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| Policy: | GG.1513 |
| Title: | **Health Network Utilization Management Reporting and Monitoring Requirements** |
| Department: | Medical Management |
| Section: | Utilization Management |
| *CEO Approval:* | */s/ Michael Hunn 12/20/2024* |
| Effective Date: | 03/01/1999 |
| Revised Date: | 12/01/2024 |
| Applicable to: | ☒ Medi-Cal<br>☒ OneCare<br>☐ PACE<br>☐ Administrative |

## I. PURPOSE

This policy defines the Utilization Management (UM) reporting requirements and the process for Monitoring a Health Network's UM reports.

## II. POLICY

A. A Health Network shall submit timely reports, in accordance with CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting.

B. CalOptima Health shall delegate UM activities to a Health Network in accordance with the CalOptima Health Contract for Health Care Services and the CalOptima Health Delegation Acknowledgement and Acceptance Agreement.

C. If CalOptima Health delegates UM activities for Covered Services to a Health Network, for which CalOptima Health is financially responsible as set forth in the CalOptima Health Contract for Health Care Services, the Health Network shall report such activities to CalOptima Health, in accordance with CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible, for purposes of timely and accurate adjudication of claims for Covered Services for which CalOptima Health is financially responsible.

## III. PROCEDURE

A. CalOptima Health's UM Department shall review and Monitor the reports for compliance with CalOptima Health and Health Network UM Standards. CalOptima Health shall review elements including, but not limited to:

1. Bed days;
2. Emergency room visits;
3. Referral denial rate;
4. Referral turn-around time;

5. Percentage of referrals that exceed the Health Network standard; and

6. UM activities.

B. CalOptima Health's UM Department shall track and trend the elements listed in Section III.A. of this Policy for over and underutilization and adherence to UM Standards via the Over/Underutilization Dashboard on an ongoing basis and in accordance with CalOptima Health Policy GG 1532: Over and Under Utilization Monitoring.

C. A Health Network that is delegated UM activities for Covered Services shall report to CalOptima Health, for purposes of Monitoring and evaluating the Health Network's performance of such activities the following:

1. All requests for authorization of inpatient admissions that were approved, modified, partially approved, or denied; and

2. All other requests for authorization of Covered Services for which authorization is required were approved, modified, partially approved, or denied.

D. The Health Network shall submit data in accordance with CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting, covering all UM reporting requirements for UM activities that occurred during the reporting period through a designated secure File Transfer Protocol (FTP) site as follows:

1. Submission through the secure FTP site of complete data files that meet layout specifications provided in the UM Specifications – UM Service Authorizations, UM Specifications – UM Admissions, and UM Specifications – UM Admission Length of Stay.

E. On a daily basis, the CalOptima Health Information Technology Services (ITS) Department shall download a Health Network's UM activities data from the secure FTP site into CalOptima Health's internal data management systems.

F. A Health Network shall submit the following UM reports and documents:

1. Annual UM Program;

2. UM program review signature page;

3. Annual UM Evaluation;

4. Annual UM Work Plan;

5. Quarterly UM report; and

6. Other resource documents as requested by CalOptima Health.

G. The CalOptima Health Executive Director of Clinical Operations or Director of UM or their designee shall attend Health Network UM committee meetings to Monitor compliance with UM Standards whenever a specific issue is identified that requires discussion with UM leadership.

H. If a Health Network is found to be out of compliance with UM Standards, the CalOptima Health UM Monitoring staff shall issue a preliminary corrective action plan request to the Health Network and shall work with the Health Network to resolve the deficiency. If the Health Network does not adequately remediate the deficiency after three (3) consecutive months, the Delegation Oversight Department shall issue a Corrective Action Plan to the Health Network for those elements that remain out of compliance after the preliminary corrective action process. If the issue remains unresolved, CalOptima Health may conduct a Focused Review, require a Corrective Action Plan, and/or implement financial sanctions, in accordance with CalOptima Health Policies HH.2005: Corrective Action Plan and GG.1619: Delegation Oversight.

