Utilization Management
Program Description

2024

Utilization Management
2024 Program Description

Signature Page

_____	_____
Date	Allison Lam, RN Senior Director, Health Care Services
_____	_____
Date	Peter Currie, Ph.D. Senior Director, Behavioral Health Services
_____	_____
Date	Rosalia Mendoza, M.D. Medical Director, Utilization Management
_____	_____
Date	Sanjay Bhatt, M.D. Senior Medical Director, Quality
_____	_____
Date	Steve O'Brien, M.D. [Donna Carey, M.D. – Interim CMO] Chief Medical Officer, Medical Management Chair, Quality Improvement Health Equity Committee
_____	_____
Date	Matthew Woodruff Chief Executive Officer
_____	_____
Date	Rebecca Gebhart Board Chair

Table of Contents

I. Background

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 citizens most in need in Alameda County. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for Alameda County residents and reflects the cultural and linguistic diversity of the community. In addition, Alliance providers, employees, and Board of Governors live in areas that the health plan serves.

The Alliance provides health care coverage to over 300,000 children and adults in Alameda County through the Medi-Cal and Group Care programs. Through active partnerships with healthcare providers and community partnerships, 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.

The Alliance's Utilization Management (UM) Program was established to provide 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 ensures parity between medical/surgical care and behavioral health care throughout all structures and functions. The UM Program is compliant with Health and Safety Code Sections 1363.5, 1367.01, 1368.1, 1374.16, 1374.72, 1374.76, and Title 28, CCR, Sections 1300.1300.67.2, 1300.70(b)(2)(H) & (c).

II. Program Purpose and Scope

The purpose of the Alliance's 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 and behavioral services.
- Improve health, including behavioral health, outcomes; and
- Assure the effectiveness and efficiency of healthcare services.

The Alliance adheres to the following operating principles for the UM Program, for both the medical/surgical services and behavioral health services:

- 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

UM Program activities promote utilization of covered services at the right time and at the most appropriate site and level of care. Activities include, but are not limited to:

- Admission and concurrent review
- Discharge planning: pre-admission, concurrent, and post-discharge follow-up with member/provider
- Coordination with Claims, including review of Provider Disputes
- Coordination with Compliance, to support monitoring and auditing activities for internal and delegated entities
- Coordination with Grievance and Appeals, including review of overturned decisions
- Continuity and coordination of care for members when a provider is terminated from the network
- Continuity and coordination of care for members newly eligible with The Alliance, receiving active care and treatment from a non-Alliance provider
- County Behavioral Health Care Services (ACBHCS)
- Discharge planning: pre-admission, concurrent, and post-discharge follow-up with member/provider

- Evaluate and refer members needing care coordination/case management (including children/youth under Medi-Cal for Kids & Teens, California Children's Services, Enhanced Care Management, Complex Case Management, Community Supports, Dental Health, Behavioral Health, or Long-Term Care)
- Integration of medical and behavioral health, including collaboration with Alameda County Behavioral Health Services
- Peer-to-peer discussions to support providers regarding clinical decision-making
- Prior authorization of services (including pre-admission education)
- Quality improvement projects, based on analysis of utilization trends
- Retrospective review

III. Program Structure

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

A. Board of Governors

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 19-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of the Alliance programs and is responsible for approving the Quality Improvement and Utilization Management Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to the Alliance Chief Medical Officer (CMO) and the Quality Improvement Health Equity Committee (QIHEC). The CMO and the QIHEC provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management Program. Utilization Management activities are the responsibility of the Alliance Health Care Services staff under the guidance of the Medical Director for Utilization Management and the Senior Director of Health Care Services, in collaboration with the Alliance CMO.

The Board of Governors appoints and oversees the QIHEC, the Peer Review and Credentialing Committees, and the Pharmacy and Therapeutics Committee (P&TC) which, in turn, provide the authority, direction, guidance, and resources to enable the Alliance staff to carry out the Quality Improvement, Utilization Management and Case Management Programs. Committee membership consists of provider representatives from the Alliance contracted networks and the community, including those who provide health care services to populations served by The Alliance (for example: Seniors and Persons with Disabilities, Dual-eligible members, and members with 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.

B. Quality Improvement Health Equity Committee (QIHEC)
The QIHEC provides oversight, direction, makes recommendations, and has final approval of the CM Program. Committee meeting minutes are maintained to summarize committee activities and decisions with appropriate signatories and dates. A full description of the QIHEC Committee responsibilities can be found in the most recent Quality Improvement Program Description.

The QIHEC provides the external physician involvement to oversee The Alliance QI and UM Programs. The QIHEC includes a minimum of four (4) practicing physician representatives with active, unrestricted licenses to practice in the State of California. The composition includes the Senior Director of 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 QIHEC functional responsibilities for the UM Program include:

- Annual review and approval of the UM Program Description
- Annual review and approval of UM Policies and Procedures
- Oversight and monitoring of the UM Program, including:
    - Recommend policy decisions
    - Review and approve clinical criteria for UM decision-making
    - 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
    - Recommend necessary actions

C. Pharmacy & Therapeutics Committee (P&TC)
The P&T Committee is responsible for oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization, and developing provider education programs on drug appropriateness. P&T Committee meeting minutes and pharmacy updates are shared with the BOG.

<u>The voting membership consists of:</u>

- Alliance Chief Medical Officer (Chair) or designee
- Alliance Director of Pharmacy Services (Co-Chair)
- Practicing physician(s) representing Internal Medicine
- Practicing physician(s) representing Family Practice
- Practicing physician(s) representing Pediatrics
- Practicing physician(s) representing common medical specialties
- Practicing community pharmacists contracted with Alliance (not to exceed 1/3 of the voting membership of the committee or three pharmacists, whichever is greater).

D. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a sub-committee of QIHEC. 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.

UMC activities reporting through the QIHEC integrates UM activities into the Quality Improvement system. While the QIHEC 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 QIHEC has delegated authority of the following functions to the UMC:

- Annual review and approval of the effectiveness of the UM/BH Program
- Annual review and approval of the UM/BH Program
- UM/BH Policies/Procedures,
- UM/BH 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.

UM Committee Membership

The UMC is chaired by the Chief Medical Officer. Members of the UMC include:

- The Alliance Chief Analytics Officer
- The Alliance Medical Directors, UM
- The Alliance Medical Director, CM
- The Alliance Senior 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 Senior Director, Behavioral Health
- 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, Utilization Management
- The Alliance Director, Long Term Services and Supports
- 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

UMC Voting Privileges

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

UMC Quorum

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

UMC Meetings

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

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 QIHEC. 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 QIHEC for review and approval.

UMC Functions

The UM Committee is a forum for facilitating clinical oversight and direction. Its 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 benchmark 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 Health Care Services
- Provide mechanism for oversight of delegated UM functions, including review and trend authorization and utilization reports for delegated entities to identify improvement opportunities.
- Maintain the annual review and approval of the UM/BH Program, UM/BH Policies/Procedures, UM/BH Criteria, and other pertinent UM documents such as the UM Delegation Oversight Plan, UM/BH Notice of Action Templates, and UM/BH and Case/Care Management Program and Policies/ Procedures.
- 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.
- Recommend actions to the Quality Improvement Health Equity 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, Behavioral Health usage and outcomes, and Discharge Rates.

- Receive updates about New Medical Technologies from the Pharmacy & Therapeutics Committee, including new applications of existing technologies that have been approved by P&T committee

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 QIHEC 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 UM committee also evaluates the impact of UM/BH programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes.

E. Staff Resources

The Alliance Health Care Services Department is responsible for the operational management and oversight of clinical programs, including the UM Program. The UM, Behavioral Health (BH), and Pharmacy Departments administer the UM Program, and the primary staff roles and responsibilities are as follows:

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

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 utilization 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.

