Policy:	GG.1541
Title:	**Utilization Management Delegation**
Department:	Medical Affairs
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 01/29/2025*
Effective Date:	11/01/2015
Revised Date:	12/31/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes the process by which CalOptima Health shall assess and monitor delegated Utilization Management (UM) activities.

II. POLICY

A. The Utilization Management (UM) and Delegation Oversight Departments shall maintain ultimate responsibility for auditing all delegated UM activities.

B. The UM and Delegation Oversight Departments shall establish and maintain an oversight process for any delegated UM activity, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight. Such oversight process shall include, but not be limited to:

1. Pre-delegation assessment;
2. On-going monitoring;
3. Annual performance reviews; and
4. Sanctions and de-delegation.

C. The Delegation Oversight Department may recommend a delegated Health Network to develop and implement an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) based on an identified deficiency, or area of non-compliance, in accordance with CalOptima Health Policies HH.2005: Corrective Action Plan.

D. The CalOptima Health Office of Compliance may impose Sanctions based on a delegated Health Network's or its agent's failure to comply with any statutory, regulatory, contractual, CalOptima Health policy, and other requirements, in accordance with CalOptima Health Policies HH.2002: Sanctions.

III. PROCEDURE

A. CalOptima Health may delegate UM activities including, but not limited to:

1. Pre-service review;

2. Concurrent review;

3. Post-service review;

4. Transition of Care and Discharge planning;

5. Notices to Members; and

6. Notices to providers.

B. Pre-delegation Assessment

1. CalOptima Health shall conduct a pre-delegation assessment of a Health Network to determine such Health Network's ability to implement delegated UM activities prior to delegating such activities, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

2. The pre-delegation assessment shall consist of a comprehensive on-site assessment utilizing the Utilization Management Evaluation Tool and shall evaluate the Health Network's capacity to provide all delegated functions including, but not limited to, the Health Network's:

   a. Ability to provide effective UM, in accordance with this policy;

   b. Ability to manage Transitions of Care across the health care continuum, to ensure the Member remains in the appropriate and least restrictive quality health care setting;

   c. Capacity to report UM data, and provide reports showing aggregate analysis of tasks and performance of Transition of Care and coordination of the Transition of Care process, as set forth in the CalOptima Health Policy MA.6030: Transition of Care; and

   d. Integration of the UM process to Credentialing and quality improvement efforts.

3. The Delegation Oversight Department shall conduct the pre-delegation assessment by evaluating the Health Network's:

   a. UM Program and UM Plan;

   b. UM Committee composition and the oversight by a governing body;

   c. UM Committee meeting structure and process;

   d. UM Transition of Care;

   e. Utilization Review criteria and guidelines;

   f. Process and procedure to ensure consistency in the application of Utilization Review criteria and guidelines;

   g. Policies and procedures for adherence to established criteria of Medical Necessity and length of stay determination;

h. Process for Member notification of expedited and routine Appeals procedure;

i. Communication capabilities with CalOptima, Members, or responsible parties, and Providers at all points of care including Transitions of Care;

j. Process for communicating UM data to CalOptima Health which includes, but is not limited to: overall rates of admissions and readmissions, emergency room visits, Under and Over Utilization of Covered Services and analysis of root causes and opportunities for improvement;

k. Processes for key activities including, but not limited to:

i. Prospective authorization process and Second Opinion;

ii. Expedited review process;

iii. Concurrent review process, which includes review of daily census reports for planned and unplanned admissions (events), screening Members admitted for potential Transition of Care issues and making referrals to the CalOptima Health Transition Interdisciplinary Team, as appropriate, and as set forth in the CalOptima Health Policies MA.6030: Transition of Care, GG.1308: Monitoring Health Network Compliance via Case Management Reports, and HH.2003: Health Network Reporting;

iv. Discharge planning;

v. Care coordination to ensure Continuity of Care;

vi. Retrospective review process, including claims review;

vii. Out-of-Network processes;

viii. Urgent Care;

ix. Emergency Services;

x. Specialty referrals; and

xi. Criteria for approving or denying Payment for services.

4. The Delegation Oversight Department shall report the pre-delegation assessment results to the Delegation Oversight Committee (DOC).

5. CalOptima's criteria for delegation of UM activities based on the Health Network's pre-delegation assessment.

a. CalOptima Health may require the Health Network to complete an ICAP, or CAP, in accordance with Section III.E. of this policy prior to delegating the UM activities.

b. If the DOC determines that the Health Network does not meet CalOptima's criteria for delegation of UM activities, CalOptima Health may reassess such Health Network not earlier than three (3) months after the initial pre-delegation assessment.

C. Monitoring

1. The Delegation Oversight Department shall monitor delegated Health Network's UM activities, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

    a. The Delegation Oversight Department shall assign a Delegation oversight nurse to provide on-going monitoring of a delegated Network's clinical and operational processes and performance.

    b. The Delegation Oversight Department shall work with a delegated Health Network to conduct ongoing improvement activities to address deficiencies and demonstrate improvement.

    c. A delegated Health Network shall submit reports to CalOptima Health in order to ensure compliance of delegated activities in accordance with CalOptima Health Policy HH.2003: Health Network Reporting.

