Policy:	GG.1532
Title:	**Over and Under Utilization Monitoring**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 01/29/2025*
Effective Date:	06/01/2014
Revised Date:	12/31/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for CalOptima Health to track and trend the appropriate utilization of medical care and services delivered to Members of CalOptima Health Direct, as well as Members assigned to a Health Network, and ensures that care is monitored, analyzed, and interventions are implemented upon the identification of under and/or over utilization patterns.

II. POLICY

A. The Utilization Management Committee (UMC) shall review and establish recommended Benchmarks to monitor and identify Under and Over Utilization of services, including but not limited to:

1. Inpatient bed days;
2. Emergency department visits;
3. Admissions/1,000;
4. Average Length of Stay (ALOS);
5. Readmission rates;
6. Behavioral health measures specific to frequency and duration of therapy sessions and applied behavior analysis (ABA);
7. Healthcare Effectiveness Data & Information Set (HEDIS) measures specific to access to services/Primary Care Providers (PCPs) for children and adults;
8. Pharmacy utilization measures specific to Over and Under Utilization;
9. Appeals/1,000 Members, Appeal overturn rates, and Member Grievances/1,000 Members;
10. PCP and specialist referral pattern analyses;

11. Identification of Members needing Enhanced Care Management (ECM);

12. Complex Case Management engagement;

13. Members who need Community Supports;

14. Grievances received related to Utilization Management decisions and referral processes; and

15. Other measures as identified through the UMC.

B. The UMC recommends annually, at a minimum, a subset of these measures and approves the benchmarks for Over and Under Utilization that are consistent across all Health Networks and consistent with industry standards, regulatory or contract requirements, and access and availability surveys, as applicable.

C. CalOptima Health identifies, analyzes, develops remediation efforts, and reports outcomes to the UMC patterns of Over and Under Utilization. Representatives from the following CalOptima Health departments may participate in these activities:

1. Utilization Management;

2. Quality Improvement;

3. Grievance and Appeals Resolution Services (GARS);

4. Quality Analytics;

5. Pharmacy Management;

6. Behavioral Health Integration;

7. Compliance;

8. Provider Relations;

9. Health Network Relations; and

10. Population Health Management.

D. Health Networks submits routine reports and data, on a regular basis, as specified in the CalOptima Health, Health Network Service Agreement and in accordance with CalOptima Health Policies GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements, and HH.2003: Health Network and Delegated Entity Reporting.

E. CalOptima Health considers the volume of Members utilizing or assigned to a Health Network, or Practitioner's area of practice, when developing Benchmarks specific to a Practitioner.

F. The UMC reviews and analyzes the utilization data and may require a Corrective Action Plan (CAP) from a Health Network or a specific Practitioner.

1. The UMC ensures the implementation and monitoring of all corrective actions that result as part of the Over and Under Utilization analysis and trending of data.

G. CalOptima Health Utilization Management leadership, the Medical director who oversees delegation oversight, and the UMC measure the effectiveness of interventions in correcting patterns of Under and Over Utilization.

H. The UMC reviews, discusses, and escalates issues of non-compliance related to Utilization Management and quality of care to the Quality Improvement Health Equity Committee (QIHEC) and/or Delegation Oversight Committee (DOC), as appropriate.

III. PROCEDURE

A. Review of Utilization Data

1. The delegation oversight Medical Director, Utilization Management Director, or Designees, review:

    a. Admission data on a concurrent basis and, in aggregate, on a quarterly basis; and

    b. Readmission data concurrently and, in aggregate, on a quarterly basis.

2. The Utilization Management (UM) Department, in consultation with the CalOptima Health departments specified in Section II.C. of this Policy, analyze the data on at least a quarterly basis and identify issues requiring reporting and remediation. The analysis includes, but is not limited to:

    a. Determination of the root cause(s) of Under or Over Utilization;

    b. Comparison against UMC goals;

    c. Comparison against nationally recognized, Evidence-Based, and external Benchmarks, when available; and

    d. Qualitative analysis to determine cause and effect of data outside identified Benchmarks.