Senior Director, Health Care Services

The Senior Director, Health Care Services is a Licensed Registered Nurse and is responsible for overall UM Department operations, staff training, and coordination of services between departments. The Senior Director's 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 regulatory and accreditation standards.
- Monitor utilization data for over and under-utilization, and coordinate interventions with the CMO to address under and over utilization concerns, as appropriate
- Monitor utilization data and activities for clinical and utilization studies;
- 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

Senior Director, Behavioral Health Services

The Senior Director, Behavioral Health Services is a licensed Psychologist and is responsible for the overall Behavioral Health department operations, staff training, and coordination of services between departments. The Senior Director's responsibilities include:

- Develop and maintain the Behavioral Health (BH) Program in collaboration with the Senior Medical Director of Quality and the CMO.
- Coordinate BH activities with the Quality, UM, Case Management, Member Services Departments, as well as other Alliance units.
- Maintain compliance with the regulatory standards.
- Maintain professional collaboration with Alameda County Behavioral Health Care Services (ACBHCS) to coordinate care and care transitions across behavioral health care systems.
- Coordinate interventions with the Senior Medical Director and the CMO to address under and over utilization concerns when appropriate.

- Develop and monitor 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 utilization criteria by BH staff, for each level and type of UM decision.

Senior Director, Pharmacy Services

The Senior Director, Pharmacy Services 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:

- Function as the authoritative source of relevant and current information on all pharmaceuticals' efficacy, safety, comparative efficacy, cost, and cost impact.
- Oversee all levels of pharmaceutical information and/or education, in a proactive and timely manner to internal staff, members and providers.
- Oversee policies and procedures, systems, and processes to assure compliance with all federal and state regulatory requirements pertaining to Formulary and benefit management.
- Co-chair the Pharmacy & Therapeutics (P&T)
- Oversee the pharmacy prior authorization, physician administered drugs pass thru pharmacy, and pharmacy appeal process to meet the regulatory and contractual requirements with federal and state government agencies, including CMS, NCQA, DMHC and DHCS.
- Monitor, research, recommend and contract with vendors and implement programs related to pharmaceuticals include but not limited to PBM, Specialty pharmacy, Identify trends and patterns in pharmaceuticals utilization.
- Develop provider and member programs to improve medication prescribing patterns and to increase patient compliance and adherence for improving quality measures.

Lead Clinical Pharmacist, Medical Drug Management

The Lead Clinical Pharmacist, Medical Drug Management is a licensed pharmacist (Pharm.D.) responsible for leading the planning and implementation of new physician administered drugs (PAD) operational and/or clinical initiatives. This position works closely with Pharmacy Supervisor, Lead Pharmacy Technician, mentors clinical pharmacists and acts as a back up for pharmacy supervisor. The scope of responsibilities of the Lead Clinical Pharrmacist includes:

- Guide the tasks performed by the pharmacy technicians and clinical pharmacists related to PAD.
- Review and make determinations for outpatient pharmacy prior authorization

(PA) requests, coverage determinations, exceptions requests, complaints, and appeals and ensure criteria and decisions are properly communicated and applied.
- Create, update PAD policies & procedures and support pharmacy related audits related to PAD in accordance with DHCS, DMHC, NCQA and CMS requirements and other regulatory and contractual requirements.
- Create and update PAD related contents of the plan communications such as letters/fax blast and websites and portals and for member and provider bulletin in accordance with NCQA, MediCal and Medicare requirements.
- Develop and train educational services for internal staff, employers, providers, and other stakeholders related to PAD topics.
- Prepare and gather PAD related reporting for internal committees and/or external publication to assist the Senior Director of Pharmacy Services.

Clinical Pharmacists

The Clinical Pharmacists are licensed pharmacists and responsible for providing clinical expertise relative to the Alliance pharmacy drug benefit programs and participating in designing, developing, and implementing pharmacy clinical programs to promote a quality, cost-effective pharmacy benefit. This position reviews and makes determinations for outpatient pharmacy prior authorization (PA) requests and in office medical drug authorizations. The scope of responsibilities of the Clinical Pharmacists includes:

- Review pharmacy related coverage determinations, exceptions requests, complaints, and appeals and ensure criteria and decisions are properly communicated and applied.
- Make presentations to develop training, reports, and other communications for internal staff, employers, providers, and to other stakeholders related to clinical pharmacy issues.
- Provide pharmacotherapy expertise, review cases, and make formal recommendations at the request of Alameda Alliance clinical staff
- Analyze pharmacy and medical utilization data to identify trends and at-risk populations; recommend and develop appropriate interventions; monitor and act on results.

Pharmacy Supervisor

The Pharmacy Supervisor is a licensed pharmacist and responsible for ensuring efficient, compliant, and productive workflows in the operational and clinical areas of pharmacy services. The Pharmacy Supervisor leads the planning and implementation of new operational and/or clinical initiatives. The Pharmacy Supervisor is responsible for the direct supervision of lead technician, and pharmacy technicians while mentoring clinical pharmacists for guidance and/or decision making. This position also develops, reviews and updates policies and procedures, medication guidelines for pharmacy prior authorization (PA) and pharmacy appeal per DHCS, DMHC, NCQA and CMS requirements. The scope of responsibilities of the Clinical Pharmacists includes:

- Supervise and lead the provision of timely, efficient, equitable, and effective

pharmacy services.

- Hold staff accountable to the standards of the department and Alameda Alliance for Health.
- Serve as the liaison to coordinate compliance and regulatory issues for areas of responsibility.
- Support clinical pharmacy workflows and practice expectations through operational planning.
- Create, update pharmacy policies & procedures and support pharmacy related audits related to formulary and benefit management and pharmacy performance in accordance with to DHCS, DMHC, NCQA and CMS requirements and other regulatory and contractual requirements.
- Lead the Alliance's Pharmacy & Therapeutics (P & T) Committee presentation materials and implement the recommendations with a PBM and specialty pharmacy on formulary and PA guidelines including benefit coding and formulary updates on websites, PA guideline implementation, and follow up on other pharmacy related initiatives resulting from the Committee's decision(s).

Lead Pharmacy Technician

The Lead Pharmacy Technician is a licensed pharmacy technician. This position supports pharmacy prior authorization (PA), P & T, and DHCS, DMHC, CMS audits and NCQA survey preparation. The scope of responsibilities of the Lead Pharmacy Technician includes:

- Train and mentor pharmacy technicians.
- Train and mentor Pharmacy Technicians on how to draft the Pharmacy and Therapeutics (P & T) meeting materials included but not limited to the meeting minutes, the post P & T summary, and assist on other pharmacy related initiatives resulting from the P & T Committee's decision(s).
- Assist physician administered drugs prior authorization passing thru pharmacy and ensure criteria and decisions are properly communicated with PBM, specialty pharmacy (SP) and internal staff.
- Retrieve drug-specific technical data and information necessary for the completion of departmental and interdepartmental pharmacy-related functions and operations.
- Create and prepare ad hoc reports as well as recurring reports using pharmacy reporting tools for pharmacy clinical programs and quality initiatives, such as HEDIS, drug utilization review (DUR), medication reconciliation, medication therapy management (MTM), inter-rater reliability (IRR) reviews, audits, root-cause analyses, PDSA cycles, corrective action plans, and other related activities.
- Create, update desktop procedures, pharmacy policies & procedures and support pharmacy related audits related to Pharmacy Operations in accordance with DHCS, DMHC, NCQA and CMS requirements and other regulatory and contractual requirements.

Pharmacy Technicians

The Pharmacy Technicians are licensed pharmacy technicians. They utilize specialized pharmacy knowledge and expertise to assist participating pharmacies, members, and

providers to ensure the efficient, timely, and effective delivery of pharmaceutical products and services to Alliance members. This position is responsible for completing daily pharmacy service operations. This position also supports clinical staff through completion of the administrative and clinical coordinator functional components of Physician Administered (PAD) Disease medication management. The scope of responsibilities of the Pharmacy Technicians include:

- Process Pharmacy Authorizations (PA) and assist physician administered drugs prior authorization passing thru pharmacy and ensure criteria and decisions are effectively communicated with PBM, specialty pharmacy (SP) and internal staff in a timely manner according to the regulatory requirements.
- Support Pharmacy Transition of Care (TOC) and pharmacy referrals from CM (e.g., via email, outreach calls and TruCare).
- Coordinate employee RxNova via PerformRx and new internal DU access for FirstCI.
- Assist with drug recall, formulary change, channel management, population health, disease management, Alliance quarterly platform updates and/or product discontinuation support for impacted member and provider notifications (e.g., Cognito requests to C&O for mailing).
- Help coordinate with business ops/internal departments to ensure appropriate member eligibility/product overrides for access to medicinal treatment.
- Pharmacy Services phone queue and email triage/support.
- Perform ad-hoc audit of the pharmacy authorization letters and claims under the guidance of a pharmacist.
- Create and prepare ad hoc reports as well as recurring reports using pharmacy reporting tool.
- Retrieve drug-specific technical data and information necessary for the completion of departmental and interdepartmental pharmacy-related functions and operations.
- Process member reimbursement requests

Director, Utilization Management

The Director, Utilization Management has day to day responsibility for the operation of the UM Program under the direction of the Senior Director, HCS, and the Chief Medical Officer**.** The Director oversees health service compliance functions, internal and delegation oversight auditing and monitoring. The Director also serves on the QIHEC, UMC, and Healthcare Internal Compliance Committee (HICE).

Director, Long-Term Services and Supports

The Director, Long-Term Services and Supports, (LTSS) reports to the Senior Director, Health Care Services (HCS) and is responsible for the operational management and directional guidance of the LTSS Department and activities including institutional Long-Term Care (LTC), Community Supports (CS), and Community Based Adult Services (CBAS). The Director is knowledgeable of and responsible for compliance with regulatory requirements of Managed Medi-Cal and Medicare for LTSS, Nursing Facility (NF-B)/Sub-

Acute Facility (NF-A)/Distinct Part of Hospital (DP-H,) ICFs, IMDs, CBAS, CS/CalAIM, long term care settings, continued stay requirements, as well as transitions of care to community settings.

Managers, Utilization Management

The Managers, Utilization Management are Registered Nurses with current, active and unrestricted California nursing licenses. They supervise all Alliance UM activities, including:

- Provide supervision of assigned UM staff
- Participate in staff training
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Monitor documentation for adequacy
- Ensure staff are following policies, procedures, and all requirements
- Are available to UM staff on site or by telephone/computer
- Collaborate with other departments on interdepartmental initiatives that involve UM activities or functions
- Participate in delegate oversight activities, including annual and/or focused audits, meetings, and joint initiatives
- Participate in regulatory audits and enact regulatory changes or process changes as required

Manager, Long Term Care

Under the general direction of Director of Long-Term Services and Supports, the Manager, Long Term Care, is responsible for the oversight and operations of the Long-Term Care Department. The Manager is knowledgeable of and responsible for compliance with regulatory requirements of Nursing Facility (NF-B)/Sub-Acute Facility (NF-A)/Distinct Part of Hospital (DP-H) long term care admissions, ICF and ICF/DD admissions, continued stay requirements as well as transitions of care to community settings and case management activities for long term care. The Manager provides leadership and executes decision-making based on subject matter expertise and judgment. Additional responsibilities include:

- Monitor program performance to maintain compliance with federal and state regulatory agencies.
- Make decisions within department guidelines and policies, conduct staff training, and facilitate learning opportunities.
- Identify trends, patterns, and opportunities for improvement and communicate findings to appropriate Alliance committees; and
- Provide daily oversight of operations and staff.
- Develops and implements departmental policies and procedures.
- Develops, implements, and monitors performance standards.
- Facilitates inter-disciplinary meetings for LTC admissions.
- Lead any technological implementations for the unit.

- Provide training, development, and continuing education to staff.
- Conduct internal audits which include regular case audits
- Track turnaround time for decision-making and ensure cases are entered into the information system and updated in a timely manner.
- Serve as the primary liaison to resolve complex issues across departments.

Clinical and Nonclinical Supervisors, Utilization Management

Clinical Supervisors, Utilization Management are Registered Nurses and Nonclinical Supervisors are qualified staff with health care and utilization management experience. Supervisors are responsible for:

- Provide day to day oversight of the staff to ensure adherence to departmental processes, productivity, and departmental functions.
- Consult on or assume responsibility for challenging cases
- Provide staff training and coaching
- Assist in audit preparation

Lead Long Term Care, Nurse Specialist

Under general direction of the Manager of Long-Term Care and working in cooperation with other departments, such as Utilization Management, the Lead Long-Term Care (LTC) Nurse Specialist provides providing health plan administrative and clinical support to staff and to Members on the admissions and continued stay services in LTC Nursing Facilities/Intermediate Care Facilities/Distinct Part Hospitals. The lead role supports the day-to-day operations of the department by providing guidance and priority-setting for front line staff and communicating operational issues to the Manager of LTC. Additional Responsibilities include:

- Coordinate the identification, documentation, and resolution of LTC facility related issues in a timely manner.
- Identify opportunities for process improvements to facilitate department functions and ensure compliance within applicable governmental program guidelines.
- Audit staff documentation according to departmental standards.
- Work as part of a multidisciplinary care team to support members as well as meet Alameda Alliance, regulatory and accreditation requirements
- Participate in program development and quality improvement initiatives

Utilization Review Clinicians

Utilization Review Clinicians are Registered Nurses or Nurse Practitioners with current, active unrestricted California nursing licenses, Physician Assistants with active California Physician Assistant license, and/or licensed Behavioral Health clinicians responsible for the review and determinations of medical necessity coverage decisions. Clinicians may approve prospective, concurrent, and retrospective inpatient or outpatient medically necessary services using established guidelines and evidenced-based medical criteria, tools, and references within the scope of their clinical training and education. Licensed Vocational Nurses (LVNs) Nurse Reviewers are supervised by a Registered Nurse (RN) and

do not make clinical approval or denial decisions. Utilization Review Clinicians also work collaboratively with case managers and assist members with transitional care and discharge planning. For cases that do not satisfy medical necessity criteria, the UM Review Clinicians refer to a Medical Director/doctoral Behavioral Health Specialist for final determination. All clinical staff involved in the authorization review process must identify and refer any potential quality issues appropriately for further investigation.

Nurse Specialist, Long Term Care

Under general direction of the Manager of Long-Term Care and working in cooperation with other departments, such as Utilization Management, the Long-Term Care (LTC)) Nurse Specialist is responsible for providing health plan administrative support and clinical support to Members on the admissions and continued stay services in LTC Nursing Facilities/Intermediate Care Facilities/Distinct Part Hospitals. The Nurse Specialist collaborates with LTC facilities to ensure appropriate physical and behavioral healthcare and social services are provided timely and efficiently for Alliance members, including performing clinical review of Skilled Nursing Facilities (NF-A/B), Distinct Part Hospitals and Intermediate Care Facility admissions and recertifications to validate the appropriate level of care. The LTC Nurse Specialist has knowledge of current upcoming programs and services that intersect with LTC services, including Enhanced Case Management, Community Support, Population Health Management, Regional Services, HCBS (Home and Community Based Services). Performs clinical review of Skilled Nursing Facilities (NF-A/B), Distinct Part Hospitals and Intermediate Care Facility admissions and recertifications to validate the appropriate level of care.

Long Term Care, Social Worker

Under general direction of the Manager of Long-Term Care (LTC), and working in cooperation with other departments, the LTC Social Worker is part of a multidisciplinary care team that includes the Social Worker, a Health Navigator, a Nurse Case Manager, Medical Director and Long Term care/Skilled nursing facility partners. The LTC Social Worker serves as a resource for the care team on best practices for psychosocial assessment and mental health interventions. The Social Worker makes referrals to the community and manages internal and external relationships. The LTC Social worker also possesses knowledge of current upcoming programs and services that intersect with LTC services, including Enhanced Case Management, Community Support, Population Health Management, Regional Services, HCBS (Home and Community Based Services). Additional responsibilities include:

- Developing patient-centered plans based on clinical needs assessments and goals
- Organize and participate in clinical case conferences, multidisciplinary care team meetings and LTC/Skilled nursing ICT/IDT meetings consisting of other health professionals and collaborate to construct a treatment plan that addresses all the members' needs.
- Support complex, care coordination, continuity of care, end of life discussions, and transition of care throughout the continuum.