D. Performance Reviews

1. CalOptima Health shall conduct an annual on-site performance review of a delegated Health Network for delegated UM activities, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

2. The Delegation Oversight Department shall report its findings from performance reviews and CAPs to the DOC with recommendations for follow-up activities.

E. Immediate Corrective Action Plan and Corrective Action Plan

1. CalOptima Health may require a delegated Health Network to develop and submit an ICAP or CAP for any area of deficiency or non-compliance related to delegated UM activities identified through the Readiness Assessment, regular reports, and performance reviews, in accordance with CalOptima Health Policies HH.2005: Corrective Action Plan.

F. De-delegation

1. If a delegated Health Network fails to achieve compliance within the timeframes set forth in the ICAP, or CAP, the Delegation Oversight Department may recommend complete or partial de-delegation of UM activities to the DOC, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

2. The Health Network shall cooperate with CalOptima Health to ensure smooth transition and continuous care for CalOptima Health Members during the transition period.

3. CalOptima Health shall re-evaluate a delegated Health Network's ability to perform delegated UM activities not less than twelve (12) months after de-delegation.

    a. CalOptima Health shall utilize the pre-delegation assessment process as described in Section III.B. of this policy.

    b. CalOptima Health shall delegate UM activities to the delegated Health Network based on the pre-delegation assessment results.

c. If the Office of Compliance approves delegation of UM activities to the delegated Health Network, CalOptima Health shall re-delegate such activities and adjust the delegated Health Network's payment accordingly.

d. If the Office of Compliance denies re-delegation of UM activities to the delegated Health Network, it may recommend additional Sanctions on the delegated Health Network, up to, and including, contract termination.

G. CalOptima Health shall inform a Health Network of the right to file a Complaint, in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint and MA.9006: Contracted Provider Complaint Process.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health, Health Network Service Agreement
D. CalOptima Health CalOptima Health Policy GG.1308: Monitoring Health Network Compliance via Case Management Reports
E. CalOptima Health Policy GG.1619: Delegation Oversight
F. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
G. CalOptima Health Policy HH.2002: Sanctions
H. CalOptima Health Policy HH.2003: Health Network Reporting
I. CalOptima Health Policy HH.2005: Corrective Action Plan
J. CalOptima Health Policy MA.6030: Transitions of Care
K. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2015	GG.1541	Utilization Management Delegation	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1541	Utilization Management Delegation	Medi-Cal OneCare OneCare Connect
Revised	11/01/2017	GG.1541	Utilization Management Delegation	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/31/2024	GG.1541	Utilization Management Delegation	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. CalOptima Health
Complaint	A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance.
Continuity of Care	For the purposes of this policy, refers to services provided to a Member rendered by an out-of-network provider with whom the Member has a pre-existing Provider relationship.
Corrective Action Plan (CAP)	For purposes of this policy, a plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, Centers of Medicare & Medicaid Services (CMS), or designated representatives. Delegates may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements identified by CalOptima Health and its regulators.

Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima

Term	Definition
	Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Credentialing	Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Delegation	Process by which CalOptima Health expressly grants, by formal written agreement, to another entity the authority to carry out a function that CalOptima Health would otherwise be required to perform in order to meet its obligations under its contract with DHCS.
Emergency Services	Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).

Term	Definition
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Immediate Corrective Action Plan (ICAP)	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary enrolled in a CalOptima Health program.
Out-of-Network	Covered services provided by a non-contracted, appropriate, Qualified Health Care Professional qualified health care professional.
Over Utilization	Unnecessary health care provided with a higher volume or cost than is appropriate in delivering quality health care services.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.
Second Opinion	A consult visit to an Appropriately Qualified Health Care Professional in order for a Member or Contracted Provider who is treating the Member, to receive the additional information for the Member to make an informed decision regarding care and treatment.
Standards of Care	A diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance conforming to an established rule that is approved and monitored for compliance by an authoritative agency or professional.
Transition of Care	The movement of a Member from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.
Under Utilization	A condition wherein the optimal healthcare resources are not being delivered in the appropriate volume to provide quality health care services.

Term	Definition
Urgent Care	Medi-Cal: Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury. OneCare: Services furnished to a Member who requires services to be furnished within twelve (12) hours in order to avoid the likely onset of an emergency medical condition.
Utilization Management (UM)	The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan.
Utilization Management (UM) Program	A written document evaluated and revised on an annual basis, that describes the Utilization Management policies, procedures, processes, programs that are implemented organizationally to attain goals set forth by the health plan, to meet health plan, State, Federal, and accrediting agency requirements.
Utilization Review	For the purposes of this policy, refers to the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities.