**2024**

**Utilization Management Program**

**Utilization Management Program Description**

Purpose

The Utilization Management (UM) Program is designed to manage the use of health care resources and to maximize the effectiveness and quality of the care provided to our enrolled Members. It is designed to promote appropriate, safe, and consistent utilization management decision- making. The Program also defines the process and structure whereby Medical Management staff and the Delegation Oversight Committee (DOC) conducts oversight of delegated activities. The Utilization Management Program interfaces with the plan’s quality management system to facilitate the achievement of its goals and objectives.

Goals

1. Provide members with equitable access to care across the Plan’s networks.
2. Ensure that qualified health professionals using appropriate clinical information and criteria sets make appropriate utilization management decisions.
3. Establish standards for the timeliness of utilization management decision-making.
4. Ensure that the reasons for any utilization management denial are clearly documented and communicated to members and practitioners.
5. Establish mechanisms for evaluation of member and practitioner satisfaction.
6. Provide, arrange, or otherwise facilitate emergency services.
7. Establish processes to ensure that the Plans Drug Formulary is based on member's need, sound pharmacological advances driven by clinical evidence, and is reviewed and updated at specific intervals.
8. Establish processes to monitor and oversee utilization of high-risk procedures and services.
9. Establish review processes to ensure that members are provided with access to the most current and appropriate medical interventions utilizing criteria for determining medical and behavioral health appropriateness that are based on sound clinical evidence, which are clearly documented and able to meet the needs of individual patients and characteristics of the various regional delivery systems.
10. Develop and update written clinical guidelines and clinical review criteria based on sound clinical evidence and illustrate procedures for applying these criteria in an appropriate manner to ensure that current technology and scientific evidence is used in the utilization review decision.
11. Develop processes and tools for discharge planning and other utilization management functions to improve efficiency, coordination of care, continuity of care and standardization of application.
12. Monitor utilization of selected services for potential under-or over-utilization against thresholds and provide feedback to improve the provider’s knowledge of current medical evidence in order that the provider can measure his/her own effectiveness to thresholds.
13. Establish processes to collect and periodically monitor data, implement interventions, and measure results of the interventions for effective strategies to achieve appropriate utilization.
14. Identify and intervene when quality of care issues is identified individually or through delegated entity utilization management review of over-or under-utilization.
15. Comply with all applicable federal and state laws, rules, regulations, and applicable accreditation requirements.
16. Consider the feasibility and desirability of exempting certain Participating Physicians from certain administrative requirements based on criteria such as physician’s delivery of quality and cost-effective medical care, accuracy, and appropriateness of claims’ submissions.

Scope

1. Overview

The UM Program is designed to manage the use of health care resources and to maximize the effectiveness and quality of the care provided to our enrolled Members. Utilization Management Program includes pre-service, concurrent review, discharge planning and post service review of inpatient and outpatient services. The scope of services also includes, but is not limited to:

* 1. Pharmaceutical management.
	2. Management and authorizations for institutionalized members, including care coordination to return to a community or home environment.
	3. Ambulatory and inpatient surgery and diagnostic procedures.
	4. Chiropractic care.
	5. Home health care
	6. Diagnostic and interventional radiology procedures
	7. Behavioral health services
	8. Durable medical equipment/prosthetics and orthotics
	9. Emergent and urgent services
	10. New technology assessments
	11. Palliative Referrals
	12. Hospice referrals
1. Delegation

The Community Health Plan of Imperial Valley (CHPIV) delegates the UM Program to an external Managed Care Organization partner, hereby designated as “The Plan”. CHPIV delegates many other health services functions to the Plan: Appeals and Grievances, Quality Improvement Health Equity, Care Management, Population Health, Pharmacy, Behavioral Health. CHPIV also delegates Members Services as well as Provider Network development to the Plan.