UM Coordinators

UM Coordinators are non-clinical staff responsible for performing basic administrative and operational UM functions. Clinical staff provides oversight to the non-clinical staff. Their 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
  - Manage and complete UM Member and Provider communications.
  - Complete administrative denials for non-eligibility
- Inpatient UM Coordinators:
  - Monitor and collect facility admissions census data
  - Complete data entry of initial case.
  - Maintain member and provider communications
  - Assist in requesting additional information as needed
  - Review of hospital referral to ensure appropriate case closure
- Ensuring efficient processing for the authorization process and maintain documentation in support of the on-site and telephonic UM nurse staff

Long Term Care, Coordinator

The Long-Term Care Coordinator supports clinical staff through completion of the administrative and nonclinical coordination functions. The Long-Term Care Coordinator is responsible for continuous processing and monitoring of the review and authorization process and ensuring that corresponding documentation is received timely. The Long-Term Care Coordinator is responsible in ensuring the quality and accuracy of any corresponding documentation. Additional responsibilities include:

- Processing and issuing member and provider notifications (mail, fax, electronic media, telephone)
- Establish, facilitate, and maintain effective ongoing relationships with network hospitals, SNFs, delegated groups, vendors and providers; facilitate communication and care coordination between network entities
- Respond to provider, member, and staff inquiries at any given time in a professional and timely manner.

Long-Term Services and Supports (LTSS) Liaison

The LTSS Liaison is trained on the rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies, prompt claims payment requirements, provider resolutions, policies and procedures, and care management, coordination and transition policies. They serve in both a provider representative and care coordination representative role, and support the facilitation of member care transitions, as needed, in collaboration with the LTC team.

Behavioral Health Navigators

The Behavioral Health Navigators are the non-clinical staff responsible for performing basic administrative and operational UM functions for behavioral health services. Behavioral Health Clinical staff provides oversight to the non-clinical staff. Their roles and responsibilities include:

- 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
- Manage and complete UM Member and Provider communications.
- Complete administrative denials for non-eligibility
- Ensuring the efficient processing for the authorization process and maintain documentation in support of the on-site and telephonic Behavioral Health Clinical staff

F. Delegated Utilization Management

The Alliance delegates utilization management 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 findings are summarized at QIHEC 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.

IV. Benefits

Benefit coverage is verified by Utilization Management staff during the utilization review process. The Alliance administers health care benefits for members, as outlined by contracts established for each product line. Medi-Cal benefits are developed by the State of California, Department of Health Care Services (DHCS), and Group Care benefits are developed by the Public Authority of Alameda County. Covered services include but are not limited to:

- Ambulatory Care
- Behavioral health (mental health and substance use disorder services)
- Care Coordination, including for linked and carved-out services, programs, and agencies
- Emergency services
- Hospital care
- Home Health care
- Hospice
- Palliative Care
- Managed Long Term Services and Support (MLTSS)
    - Community-based Adult Services
    - Long-term Care in skilled nursing facilities
    - Intermediate care facility/developmentally disabled (ICF/DD)
    - Intermediate care facility/developmentally disabled-habilitative (ICF/DDH)
    - Intermediate care facility/developmentally disabled-nursing (ICF/DD-N)
- Pharmacy
- Rehabilitation services
- Skilled nursing services - Acute
- Transplant Services
- Transportation
- Pharmacy

A full list of covered services is available to members in the Evidence of Coverage, published online and available in print, upon request. Covered services are provided through a contracted network of providers that include hospitals, nursing facilities, ancillary providers, and contracted vendors. The UM program, in coordination with the Contracting and Quality teams, monitor the adequacy of the Alliance's contracted network to ensure members have access to care within time and distance standards. As needed, contracting arrangements are made with providers outside of the network if Alliance's contracted network is not available to service the need.

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.

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.

V. Utilization Management Information System

The Alliance maintains a core clinical information system, TruCare®, that is utilized by all Utilization Management, Long-Term Care, Case Management and Pharmacy teams. TruCare® is a member-centric application that aligns necessary clinical and administrative information related to members' care into a single chart record and allows seamless multidisciplinary collaboration within a case. The clinical information system tracks all authorized, denied, deferred, and modified service requests and includes timeliness records. Clinical staff, in collaboration with the Information Technology (IT) team, identify opportunities to enhance the functionality of the system and optimize the systems' performance. Thorough vetting processes are established between clinical and IT teams to ensure any enhancements and upgrades to the platform are amenable to all system users. System optimization and upgrades are ongoing as standard practices, including staff training to ensure competence in using the platform and alignment on best practice workflows.

The core clinical information system is designed to ensure the accuracy, confidentiality and security of paper and electronic data and information. The Alliance has comprehensive security controls and established monitoring processes to ensure secure data management, and to prevent inappropriate modification of UM denials, including any inappropriate modification to receipt and denial notification dates.

VI. Clinical Decision Support Tools

A. Utilization Management Clinical Decision Making

Clinical decision-making tools and screening criteria are designed to assist UM staff, and UM-delegated entities, in assessing the appropriateness of care for medical and behavioral health services. Application of the criteria is based on the specific and individualized health care needs of the member (including social determinant of health needs), medical risk factors, and in accordance with the member's plan benefits and capacity of the health care delivery systems.

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 UM, BH, and Pharmacy review staff apply professional judgment during all phases of decision-making regarding the Alliance members. Decision Support Tools are intended for use 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 professional clinical judgment.

All utilization review staff document the clinical review criteria used to support authorization decisions. All decision-making criteria are available to members and providers upon request.

B. Clinical Review Criteria and Hierarchy

Review Criteria

The Alliance adopts the following definition of medical necessity from the DHCS contract:

> ***Medically Necessary*** *or* ***Medical Necessity*** *means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.*
>
> *For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.*

Medical necessity determinations are made based on a consistently applied, systematic evaluation of clinical criteria. The following clinical criteria and hierarchy are applied by UM staff and Medical Directors:

1. Regulatory and contractual guidelines/regulations, including:
    - Department of Health Care Services (DHCS) Medi-Cal Provider Manuals and All-Plan Letters
    - Department of Managed Health Care (DMHC) All-Plan Letters
    - WPATH Standards of Care (SOC) for Gender-Affirming Care
    - LOCUS/CALOCUS, CASII/ECSII/ASAM for Mental Health and Substance Use Disorders
    - 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
2. Evidence based guidelines, primarily MCG®, US Preventive Services Task Force, National Comprehensive Cancer Network, and if needed, UpToDate®[1]
3. Alliance guidelines, as approved through governing committees (including QIHEC and P&T)

[1] a collection of well-referenced topics, guidelines, and updated research. UpToDate® makes updates three times a year, and new information goes through a multilevel peer-review process (Fam Pract Manag. 2003;10(7):49-52)

4. National medical association guidelines (including American Commission of Obstetrics and Gynecology (ACOG), American Association of Pediatrics (AAP), American Diabetes Association (ADA)
5. Independent Medical Review for specialty consultation
6. Medical necessity/medical judgment

The UMC and QIHEC review and approve clinical criteria and hierarchy for clinical decision-making at least annually, and more often as needed for changes and updates.

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 coverage and review processes 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 UMC and Pharmacy and Therapeutics Committee are responsible for evaluating and recommending new technology to the QIHEC. 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.

After QIHEC approves utilization of a new technology or new application of an existing technology, the Alliance adopts the policy and follows all required processes to notify providers. 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.

C. Consistency in Application of Criteria

The Alliance evaluates inter-rater reliability (IRR) to monitor consistency with which physicians, non-physicians, pharmacists, and behavioral health practitioners apply clinical decision-making criteria. It provides a score of how much homogeneity or consensus there is when using clinical criteria to make a medical necessity determination. A full description of the IRR testing methodology is referenced in Alliance policy and procedure QI-133, and the methodology is evaluated at least annually to ensure effectiveness of the IRR evaluation and remediation processes. IRR test results are collated and reviewed by department management, and annually reviewed and approved by the UMC and QIHEC. The Alliance also reviews the IRR process and score reports for delegated entities engaged in utilization management activities.

