ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	UM-004
Policy Name	Over and Under Utilization
Department Name	Health Care Services
Department Officer	Chief Medical Director
Policy Owner	~~Sr. Director of Health Care Services~~Director Utilization
Lines of Business	All
Effective Date	01/01/2008
Subcommittee Name	Health Care Quality Committee
Subcommittee Approval Date	~~5/19/2023~~TBD
Compliance Committee Approval Date	TBD~~6/20/2023~~

OVERVIEW

Alameda Alliance maintains processes and mechanisms to monitor, detect, and correct Over/Under Utilization of Medi-Cal and Group Care services to ensure appropriate access, quality, and appropriateness of care.

POLICY

1. Alameda Alliance maintains processes and mechanisms to monitor, detect, and correct Over/Under Utilization of Medi-Cal and Group Care services to ensure appropriate access, quality, and appropriateness of care.

2. The over- and under- utilization review process is a component of the UM Program Evaluation and Work Plan.

3. Over/Under Utilization Monitoring/Detection/Correction processes shall include, but are not limited to:
   a. R~~r~~eview of services for appropriate and cost-effective patient care for detecting/correcting over- and under-utilization.
   b. R~~r~~eview for inappropriate utilization and/or care provided in an inappropriate setting(s) that may be indicative of barriers to health care services.
   c. M~~m~~onitoring over- and under- utilization for selected activities using UM measures to identify potential patterns and trends.

4. The UM Committee (UMC) is responsible for the review and analysis of network

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trend reports to identify potential areas of under- and over- utilization of services. These reports include, but are not limited to:

a. Ambulatory services (e.g., primary care visits, specialist services, preventive health care services and emergency room visits~~,~~)
b. Acute hospitalization (e.g., bed days, average length of stay and discharges)
c. Out of network activities (e.g., specialist services, behavioral health care)
d. Behavioral health utilization data
e. Pharmacy utilization (e.g., antibiotics, emergency service usage, opioid use, medication management, etc.)
f. HEDIS use of service metrics.

5. The UMC is responsible for identifying and adopt available industry benchmarks to measure network performance.

6. The UMC is responsible for developing and monitoring corrective action plans developed to address noted deficiencies.

~~7.~~ Reports will be presented to the UM Sub-Committee and Quality Improvement Health Equity Committee (QIHEC) ~~Health Care Quality Committee (HCQC)~~ for review, comment, and consideration of utilization control strategies.

~~8.~~7. The internal reporting mechanisms used to detect member utilization patterns shall be reported to the Department of Health Care Services (DHCS) upon request.

~~9.~~8. The Compliance and Utilization Management Department are responsible for the review and annual update to policies for compliance with regulatory and contractual requirements.

a. All policies will be presented and approved by the UM Sub-Committee and Quality Improvement Health Equity Committee. ~~Healthcare Quality Committee.~~

PROCEDURE

1. Reports are generated from data from various sources:
   a. Authorization data systems
   b. Claims and payments.
   c. Encounter data
   d. Medical records

2. The data is compared to available sources of comparable data and benchmarks that are external to Alameda Alliance:
   a. Internally developed performance measures e.g., Admits per 1000, Bed-days per 1,000, ER Visits per 1000.
   b. DHCS-established Minimum Performance Levels (MPLs) and High Performance Levels (HPLs).

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c. National Medicaid HEDIS results for the 25th and 75th percentiles for measures related to over and under-utilization.
d. Previous year's network performance
e. CMS benchmarks when applicable
f. NCQA 75th percentile for industry standards
g. MCG criteria when applicable

3. The Behavioral Health department collects utilization management statistics, on at least a quarterly basis, to assess potential areas of under- or over-utilization of services.
   a. Out of Network Behavioral Health Data is collected by Behavioral Health department and is submitted to Alameda Alliance UMC on a quarterly basis.
      i. These data are reviewed by the Utilization Management Committee, which oversees the process for appropriate utilization of services.
      ii. Findings are reported at both the Utilization Management and the Quality Improvement Health Equity Committee meetings because both quality and utilization components are included.
      iii. Detailed analysis may be conducted to determine the root cause of an identified trend.
      iv. Interventions are developed and approved by the Utilization Management and Quality Improvement Health Equity Committees and carried out by assigned departments.

4. Aggregation of all out of network data including Alameda Alliance and delegates.~~,~~
5. Alameda Alliance generates monthly reports to monitor the network performance with the established measures, which is reported at least quarterly.
   a. A statistical report is generated for outlier practitioners.
      i. A Practitioner Corrective Action Plan is developed as appropriate for outlier providers.
   b. A statistical report of network adequacy is generated.
      i. A referral to Provider Services is made when network adequacy problems are identified.
6. Data from the monthly analysis is submitted as part of the UM Work Plan to the UMC for discussion and recommendations for addressing outlier results.
7. The results and the UMC recommendations are forwarded to the Quality Improvement Health Equity ~~Care Quality~~ Committee.
   a. For the process of measuring potential under- utilization of primary and preventive services in capitated setting, UM and Data Analytics collaborate to perform the following selected measures Out of Network specialty utilization.
      i. Out of Network behavioral health utilization
   b. Monthly or bi-monthly encounter data are reviewed

DEFINITIONS

None

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Quality Management
Health Care Analytics
Behavioral Health

RELATED POLICIES AND PROCEDURES

1. UM Program Description
2. UM-001 Utilization Management Program
3. UM-047 UM Sub- ~~UM~~ Committee
4. Quality Improvement Health Equity (QI~~M~~ HE) Program Description
5. QI-101 Quality Improvement Health Equity Program~~Program~~
6. QI-111 Delegation Management and Oversight
7. BH-002 Behavioral Health Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

NONE

REVISION HISTORY

1/1/2008, 10/28/2009, 8/24/2012, 4/4/2014, 1/10/2016, 12/15/2016, 10/12/2017, 5/3/2018, 7/19/2019, 3/18/2021, 3/22/2022, 6/20/2023

REFERENCES

1. 28 California Code of Regulations 28 CCR 1300.70(a)(1); 28 CCR 1300.70(b)(2)(G)(5); 1300.70(b) (H)(2)
2. DHCS Contract Exhibit A, Attachment 4, Section 9.B

MONITORING

The Utilization Management (UM) team monitors, tracks, and analyzes utilization statistics to detect over and under-utilization and reports its findings, with recommendations quarterly to the UM Committee and Health Care Quality Committee (HCQC).

The HCQC will develop corrective action plans for UM team implementation, when appropriate, based upon that analysis.