider

Annually, the Alliance surveys its providers for their experience with the plan's utilization management processes and services. A vendor employed by the plan contacts a sample of network providers by mail and/or internet. Among the survey questions, six (6) questions ask providers to rate the plan on:

- Access to knowledgeable UM staff.
- Procedures for obtaining prior authorization information.
- Timeliness for obtaining prior authorization information.

- The Plan's facilitation/support of appropriate clinical care for patients.
- Degree to which the Plan covers and encourages preventive care and wellness. Alliance provider survey responses are benchmarked against other Medi-Cal/Medicaid plans that use the same vendor's survey.

Alliance conducts quantitative and qualitative analysis to identify areas for improvement. Outcomes of the assessments are presented to the UMC and HCQC to assist in identifying opportunities for improvement. If the analysis indicates that there are opportunities to improve experience with UM, Alliance UM Department participates on the provider satisfaction team. Activities identified to improve the member and provider experience with UM are used to update the following years UM Program.

C. Grievances and Appeals

The Alliance maintains an effective member grievance and appeals (G&A) process that follows all regulatory, contractual and accreditation requirements. G&A is managed within Health Care Services, and complaints identified with clinical service needs are supported by UM Nurses and Physicians. Trending data for clinical appeals and fair hearings is reported to the UMC for the identification and recommendations of opportunities to improve the UM experience for members and providers. On a quarterly basis, the UM Department will review and analyze grievance data. The evaluation is reported to the UMC.

Appeal decisions are made by a practitioner who was not involved in the initial decision unless the case is overturned. A same-or similar specialist review is required for all appeals of medical necessity decisions. The details of the appeal process are outlined in the Alliance Appeals Policy and Procedure.

D. Potential Quality of Care/ Provider Preventable Reportable Conditions

At any time during an UM review, staff identify a condition or situation that appears to deviate from the professional standard of care or identified by regulatory guidance as a Potential Quality of Care or Provider Preventable Reportable Condition, are referred to the Quality Improvement Department to be evaluated per policy and procedure.

E. UM Delegation Activities

The Alliance delegates UM activities to provider groups, vendor networks and healthcare organizations that meet delegation agreement 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 to the Alliance; 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 standards and requirements. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department will work with other respective departments to conduct the annual delegation oversight audits. Delegate work plans, reports and evaluations are reviewed by

the Alliance and the finding are summarized at HCQC and Compliance Committee meetings, as appropriate. The Compliance Department in conjunction with each respective department monitors the delegated functions of each delegate through reports and annual oversight audits.

As part of delegation responsibilities, delegated providers must:

- Develop, enact, and monitor a UM Program description that addresses all State, Federal, health plan and accreditation requirements.
- Provide encounter information and access to medical records pertaining to Alliance members.
- Submit at least quarterly reports, annual evaluations, and program descriptions and work plans; and
- Cooperate with annual audits and complete any corrective actions necessary by the Alliance.
- Participate in performance improvement activities.

F. Inter-Rater Reliability Testing

Inter-Rater Reliability (IRR) Testing is a method used at the Alliance to assess the degree of agreement among personnel who make utilization management decisions. It provides a score of how much homogeneity or consensus there is in responses to utilization management cases. The purpose is for the Alliance to provide consistency and accuracy of review criteria applied by all reviewers - physicians and non-physicians and to act on improvement opportunities identified through this testing. This report provides an analysis of the Alliance's testing for each year and fulfills regulatory, contractual and accreditation requirements associated with ensuring the consistency in applying UM criteria and acting on identified improvement opportunities.

IRR testing is conducted following the Alliance internal policy (QI-133 Inter-Rater Reliability—Testing for Clinical Decision Making) for UM, QM and Pharmacy staff that participates in the Health Services medical necessity decision making process. IRR test results are collated and reviewed by management.

Reports on IRR test results are reviewed and approved by the HCQC. The IRR process and reports are reviewed for delegated entities during the annual auditing process.

G. UM Department – Internal Quality Review

To ensure the oversight of the internal UM process, Alliance UM Department conducts ongoing auditing and monitoring of key operational areas to ensure compliance with all federal, state, regulatory, contractual and accreditation standards. Alliance UM Department has implemented 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 routine and/or periodic basis.