VII. Utilization Management Processes

The UM Program consists of comprehensive and systematic functions, services, and processes that provide care management to members, including utilization review to determine the medical necessity of covered services. Utilization review procedures are further described below.

A. Communication to Members and Providers

Alliance members, providers, and the public can access information about the UM program in various ways.

Members and providers may contact the UM department to discuss any aspect of the UM program.

- Members may contact the Member Services Department and be warm-transferred to UM management.
- Providers may 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-hour 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 or behavioral health crisis services 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.

The UM voicemail system is secured with password protections, accessible only by designated individuals in the UM department. The facsimile machines used for utilization review information are located within the Department to monitor and protect confidential health information.

The UM program description, and other core documents containing UM policies and procedures, can be found as follows:

- **Provider Manual**: available on the Alliance web site, and in print upon request, 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.
- **Provider Bulletins:** periodic newsletter distributed to all contracted provider sites and delegated groups on topics relevant to the provider community, include new or updated UM policies, procedures, and activities.

- **Member Alert:** a periodic newsletter distributed to all Alliance members; each issue covers different topics of interest to members about their health, and may include information about UM policies and procedures
- **Evidence of Coverage (EOC):** distributed to members, based on their product line, provides details on benefits and authorization processes, including description of members' 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.

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

The Alliance's contracted provider network also provides 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 Alliance provides members the Alliance's nurse advice line and/or a behavioral health crisis service call line, 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.

Emergency health care services are available and accessible within the service area 24 hours a day, 7 days per week. The Alliance provides 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. Inpatient UM Staff are available for extended hours in the Evenings and on Weekends to assist with post-stabilization and/or discharge authorization needs. If an after-hours call is received, but not answered within 30 minutes, the Alliance allows for automatic approval until the member is stable, and UM staff is available to coordinate the transfer of stabilized Members in an emergency department, if necessary.

Emergency health care services, including behavioral 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.

*Prudent Layperson is defined as 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. Additionally, the Alliance provides access to the Alameda County Crisis Services to respond to behavioral health calls after hours. The Alliance will honor health plan coverage for services when directed by any Alliance staff member or delegated representative.

B. Utilization Review Procedures

The Alliance follows all regulatory, contractual, and NCQA requirements to effectively administer utilization review procedures, including decision turn-around times and member and provider notification standards. For services that require prior authorization, the UM process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. Only physicians, pharmacists, or doctoral level behavioral health specialists can make determinations to deny or modify care based on medical necessity.

Services Exempt from Prior Authorization

For both Managed Medi-Cal and Group Care products, there are services exempt from prior authorization. Exemptions include, but are not limited to:

- Emergency Services
- Urgent Care
- Primary Care Visits
- Preventative Services including immunizations
- 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*
- Family planning services, including counseling, pregnancy tests, medications, and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention
- HIV testing and counseling
- COVID-19 testing and therapies

- Second Opinions from In Network providers arranged by the assigned PCP
- Initial Mental Health Assessments
- Early and Periodic Screening, Diagnostic and Treatment
- Biomarker testing for members with advanced or metastatic cancer stage 3 or 4
- Annual Cognitive Assessment for Medi-Cal members over 65 without Medicare

Services Requiring Prior Authorization

The Alliance communicates to all contracted providers the procedures, treatments, and services that require prior authorization. Services that require prior authorization include, but are not limited to:

- Non-emergency/ elective out-of-area care
- Out-of-network care, for services not provided by contracted provider
- Inpatient Admissions if non-emergency/ elective
- Inpatient Admissions to Acute 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 including CT Scans, MRIs, cardiac catheterization, PET
- Durable Medical Equipment, standard or customized; rental or purchased
- Infusion Services
- Medical Supplies
- Prosthetics and Orthotics
- Podiatry services
- Home Health Care, including skilled nursing, nursing aides, rehabilitation therapies, and social workers
- Transplant Services
- Tertiary/Quaternary office visits and consultations at academic centers
- Experimental or Investigational Services
- Cancer Clinical Trials
- LTSS, including Community Based Adult Services (CBAS), LTC in SNF and Subacute facilities, and ICF/DD
- Acupuncture, greater than 4 visits per month
- Chiropractic Services
- Second Opinions from out-of-Network providers
- Select behavioral health services

The Alliance also maintains an auto-authorization scope list that is reviewed and approved annually by the UMC and QIHEC, for services that do not require clinical review. The Alliance routinely analyzes utilization patterns to determine whether it would be in members' best interests to add or remove services from prior authorization requirements. All decisions to adjust prior authorization requirements are reviewed and approved by the appropriate committees (including UMC or P&TC, and QIHEC).

Review Types

Authorizations are processed based on the date the Alliance receives the request. Below are the types of utilization reviews:

- **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** 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 (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. Retrospective requests received within 90 days from the date of service are reviewed for medical necessity. Retrospective received after 90 days from the date of service are denied for not obtaining prior authorization (with limited exceptions, including member eligibility issues, if the services were emergent/urgent, or inpatient services where the facility is unable to confirm enrollment with the Alliance).

Medical Necessity Review

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/doctoral behavioral health specialists 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. 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.

Board certified physician and doctoral level Behavioral Health Specialist 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.

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.

In addition to guidelines and criterion, patient records and conversations with appropriate practitioners are used in the decision-making process. UM staff collects relevant clinical information from health care providers to complete prospective, concurrent, and retrospective utilization review for medical necessity and health plan benefit coverage determinations. The Alliance collects only the minimum amount of information necessary to conduct reviews. 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.

Prospective (pre-service) Authorization Management

Alliance network physicians are the primary care managers for member healthcare services. Based on the member's assignment, authorizations 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. Tertiary/Quaternary evaluations require prior authorization. For services identified as requiring prior authorization, practitioners and providers must submit and coordinate prior authorization for 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.

Practitioners and providers send requests for prior authorization to the UM Department via the Alliance provider portal, mail, fax and/or telephone, based on the urgency of the requested service. Requests 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

Authorization determinations related to Medi-Cal and GroupCare are defined, as follows:

- 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

If non-physician UM reviewers have questions about the medical necessity of services, or the appropriateness of the level of care for service based on clinical criteria and guidelines, the case is referred to the Medical Director/doctoral Behavioral Health Specialist for review. The Medical Director/doctoral BH Specialist, or physician designee, may contact the attending physician to discuss the case, if necessary.

If a Medical Director or physician designee/doctoral Behavior Health specialist determine that requested services are not medically necessary or indicated, a denial determination may be made by the Medical Director/doctoral Behavioral Health specialist. Denial notification and communication to members and providers 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.

Concurrent/Continued Stay Review (including Acute, Skilled, Rehabilitation, Long-Term Care/Custodial, Subacute and ICF/DD)

Concurrent/Continued Stay Review is performed during the course of a member's inpatient stay, which may include acute hospital, skilled nursing, acute rehabilitation and long-term care facilities, to assess the medical necessity and appropriateness of continuation of services at the requested level of care. Concurrent Review is performed

for both contracted and non-contracted facilities. Telephonic, facsimile, or electronic medical record reviews are completed daily, and/or on intervals based on a member's clinical status. If a scheduled review date falls on a weekend or holiday, UM staff coordinate a Concurrent Review on the workday prior to the scheduled review date, or not later than the first workday after the holiday or weekend.

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 Transitional Care Services and ongoing Case Management services.

Continued inpatient care that does not meet continued stay criteria are referred to the Medical Director/doctoral BH Specialist, 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.

Timeliness Standards

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. The Alliance maintains established timeliness standards for medical necessity determinations for routine and urgent Authorization Requests, in compliance with the strictest Regulatory Standards for each Product Line.

Review Type	Managed Medi-Cal	Group Care
Pre-Service – Urgent	72 hours	72 hours
Pre-Service – Routine	5 business days	5 business days
Concurrent	24 hours	24 hours
Retrospective	30 calendar days	30 calendar days

For routine pre-service and retrospective decisions, notifications of the decision must be sent to members within 2 business days and to providers within 24 hours of the decision.

For urgent pre-service and concurrent decisions, notifications of the decision must be sent to members and providers within 72 hours of receiving all information needed to make a decision.

Notice of Action Requirements

Decisions affecting care are communicated in writing to the provider and member in a timely manner, in accordance with regulatory guidelines for timeliness and translation, 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.

For any adverse benefit determination (including denial, delay, modification, termination, suspension, reduction, or carve-out of a treatment or service), the Alliance provides members and providers with a written Notice of Action (NOA). The Notice of Action includes all DHCS-required templates to inform members of their rights, and the content of the notification includes all the following:

a. A statement of the action the Alliance intends to take.
b. A clear and concise explanation of the reasons for the decision.
c. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guideline.
d. The clinical reasons for the decision. The Alliance must explicitly state how the member's condition does not meet the criteria or guidelines.
e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions must be communicated to the member in writing. In addition, with the exception of decisions rendered retrospectively, decisions must be communicated to the provider initially by telephone or facsimile and also in writing.

The NOA includes 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. Providers are informed how to contact and speak with the Medical Director/doctoral Behavioral Health Specialist who made the decision.

The NOA also 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 at no cost.

Peer-to-Peer Review (Discussing a Denial with a Peer Reviewer)

All NOAs for adverse benefit determinations include a name and phone number for contacting the Peer Reviewer, allowing the Requesting Practitioner the opportunity to discuss

issues or concerns regarding the decision. A practitioner can request a peer-to-peer by calling or writing, and the Peer Reviewer will make himself/herself available for discussion of the denial decision within one business day of the receipt of the provider's request. Upon completion of the peer-to-peer, the requesting practitioner can initiate an expedited or standard appeal, as appropriate.

Second Opinions

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 the medical group, a referral is provided within the Alliance's network. If a 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.

Standing Referrals

The Alliance maintains processes to provide members a standing referral to a specialist. The procedure shall provide for a standing referral if the PCP, in consultation with the specialist 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) that has expertise in treating the condition or disease. For Members with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling, the Alliance has procedures to provide a standing referral to a specialist or SCC that has expertise in treating the condition or disease, for the purpose of having the specialist coordinate the Member's health care.

The Alliance may require the PCP to submit a treatment plan during care or prior to the referral, 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 member, 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 during which visits are authorized, or require that the specialist provide the PCP with regular reports on the care and treatment provided to the enrollee.

Standing referrals 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.

Transitional Care Services and Discharge Planning

Transitional Care Services 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/psychiatric/SUD facility.

Transitional Care Services (TCS) refers to activities related to transferring a member from one setting or level of care to another, including but are not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings.

Depending on a member's risk level (high or low), TCS involves the identification of a single point of contact and/or entity to support members through the inpatient stay to the post-discharge period. In collaboration with the discharging facility, TCS also involves completing a discharge risk assessment, facilitating completion, and sharing of the discharge document with the member and appropriate providers, and post-discharge follow-up (including medication reconciliation and appointment scheduling). The discharge document includes the following information:

1. Pre-admission status, including living arrangements, physical and mental function, SUD needs, social support, DME uses, and other services received prior to admission;
2. Pre-discharge factors, including the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge;

3. The hospital, institution or facility to which the Member was admitted;
4. Specific agency or home recommended by the hospital, institution or facility after the Member's discharge based upon Member needs and preferences; specific services needed after the Member's discharge; specific description of the type of placement preferred by the Member, specific description of type of placement agreed to by the Member, specific description of agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling;
5. Summary of the nature and outcome of participation of Member, Member's parents, legal guardians, or ARs in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital, institution, or facility to be included in the Member's Medical Record; and
6. Information regarding available care, services, and support that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.

TCS begins at the point of admission to an inpatient facility, 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/BH staff, assigned TCS Care Manager, health care delivery organizations, and community resources to coordinate care and services.

Additionally, for nursing facility transitions, the Alliance ensures timely transitions that do not delay or interrupt any Medically Necessary services. UM staff coordinate with facility discharge planners and assist members and their authorized representatives by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS, and other Home and Community Based Services (HCBS). Once discharged from the hospital, UM staff verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting, and follow-up with members, as appropriate, to ensure their needs are met.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of high-risk medical/psycho-social issues with potential need for post-hospital intervention, including a discharge risk assessment.
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member's care.
- Communication with 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, assigned TCS Care Manager, and UM staff.

- Referral to Transitional Care Services or Home Health Programs within or outside of AAH programs.

Continuity of Care

Continuity of Care (CoC) provisions ensure 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 provides Continuity of Care with an out-of-network provider according to all applicable laws, regulations, and state guidelines, if the below criteria are met:

- 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 member has seen an out-of-network primary care provider (PCP), behavioral health provider 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. CoC also extends to the following select ancillary providers: physical therapy, occupational therapy, speech therapy, respiratory therapy, and Behavioral Health Treatment (BHT) providers.
- 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 Medi-Cal 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.

As outlined in DHCS APL 23-022, the Alliance also ensures CoC provisions for:

- Durable Medical Equipment (DME) Rentals and Medical Supplies
- Non-Emergency Medical Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Mandatorily enrolled members with active course of treatment
- Newly enrolled members with acute or serious chronic conditions
- Pregnant and post-partum members
- Newborns between Birth through age 36 months
- Members with Terminal Illness
- Members with denied Medical Exemption Requests (MER)
- Members needing to complete a course of treatment with a terminated provider

The Alliance is not required to provide CoC for services not covered by Medi-Cal or those services managed directly by DHCS. In addition, CoC protections do not extend to additional

ancillary services.

The UM staff work with the member's current treating physician and/or PCP to assist the member in continuity of care. For members who are assigned to a Provider Group, if the current treating physician is not affiliated with the existing Provider Group's network, the UM staff works with the Provider Group 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 Provider Group. As needed, members are referred to Case Management for additional support with coordination of care with in-network and out-of-network providers.

Required Reporting

As applicable, UM staff are required to report the following activities during the course of utilization review activities:

- 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 the UM Manager

C. Long-Term Services and Supports (LTSS)

The LTSS Department is an extension of the Utilization Management program, adhering to utilization management procedures as described above. The LTSS department is responsible for the provision of Long-Term Services and Supports, defined in the DHCS contract as:

> *"Services and supports designed to allow a member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS) programs and includes carved-in and carved-out services"*

The LTSS department consists of clinical and non-clinical staff who administer the program, providing oversight & monitoring to ensure adherence to all regulatory requirements and performance standards. Team members work collaboratively with other internal departments (including UM, Case Management, Pharmacy, and Behavioral Health), delegated entities, and safety net providers within the community to deliver timely, appropriate, cost-effective, and quality healthcare to members using LTSS benefits.

Long Term Care (LTC)

DHCS defines LTC as specialized rehabilitative services and care provided in the following

settings:

- Skilled Nursing Facility (SNF)
- Adult subacute facility
- Pediatric subacute facility
- Intermediate Care Facility/Developmentally Disabled (ICF/DD)
- ICF/DD-Habilitative (ICF/DD-H)
- ICF/DD-Nursing (ICF/DD-N)

The LTC Program provides a comprehensive framework for oversight and monitoring of the delivery of healthcare services to members in LTC settings. Its purpose is to:

- Ensure that members in LTC settings are receiving the care and services to meet their needs in the least restrictive environment.
- Comply with State and Federal laws and requirements to assure governmental payors and other regulatory agency guidelines, standards, and criteria are adhered to, as applicable.
- Educate staff, delegates, contracted network providers and facilities on the policies and procedures to ensure compliance with the goals and objectives of the Program.
- Identify institutionalized Members who may benefit from transitioning back to the community with support.
- Optimize the member's health benefits by ensuring and supporting transitional care and coordination of services with the appropriate county/state sponsored programs.
- Monitor care delivery through internal and oversight auditing and monitoring activities.
- Provide Transitional Care Services
- Provide Basic and Intensive Care management, as needed

Community-Based Adult Services (CBAS)

DHCS defines HCBS programs as programs that include but are not limited to HCBS programs authorized under the Social Security Act (SSA) at 42 USC section 1396n(c), the California Medicaid State Plan option authorized under 42 USC section 1396n(k), California Medicaid State Plan HCBS benefits authorized under 42 USC section 1396n(k), and other State and federally funded Medi-Cal HCBS programs.

CBAS is a type of LTSS benefit under the HCBS umbrella of program. CBAS centers offer services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. The Alliance maintains procedures, processes, and mechanisms for administering assessments and re-assessments for CBAS services, including CBAS Emergency Remote Services (ERS), when appropriate.

The Alliance is responsible for ensuring Members who are eligible to receive LTSS, including CBAS, are identified and referred, and dedicates an RN on the UM team to

provide assessment, re-assessment, and re-authorization of CBAS services to members.

D. Behavioral Health Services

Behavioral Health Services are integrated with the Utilization Management program, adhering to utilization management procedures as described above and ensuring parity between medical and behavioral health services. 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-based services, free-standing and hospital-based programs, residential treatment programs and facility based acute care treatment units. Medical necessity is determined by applying level of care criteria, while the clinical appropriateness of services is evaluated using criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.

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. For Medi-Cal beneficiaries, Alameda County Behavioral Health Care Services (ACBHCS) provides Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) services. The Alliance provides mild-to-moderate behavioral health and substance abuse services not covered through ACBHCS. The Alliance also provides Behavioral Health Therapy (BHT) services for Medi-Cal members under the age of 21 for the treatment of Autism Spectrum Disorder and other conditions where excessive and/or deficits of behaviors significantly interfere with home and community activities. The Alliance provides behavioral health utilization management activities and maintains the provider network for behavioral health and substance abuse services.

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.

Behavioral Health Treatment Coverage

The Alliance is responsible for providing Early and Periodic Screening, Diagnosis, and Treatment (Medi-Cal for Kids and Teens,) 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 children with any diagnosis including 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.

Behavioral Health Integration

Members may contact the Alliance Behavioral Health Service department 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 QIHEC meetings to support, advise, and coordinate behavioral healthcare aspects into UM Program policies, procedures, and processes.
- The Senior Director of Behavioral Health Services directs all aspects of the BH program to ensure that the program meets all regulatory requirements and integrates with the UM Program, Case Management Program, Member Services, and other departments within the Alliance.
- 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 generates clinical reports reflecting metrics and outcomes of the Behavioral Health Services program, which are reviewed and acted upon as needed at appropriate AAH Committees and QIHEC.
- The Alliance participates in periodic operational meetings with ACBHCS to review and coordinate administrative, clinical, and operational activities.

E. Pharmacy Management

The pharmacy benefit for Medi-Cal members is carved-out and administered by the DHCS Medi-Cal Rx program. Non-capitated carved-out drugs, such as HIV/AIDS/Hepatitis B treatment drugs, alcohol and heroin detoxification and dependency treatment drugs, Blood Factors: Clotting Factor Disorder Treatment and psychiatric drugs are covered by Medi-Cal Fee-For-Service Intermediary.

For those pharmacy benefits that are not carved-out to Medi-Cal Rx and for Group Care members, the Alliance ensures the provision of pharmacy management to a pharmacy benefit manager (PBM). 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 (PA) 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 regulatory requirements. Pharmacy UM decision monitoring is reported through the UMC.

F. Linked and Carved Out Services

Linked and carved-out services are those that are not covered by the Alliance but are still available to Alliance members through other Medi-Cal programs. The Alliance provides linkages with such 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 specific program Memoranda of Understanding (MOU) with community agencies, such as the California Children's Services and the Regional Center of the East Bay (RCEB).

UM staff and delegated entity practitioners identify members who may be eligible for services, and coordinate referral to appropriate 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 transition to other care, if necessary, when benefits end. This includes informing members about other sources to continue care.

VIII. 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 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.

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

Medi-Cal Members are covered for medically necessary organ transplants, including related services such as organ procurement and living donor care. Coverage provisions are as follows:

a) The Alliance covers the following Major Organ Transplants: bone marrow transplant (BMT), heart, heart/lung, kidney/pancreas, liver, liver/small bowel, lung, pancreas, and small bowel. The Alliance also covers kidney and corneal transplants.
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 CCS-eligible members to the transplant Special Care Centers (SCC) for review and follow-up.
c) For member 21 years of age and older, Major Organ Transplant evaluations are referred to a Medi-Cal approved Center of Excellence (CoE) on the most recent DHCS CoE list of facilities. The Alliance authorizes the request for a transplant after the transplant program confirms the member is a suitable transplant candidate.
d) Kidney and corneal transplants are provided through Alliance-approved practitioners. 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.

B. 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 the 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 authorizations.

Palliative care services follow the utilization review procedures as described above. 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.

IX. UM Program Monitoring and Oversight

A. Evaluating Program Effectiveness

The effective of the UM Program is monitored through quality assurance activities that support positive medical and behavioral health outcomes, and continuous quality improvement. The CMO guides these activities in collaboration with the Senior Director, Health Care Services, the Senior Director, Behavioral Health, the Senior Director, Quality, and the Director of Accreditation, with oversight by the QIHEC. Performance results are analyzed and reviewed, with opportunities for improvement identified for intervention and performance management. The following quality assurance activities are conducted:

- Monitoring Under and Over Utilization (used to inform activities related to network adequacy)
- Monitoring Utilization Review Measures
- Monitoring Internal Operational Quality Measures
- Monitoring Member Experience with the UM process
- Monitoring Grievances and Appeals (including Overturns)
- Monitoring Potential Quality Issue (PQIs), including Provider Preventable Condition identification and referral
- Operational Quality Audits
- Delegation oversight, including monitoring of Corrective Action Plans (as applicable)

Data sources used for quality assurance activities may 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.

Utilization Review Measures

The Alliance monitors, measures, and evaluates utilization review procedures as follows:

- Volume of authorization requests, including determination status
- Denial Rate (the established threshold is 5% denial rate)
- Compliance with timeliness standards (the established threshold is 95% compliance)
- Compliance with NOA requirements, including appropriate content and enclosures

Internal Operational Quality

The Alliance UM Department conducts ongoing auditing and monitoring of key operational functions to ensure compliance with all federal, state, regulatory, contractual and accreditation standards. The monitoring process allows for early identification of compliance risks and opportunities for retraining of staff. Internal quality monitoring consists of monthly, and as-needed, audits as follows:

- **UM File Review**: Files are assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement. 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 criteria, and appropriate referral to physician reviewers, as applicable. For cases that are denied or modified, the file is also assessed for the NOA requirements for communication to the member and provider.

- **Authorization Turn-Around-Time (TAT):** An authorization aging report is used to monitor TATs for authorizations. Any open authorization without a final determination will appear in this report. The UM Manager or designee monitors the report daily to ensure all authorization determinations are compliant with UM TATs.

Monitoring Over and Under Utilization

The Alliance monitors potential over and under-utilization of covered services (including medical and behavioral health services), based on population and member-specific analysis of service utilization trends. Assessment and monitoring of Over and Under Utilization is a collaborative effort between the Quality Management and UM Department. The UM Department monitors over- and under-utilization for:

- Emergency Room Visits
- Acute Inpatient Hospitalizations
- Specialty and Ancillary visits (including out-of-network activities)
- Unused Authorizations

In the absence of national or regional benchmarks, the Alliance monitors monthly, quarterly, and annual utilization data (including claims, encounters, and authorizations) for significant trends. Root cause analysis is conducted to determine potential drivers

for trends, and recommendations are presented to the UMC and QIHEC, at least quarterly. Insights from committee members are used to identify opportunities for improvement, as necessary.

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 staff and Medical Directors. Trending data for clinical appeals and fair hearings is reported to the UMC to identify opportunities to improve the UM experience for members and providers.