CHPIV evaluates the Plan’s ability to perform UM functions by means of a robust delegate oversight process. In its delegate oversight process, CHPIV performs continuous monitoring and regular audits. CHPIV has designated UM auditors specially trained to perform these evaluation functions. UM auditors evaluate and monitor delegated entities annually, or more frequently if needed, to ensure compliance with Federal, State, Contractual, applicable National Committee on Quality Assurance (NCQA) and The Plan’s criteria for delegated activities. When the monitoring and auditing process identifies gaps between performance targets and actual performance, root cause analysis will be completed, and corrective action plans (CAP) created. Follow up monitoring and auditing are performed to ensure the CAPs are completed and performance gaps are resolved.

1. Impact

The UM Program impacts:

* 1. Members
	2. Network Providers and Practitioners
	3. Aspects of Care – including level of care, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and service
	4. Services covered by CHPIV - including preventive care, primary care, specialty care, telehealth, ancillary care, emergency services, behavioral health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, Health Homes Program (HHP), long term care (LTC), Long Term Services and Supports (LTSS): Community Based Adult Services (CBAS)
	5. Internal Administrative Processes – relating to care management services, utilization review activities, and quality improvement.
1. Functional Areas
	1. Standing Referrals to Specialty Care

CHPIV ensures Members timely Standing Referrals for specialized medical care over a prolonged period, specific to those with a condition or disease that may be life-threatening, degenerative, or disabling. A Standing Referral allows the member to obtain care without requiring a specific referral for each visit.

* 1. Second Opinion

CHPIV ensures that Members are provided with second opinions in accordance with California state and Federal Regulations. CHPIV ensures that Members may obtain a second opinion from a qualified health care professional. If an appropriate professional is not available in-network, CHPIV will ensure arrangements for the member to obtain a second opinion out-of-network at no cost to the member.

* 1. Pre-Service Decisions

Pre-service decisions include both the initial determination of requests for immediate, urgent, and non-urgent services and requests for continuation of services previously approved. Preservice decisions are required for elective inpatient admissions, referrals for selected ambulatory surgery, home health care (where applicable), durable medical equipment, home IV infusion, and selected diagnostic and radiology procedures.

CHPIV ensures a structured approach to pre-service decisions. The purpose of obtaining a preservice decision is to prospectively evaluate the proposed services to determine if they are medically necessary, covered by the member’s benefit plan, the most current and appropriate medical interventions utilizing criteria for determining medical and behavioral health appropriateness that are based on sound clinical evidence, provided by a contracted practitioner or provider, where appropriate or possible, and provided in the most appropriate setting.

* 1. Utilization Management Decision Process

In the utilization management decision process, established guidelines and clinical criteria used to guide utilization management decision-making and medical necessity determinations. The following list describes a general hierarchy relevant to utilization management decisions:

1. Federal Law
2. State Law/Guidelines
3. Plan-specific/Vendor-specific criteria
4. Plan-specific Clinical policies
5. Nationally recognized decision support tools
6. Professional standards/Published standards/Medical Association publications

Typically, guidelines and clinical criteria are reviewed at least annually.

CHPIV ensures maintenance and adherence to a robust utilization management decision process.

* 1. Medical Necessity

The term “Medically Necessary” includes all Covered Services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. Furthermore, for Members under 21 years of age, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services are considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services.

CHPIV ensures that UM decision-making will always include medically necessity consideration.

* 1. Benefit Determinations

CHPIV ensures adherence to guidelines for benefit determinations:

1. Medi-Cal Benefit Plan Contract
2. Applicable State and Federal Requirements
3. Member Handbook/Evidence of Coverage
4. Preferred Drug list (PDL)

	1. Prior Authorization List Maintenance

CHPIV ensures periodic reviews of the list of procedures, services, and items on the Prior Authorization (PA) list in accordance with a national or state developed methodology to determine appropriateness for inclusion and potential deletions to the list.