## IV. ATTACHMENT(S)

Not Applicable

## V. REFERENCE(S)

A. CalOptima Health Contract for Health Care Services
B. CalOptima Health Delegation Acknowledgement and Acceptance Agreement
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible
F. CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring
G. CalOptima Health Policy GG.1619: Delegation Oversight
H. CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting
I. CalOptima Health Policy HH.2005: Corrective Action Plan

## VI. REGULATORY AGENCY APPROVAL(S)

None to Date

## VII. BOARD ACTION(S)

| Date | Meeting |
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| 04/07/2022 | Regular Meeting of the CalOptima Board of Directors |

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 03/01/1999 | GG.1513 | Utilization Management Monitoring of Quarterly and Annual Reports | Medi-Cal |
| Revised | 01/01/2007 | GG.1513 | Utilization Management Monitoring of Quarterly and Annual Reports | Medi-Cal |
| Revised | 11/01/2015 | GG.1513 | Health Network Utilization Management Reporting and Monitoring Requirements | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 10/01/2016 | GG.1513 | Health Network Utilization Management Reporting and Monitoring Requirements | Medi-Cal<br>OneCare<br>OneCare Connect |

| Action | Date | Policy | Policy Title | Program(s) |
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| Revised | 12/01/2016 | GG.1513 | Health Network Utilization Management Reporting and Monitoring Requirements | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 08/01/2017 | GG.1513 | Health Network Utilization Management Reporting and Monitoring Requirements | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 10/01/2017 | GG.1513 | Health Network Utilization Management Reporting and Monitoring Requirements | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 01/01/2018 | GG.1513 | Health Network Utilization Management Reporting and Monitoring Requirements | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 04/07/2022 | GG.1513 | Health Network Utilization Management Reporting and Monitoring Requirements | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 12/31/2022 | GG.1513 | Health Network Utilization Management Reporting and Monitoring Requirements | Medi-Cal<br>OneCare |
| Revised | 12/31/2023 | GG.1513 | Health Network Utilization Management Reporting and Monitoring Requirements | Medi-Cal<br>OneCare |
| Revised | 12/01/2024 | GG.1513 | Health Network Utilization Management Reporting and Monitoring Requirements | Medi-Cal<br>OneCare |

## IX. GLOSSARY

| Term | Definition |
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| 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.<br><br>Covered Services do not include:<br><br>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;<br>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;<br>3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services);<br>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);<br>5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members);<br>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);<br>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;<br>8. Prayer or spiritual healing as specified in 22 CCR section 51312;<br>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 |

| Term | Definition |
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| | 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 Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services);<br>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);<br>11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services;<br>12. State Supported Services;<br>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;<br>14. Childhood lead poisoning case management provided by county health departments;<br>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;<br>16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and<br>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.<br><br><u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. |
| Focused Review | For the purposes of this policy, refers to an audit that specifically targets areas of potential deficiency. |
| Health Network | A Physician Hospital Consortium, Physician Medical Group (PMG) or a Shared Risk 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. |
| Member | A beneficiary enrolled in a CalOptima Health program. |
| Monitoring or Monitor | Regular reviews directed by CalOptima Health management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective. |
| Shared Risk Group (SRG) | A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima Health as the responsible partner for facility services. |

| Term | Definition |
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| 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 Management (UM) Standards | Conforming to an established rule that is approved and monitored for compliance by an authoritative agency or professional. |
| Utilization Management (UM) Workplan | A written document evaluated and revised on an annual basis that documents the progress of the initiatives, activities, results and analysis of the Utilization Management Program Description, State and Federal contractual obligations, and accrediting agency requirements. |
| Utilization Management (UM) Workplan Evaluation | A written document, updated and revised annually, that evaluates the overall effectiveness of the Utilization Management (UM) Program. |