Potential Quality Issues

At any time during the utilization review process, staff may identify a condition or situation that appears to deviate from the professional standard of care. In such instances, a Potential Quality Issue (PQI), including Provider Preventable Conditions, is referred to the Quality Improvement Department to be evaluated per policy and procedure.

Member and Provider Experience with Utilization Management

Annually, Alliance members and providers are surveyed to assess their experience with the utilization management processes and services. Satisfaction surveys assess the efficacy of the UM program from the perspective and experience of members and providers.

- **Member Experience:** The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by mail to Alliance Medi-Cal members. UM program efficacy is evaluated using the below composite measures:
  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

- **Provider Experience:** 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:
  1. Access to knowledgeable UM staff.
  2. Procedures for obtaining prior authorization information.
  3. Timeliness for obtaining prior authorization information.
  4. The Plan's facilitation/support of appropriate clinical care for patients.
  5. Degree to which the Plan covers and encourages preventive care and wellness.

  The Alliance conducts quantitative and qualitative analysis to identify areas for improvement. Survey outcomes, analysis, and recommendations are presented to the UMC and QIHEC to assist in identifying opportunities for improvement. The Alliance

UM Department actively participates in ideation to improve the member and provider experience with the UM process.

Delegation of Utilization Management Activities

The Alliance provides covered services to members through a delegated network. For UM-delegated entities, the Alliance has shared-risk arrangements, meaning the delegated entity is typically responsible for outpatient authorization reviews, while the Alliance UM Department is typically responsible for certain outpatient and inpatient authorization reviews. UM-delegated entities perform utilization management activities based on their contract, which includes agreements on divisions of responsibility.

The Compliance Department is responsible for monitoring and tracking the overall performance of delegates, including completion of annual audits. UM department staff review the UM components of the annual audit, which includes a review of delegates' policies and procedures and member case files. The UM team also reviews the delegated entities annual work plans/evaluations, and other standing reporting activities, as required. The Compliance Department is responsible for finalizing the audit findings. For entities that do not meet thresholds, a corrective action plan may be issued and tracked to ensure adequate resolution of the deficiency. All audit findings are reported to the Compliance Committee and the QIHEC.

Annual UM Evaluation

The Chief Medical Officer, the Senior Director, Health Care Services, and the Directors of UM and LTSS collaboratively conduct an annual evaluation of the Alliance UM program. 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
- Recommendations for program enhancements

The results of the annual program evaluation are reported to the UMC and QIHEC for review and feedback. The UMC and QIHEC make recommendations for actions and/or interventions to improve program performance, as appropriate.

Annual UM Workplan

Each year, the Alliance establishes objectives and priorities based on findings from the Annual Program Evaluation and outlines a strategic workplan for the coming year. The workplan incorporates goals, measures, anticipated completion timeframes, and responsible parties, and is maintained throughout the year to monitor progress towards goals and adjust goals, as necessary. The CM workplan is reviewed and approved by the UMC and QIHEC annually.

B. Summary of Program Enhancements in 2024

Operational Efficiency and Compliance:

Inpatient and Outpatient UM:

- Continued monitoring and process improvements to meet NOA compliance
- End-to-end authorization system enhancements to streamline authorization processing and eliminate manual workarounds
- Continued evaluation of services that do not require prior authorization with goal to remove unnecessary reviews
- Continue the Tertiary Quaternary Policy
- Develop Authorization and claims stay level configuration for inpatient levels of care and facility types
- Validate different network contracting to ensure accurate out-of-network utilization is reflected in Plan analytical reports and aligned with Delegate utilization reporting.
- Increased alignment with case management, specifically related to transitional care services in alignment with DHCS population health management policy guide

LTSS:

- Hire LTSS Medical Director to provide dedicated LTSS clinical leadership support
- Continued monitoring and process improvements to meet TAT compliance goals
- Successful implementation of LTC care management program, including transitional care services in alignment with DHCS population health management policy guide
- Improve facility awareness to notify the Alliance about changes to LTC member Transition of Care status, and timely Bed Hold and Admission LTC authorizations.
- Continuing to collaborate with LTSS liaison and provider services to establish relationships with facility partners, including consistent onsite facility visits from LTSS social workers
- Ensure the Quality Management department develops quality performance measures for LTC facilities

Pharmacy Services:

- Investigating utilization of unclassified drugs and unclassified biologics for drug utilization patterns and appropriate coding.
- Fully transition Advisor Reviews for Physician Administered Medications/Injections from Alliance Medical Directors to Pharmacists

Behavioral Health Services:

- Enhance process defects impacting TAT performance and implement interventions to meet TAT goals in 2024.
- Increase access as measured by an increase in unique utilizers of mental health and BHT/ABA services.
- Ensure that Contracting continues to increase network capacity, particularly for ABA services.

G&A:

- Continued monitoring appeals for Carpal Tunnel Surgery during Q1 2024 to see if the overturn trend continues and warrants continued education and ongoing monitoring.

Delegated Utilization Management:

- Partner with the Compliance Department to evaluate audit tools and establish metrics that align with The Alliance's key performance indicators.
- Monitor and support Delegate CAP activities, in coordination with the Compliance Department
- Validate different network contracting to ensure accurate out-of-network utilization is reflected in the Plan's analytical reports and aligned with Delegate utilization reporting.
- Provider regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance's Population Health Management strategy

Quality Improvement

Management of Emergency Room Utilization:

- Continue collaboration with Quality Management and Population Health Management team to ensure access to post-discharge care, particularly with primary care providers.
- Monitor diagnosis drivers for emergency room visits, especially for repeat utilizers and for facilities with high emergency room rates.
- Monitor PCP primary care homes for facilities with high ER rates and for repeat utilizers and facilities with high emergency room rates: Identify Teledoc opportunities and those diagnoses that could be managed in primary care offices.
- Track ED utilization that is associated with members who readmit to the hospital, for case escalation to the Case Management department and supports.
- Increase collaboration with Behavioral Health team and Alameda County Behavioral Health Services to support access to necessary BH/SUD treatment

Management of Acute Hospitalizations:

- Expand ADT feeds and comparable data sharing sources for acute hospitals that are not yet established (Stanford, UCSF, Childrens Hospital).
- Build staffing capacity to manage new membership and inpatient volume for new Long-Term Care higher utilization and 2024 Managed Care Plan to Managed Care Plan and Fee-For-Service Medi-Cal Transitions
- Improve identification members who are at-risk for readmission or who re-admitted, including revision of risk-stratification methodology, and use of additional data sources as available to DHCS or community-based partners

- Implement Inpatient MCG medical necessity criteria trainings, particularly for extended stay evaluations and develop updated UM standard workflows for care optimization
- Provide training on referral criteria and referral process for Enhanced Care Management and Community Supports, with goal to link members to appropriate resources for next level of care
- Foster continued collaboration and relationship building with hospital and skilled nursing facility partners to support discharge management, and complex case rounds for members with long length of stay or complex discharge barriers.
- Coordinate collaboration between the Alliance and its delegates around identifying Potential Quality Issues, Avoidable days variance, Provider Preventable Conditions, and preventable readmissions
- Expand screening for appropriate Case Management referrals for palliative/hospice eligible members

Management of Specialty Care Utilization:

- Monitoring elective hospitalizations, Inpatient hospitalizations through the emergency room, Hospital transfers for higher level of care, and provider visits and ancillary services, related to established with the Oncology and Transplant Program enrollment.
- Continued partnership with Contracting team to provide insights on network needs, based on utilization patterns and identified access barriers, especially for tertiary and quaternary academic centers.

Management of Unused Authorizations:

- Continued partnership with Contracting team to provide insights on network needs, based on utilization patterns and identified access barriers
- Continued monitoring and root-cause analysis of unused authorizations

Member and Provider Satisfaction with UM*:*

- Streamline and improve the accessibility of prior authorization information to providers, including increase visibility of authorization details on public portals and secure online platforms
- Ensure providers receive appropriate training to access the resources
- Participate in the review of satisfaction survey data for measurement year 2023, using those survey insights to further inform process improvement efforts