* 1. Inpatient Facility Concurrent Review

Concurrent Review (CCR) is an assessment that determines medical necessity or appropriateness of services as they are rendered, i.e., an assessment of the need for continued inpatient care for hospitalized patients. CHPIV ensures that the CCR supports Member’s and the Member’s Healthcare Team by ensuring:

1. Services are accessed in a timely manner
2. Education to the Member’s healthcare team on the Member’s benefit structure and resources
3. Facilitation of expeditious authorizations of services when appropriate
4. Facilitation of referrals to appropriate Member resources, such as Behavioral Health, Case Management, and/or community resources
	1. Discharge Planning

The Plan, the behavioral health administrator, and/ or delegated entities conduct and facilitate member discharge planning to promote continuity and coordination of care in conjunction with the member’s practitioner(s), the member, and the member’s family to ensure a timely and safe discharge. Discharge planning begins pre-service or on the first day of the member’s inpatient admission, whenever possible.

CHPIV ensures that discharge planning is administered in a Member-centric manner with adherence to Federal and state regulations as well as to nationally-recognized guidelines. Discharge planning includes, but is not limited to:

1. Assessment of continuity of care needs.
2. Assessment of member's support system to determine necessary services.
3. Development of a plan of care based on short-term medical/psychosocial needs.
4. Coordination and implementation of services requested in the plan of care.
	1. Inpatient Management

CHPIV ensures that Members receive inpatient care management as necessary while they are hospitalized. Reviews may be conducted via telephone contact with facilities’ UM staff or the member’s attending physicians or through onsite facility reviews.

* 1. Transition Management

The purpose of Transition Management (TM) is to provide a comprehensive, integrated transition process that supports Health Net’s members during movement between levels of care. The TM process strives to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a patient centric approach, the TM process incorporates three evidenced based care elements of inter-disciplinary communication and collaboration, patient/participant engagement and enhance post-acute care follow-up. After the post discharge period, the transition of care staff performs a warm hand off for continued case management needs as necessary. Benefits of the TM process include:

1. Increasing member engagement reduces risk of adverse post discharge outcomes and/or readmission
2. Positive experience with Transition Management increases member satisfaction
3. Coaching interventions encourage active participation of the member/member’s representative in the health care continuum. Member becomes more apt to take an assertive role in his/her own care.

CHPIV ensures that a robust TM program is available to all Members.

* 1. Post-Service Review

The post-service review process involves a review of medical records when services that required prior authorization were rendered having not been previously authorized. CHPIV ensures that a robust post-review process is used to evaluate the request for payment against documented evidence that the member received the services and that services meet clinical criteria for medical necessity and were provided within the context of the Medi-Cal benefit contract.

* 1. Access

CHPIV will ensure the Plan’s UM, Care Management, and Provider Network Management work closely to ensure that ensuring the Plan attains adequate network needed to support the membership’s health care needs.

* 1. Behavioral Health Care Services

The core objective of Behavioral Health UM is to manage the available behavioral health care and SUD benefits to achieve the best possible clinical outcomes for members. The Plan has developed a clinical infrastructure to support the core objective:

1. Treatment in the least restrictive setting at which safe and effective treatment can be rendered; this helps to preserve and foster as much independence, freedom and autonomy for the patient as possible
2. Multidisciplinary cooperation to incorporate the unique perspectives and skills of behavioral health disciplines
3. A systems orientation which views the Member as an integral part of his/her family, job social system and community network, all of which may be involved in the treatment plan
4. The behavioral health/SUD utilization management program encompasses pre-service, concurrent, and post-service review for inpatient, alternative and some outpatient care of Health Net members. Licensed professionals and Care Managers coordinate these activities.
5. A behavioral health/SUD physician or appropriate behavioral health practitioner such as a doctoral-level clinical psychologist makes all medical necessity decisions.

The Plan provides centralized triage and referral for behavioral health services which are implemented, monitored and professionally managed by:

1. Making triage and referral decisions according to protocols that define the level of urgency and appropriate setting of care.
2. Adopting triage and referral protocols that are based on sound clinical evidence and currently accepted practices within the industry. Reviewing and revising, as needed, protocols and guidelines every year.
3. Ensuring that a licensed psychiatrist or an appropriately licensed doctoral-level clinical psychologist experienced in clinical risk management oversees triage and referral decisions.