1. **UM File Review**
   UM will complete file reviews using a defined methodology for the file selection. Files will be assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement. The process outcomes will also be utilized for staff performance. Elements of the review include, but are not limited to, ensuring the appropriate medical information is obtained, use of criteria, application of clinical decision making, and appropriate referral to physician reviewers as needed. For cases that are denied or modified, the file will assess the NOA requirements for communication to the member and provider.

2. **Audit of Authorization Processing Turn-Around-Time (TAT)**
   An authorization aging report is used to monitor TATs for authorizations. Any opened authorization without a final determination will appear in this report. The UM Manager or designee will work this report daily to ensure all authorization determinations are compliant with UM will complete file reviews using a defined methodology for the file selection. Files will be assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement.

H. Annual UM Workplan

Each year, the Alliance establishes objectives and priorities and outlines a strategic UM Workplan for the coming year. The UM Workplan incorporates anticipated timeframes, responsible parties, and status of activities. The UM Workplan is submitted to the UM Committee for approval annually. See Attachment B – 2022 UM Workplan.

I. Annual UM Evaluation

Members of the UM Program management team annually evaluate and update the UM Program to ensure the overall effectiveness of UM Program objectives, structure, scope. and processes. The evaluation includes, at a minimum:

- Review of changes in staffing, reorganization, structure, or scope of the program.
- Resources allocated to support the program.
- Review of completed and ongoing UM work plan activities.
- Assessment of performance indicators.
- Review of delegated arrangement activities; and
- Recommendations for program revisions and modifications

The UM Program management team presents a written program evaluation to the UMC and HCQC. The UMC and HCQC reviews and approves the UM Program evaluation on an annual basis. The review and revision of the UM program description may be conducted more frequently as deemed appropriate by the UMC, HCQC, CMO, CEO, or BOG.

The HCQC's recommendations for revision are incorporated into the UM Program description, as appropriate, which is reviewed and approved by the BOG and submitted to DHCS on an annual basis.

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 particularly focus on the Stanford analysis.
- Continued monitoring of Specialty Referrals.
- Collaboration with the Alliance Compliance Department on the full implementation of the UM process for internal performance monitoring of UM decisions.
- Strengthen programs around oversight of clinical decision making, both internally and for Delegates.
- Continue the Transition of Care program in partnership with Highland Hospital and expansion to other hospitals, with attention to readmission risk screening and disease management
-
- 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.
- 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.
- Evaluate the options to develop and refine the ADT feed coming from contracted hospitals to enhance communication, coordination of care, and automation of UM Case creation in TruCare.
- Explore Quality initiatives with the Quality Department around PQIs, HEDIS measures, and PPCs.
- 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.
- Provider leadership to the initiative for enhanced care coordination for high-risk hemodialysis members with DaVita.
- Analyze the opportunity and implement the process to increase the number of authorizations that are appropriate for automatic approval.
- Improve reporting and analysis of grievance and appeals activities related to UM decision making and analysis for member and provider experience with UM.
- Continue implementation for tracking and intervening with unused Authorizations to ensure that members receive appropriate care and follow up.

- Enhance collaboration opportunities with California Children's Service to ensure coordination of care for members carved out to CCS care.
- Fully implement the carve in of all Major Organ Transplants to the plan.
- Continue to monitor and enhance the use of the Palliative Care benefit for members in collaboration with outside partners.
- Continue the development for the Stanford Oncology program, including streamlining authorizations and coordination with Case Management.
- Continue the analysis of hospital data and develop an individual hospital strategy for management of members for appropriate length of stay.
- Hardwire the standardized work and training for the UM department staff to ensure regulatory compliance.
- 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.

Attachment A

2022 The Alliance Delegated Network or Vendor Relationships

Delegate	Provider Type		Delegated Activity - UM	Delegated Activity – Grievance and Appeals	Exceptions
Kaiser	HMO		X	X	
Alameda Health System	Delivery System			NA	
CHCN	Medical Group		X	NA	
CFMG	Medical Group		X	NA	
California Home Medical Equipment (CHME)	Vendor DME		X*	NA	* Not delegated for denials
Beacon/College Health IPA (CHIPA)	MBHO		X	NA	
ModivCare	Vendor -		NA	NA	* Not

	Transportation				delegated for denials
March Vision	Vendor – Vision Services		NA	NA	

Attachment B – 2022 UM Work Plan

See attached document.