CHPIV ensures delegate oversight over the Plan’s Behavioral Health Services program.

* 1. Continuity and Coordination of Care

	The Plan implements mechanisms to monitor, evaluate, and facilitate continuity and coordination of care for enrolled members. These mechanisms include:
1. UM Care Managers may refer members in need of multiple health resources to Complex Care Management.
2. Continuity of Care services are provided for newly enrolled members as well as current members whose providers leave the network, based on product line and state regulations. Typically, Continuity of Care is requested by new enrollees or the current enrollee when a provider terminates its contract with Health Net. Following the policies and regulations, the members referred into Case Management receive care as reasonably necessary to affect a safe transition to a contracted provider.

CHPIV will ensure maintenance of a robust Continuity and Coordination of Care program.

* 1. Separation of Medical Decisions from Fiscal or Administrative Concerns

CHPIV ensures that the UM program’s medical decisions made by the Health Plan or downstream delegates are not influenced by fiscal or administrative concerns. To accomplish this:

1. UM-decision making is based on appropriateness of care, service, and existence of coverage (medical necessity and medical appropriateness).
2. Practitioners or other individuals conducting utilization review are not specifically rewarded or compensated for issuing denials of coverage or service care.
3. The Plan distributes a statement describing its policy on financial incentives to all appropriate practitioners, providers, members and employees who make utilization decisions.
4. None of Health Net’s Medical Directors report to Health Net’s Chief Financial Officer or Marketing Director.
	1. Standards of Timeliness

The Plan has established standards and timeframes (as dictate by regulations) for decision-making and notification to accommodate the clinical urgency of the request/situation for behavioral and non-behavioral health UM decisions. Member correspondence will be offered to the members in an appropriate reading-level, cultural, and linguistic manner. CHPIV ensures that decision-making and notification continue to meet established standards and timeframes.

* 1. Denials

When UM medical necessity criteria is not met, the Member case is referred to appropriate clinical practitioner, i.e., Medical Director, Behavioral Health Practitioner (Psychiatrist or doctoral-level Clinical Psychologist), or a Pharmacist. If it is confirmed that medical necessity is not met, the decision by the appropriate clinical provider may result in a denial.

Clear reasoning must be given for the denial. Members, practitioners, and providers receive written notification of all denials in accordance with all regulatory guidelines. Denial notification letters include at a minimum:

1. Reason for the denial in easily understandable language
2. Reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based
3. Notification to the member that they are entitled to receive, upon request, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based on, as applicable
4. A list of titles and qualifications of individuals participating in the denial review
5. Description of the appeal mechanism and/or right to a fair hearing
6. Alternative recommendations, when appropriate

Should the requesting practitioner wish to discuss the case related to the denial decision, they are provided with the telephone number of the individual who issued the denial.

CHPIV ensures a robust process for establishing, processing, and communication of Member case denials.

* 1. Over/Under Utilization

CHPIV ensures that the Plan can detect and correct potential under- and over-utilization of health care services, including behavioral health services, by:

1. Monitoring and routinely analyzing utilization data collected to detect potential under- and over-utilization.
2. Implementing appropriate interventions when problems are identified
3. Measuring whether the interventions have been effective and implementing strategies to achieve appropriate utilization.
4. Monitoring and reporting any suspected fraud, waste, and abuse of medical services.
	1. Appointed Representative

An appointed representative is an individual either appointed by a member or authorized under state or other applicable law to act on behalf of the member in requesting a grievance, obtaining a coverage determination or in dealing with any of the levels of the appeals process. Unless otherwise prohibited by state or federal law, the appointed representative has all of the rights and responsibilities of an enrollee in obtaining a coverage determination or in dealing with any of the levels of the appeals process. CHPIV ensures that the Plan maintains and adheres to an established Appointed Representative process.

* 1. Appeals

CHPIV ensures the Member Appeals Process is maintained and follows established procedures for standard and expedited appeals based on state and federal regulations and guidelines. CHPIV ensures the following Member Appeals processes including, but not limited to:

1. Well-publicized and readily available appeal mechanisms for members and practitioners for medical necessity denials
2. Denial letters sent to the member including the member’s right to appeal and/or fair hearing independent medical review, and instructions on how to initiate a routine or expedited appeal.
3. Communication of the member’s right of appeal to the practitioners in the Plan’s Provider Operations Manual.
4. The Member Contract/Handbook also delineates the appeals process for the Member, describing how to initiate an appeal verbally by contacting Member Services Department, by phone.
5. Practitioner appeals are forwarded to the Provider Services Department. Appeals initiated by practitioners on behalf of a member for medical services that have not yet been provided are considered to be member appeals.
6. Resolution of the appeal, including:
	* Designated clinical staff, who was not involved in the initial determination, to review the appeal,
	* Written notification to the member of the disposition of the appeal and the right to further appeal or a fair hearing.
7. Procedures for registering and responding to expedited appeals. An expedited appeal may be initiated by the member or by a practitioner acting on behalf of the member or an authorized representative acting on behalf of the member. Once the expedited appeal decision has been made, the Member and Practitioner are noticed as expeditiously as possible.
	1. Emergency Services

Emergency services are provided to members when they present with acute symptoms of sufficient severity such that a prudent layperson with an average knowledge of health and medicine could reasonably expect serious impairment of his or her person from the presenting symptoms without such care. Emergency services are covered inpatient and outpatient medical, surgical or psychiatric services when furnished by a qualified provider and needed to stabilize an emergency medical condition. CHPIV will ensure that emergency services are covered both inside and outside the plan or network and do not require prior authorization.

Furthermore, CHPIV will ensure a response to a non-contracted hospital within in at least 30 minutes from the initial contact by a non-contracting hospital to do either of the following:

1. Authorize post-stabilization care
2. Inform the non-contracted hospital that arrangements will be made for the prompt transfer of the Member to another hospital
	1. Confidentiality

CHPIV ensures the creation of a culture that effectively encourages its associates to comply with applicable laws, regulations and policies related to privacy of health information and to perform work duties with a conscious regard for the privacy right of its members. CHPIV is committed to maintaining the privacy and security of all individually identifiable health information. CHPIV ensures security policies and procedures to protect individually identifiable health care information has adopted additional policies and procedures as needed to comply with the proposed HIPPA regulations, Security and Electronic Signatures Standards.

* 1. Pharmacy

CHPIV ensures Pharmacy UM manages the available pharmacy benefits to achieve the best possible clinical outcomes for members. Pharmacy UM processes include:

1. Pharmacy Prior Authorization
2. Drug List/Formulary Management
3. Communication and Education for Practitioners, Pharmacies, and Members
4. Pharmaceutical Safety

CHPIV UM Program Structure

1. UM Committee Structure

	1. Quality Improvement Health Equity Committee QIHEC)

The QIHEC is charged with monitoring medical management, health equity activities, and quality of care and services provided to Members, including identifying and selecting opportunities for improvement, and monitoring and evaluating the effectiveness of interventions. The QIHEC is responsible for review, reporting, and delegate oversight over all UM functions.

1. Administrative Oversight
	1. Chief Medical Officer/Chief Health Equity Officer (CMO/CHEO)

This position has oversight responsibility for the all Health Services Programs. The CMO/CHEO has oversight of the development, implementation and evaluation of all UM functions. The CMO/CHEO serves as Chairmen of the QIHEC.

* 1. Senior Director of Health Services

This position reports to and works closely with the CMO/CHEO to provide oversight over CHPIV’s UM. The Senior Director of Health Services will be responsible for the development of monitoring and auditing tools used in delegate oversight of UM activities.

* 1. Quality Review Nursing Staff

The Quality Review Nurses report to the Senior Director of Health Services and perform many of the day-to-day monitoring and yearly auditing activities.