3. CalOptima Health utilize approved, nationally recognized, Evidence-Based criteria and guidelines, when available, to identify outliers.

4. CalOptima Health analyzes utilization data and reports provided by Health Networks, as set forth in Section II.D. of this Policy, as well as other data available to CalOptima Health.

B. Steps Upon Identification of Potential Under and Over Utilization

1. Upon identification of potential Under or Over Utilization, CalOptima Health evaluates the extent of the problem and identifies key variables lending to the root cause including, but not limited to:

    a. Change in data collection or definition of terms;

    b. Patterns within a Health Network, facility, or service provider;

    c. Metrics requiring escalation to the appropriate CalOptima Health department due to Over or Under Utilization, as well as analysis with a remediation plan; and

d. CAP issuance due to unsatisfactory performance.

2. If a Health Network or a Provider is identified as the root cause of a deficiency after analysis of all causative factors impacting performance, the members of the UMC, and representatives of the CalOptima Health departments specified in Section II.C. of this Policy, shall collaborate to develop a remediation plan. All issues of non-compliance will be escalated to the DOC for further evaluation and remediation, if necessary.

3. The UMC may request the Health Network Relations Department or Provider Relations Department, in conjunction with the Utilization Management Department Director or Designee, to comment and educate a Provider or Health Network based on data analysis and make recommendations for improvement.

4. CalOptima Health shall report the Under or Over Utilization data analysis to the UMC and/or QIHEC on a quarterly basis.

5. Upon recommendation from the UMC or DOC, CalOptima Health may require a Health Network or a Provider to develop a CAP in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

IV. ATTACHMENT(S)

A. CHCN Over/Under Utilization Dashboard

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 Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements
E. CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting
F. CalOptima Health Policy HH.2005: Corrective Action Plan

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	06/01/2014	GG.1532	Over and Under Utilization Monitoring	Medi-Cal
Revised	11/01/2015	GG.1532	Over and Under Utilization Monitoring	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1532	Over and Under Utilization Monitoring	Medi-Cal OneCare OneCare Connect
Correction	12/01/2016	GG.1532	Over and Under Utilization Monitoring	Medi-Cal OneCare OneCare Connect
Revised	12/01/2017	GG.1532	Over and Under Utilization Monitoring	Medi-Cal OneCare OneCare Connect
Revised	01/01/2019	GG.1532	Over and Under Utilization Monitoring	Medi-Cal OneCare OneCare Connect
Revised	09/01/2022	GG.1532	Over and Under Utilization Monitoring	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1532	Over and Under Utilization Monitoring	Medi-Cal OneCare
Revised	02/01/2023	GG.1532	Over and Under Utilization Monitoring	Medi-Cal OneCare
Revised	12/31/2024	GG.1532	Over and Under Utilization Monitoring	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Abuse	For purposes of this Policy, a Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the Medi-Cal and/or Medicare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the Medi-Cal and/or Medicare program.
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 service; 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: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima Health on health care services or benefits under Part C or D the Member 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 Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR § 422.566(b) and § 423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review.
Benchmark	Performance information used to identify the operational and clinical practices that lead to the best outcome.
CalOptima Health Direct (COHD)	For purposes of this Policy, a direct health care program operated by CalOptima Health that includes both COD-Administrative (COHD-A) and CalOptima Health Community Network (CHCN).
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima Health's capitation rate and count toward the medical expense component of CalOptima Health's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima Health and the Member and must be approved by DHCS.

Term	Definition
Complex Case Management (Care Management Level)	Case Management provided to Members who are at high-risk; defined as having medically complex conditions that include the following but is not limited to: 1. Spinal injuries; 2. Transplants; 3. Cancer; 4. Serious Trauma; 5. AIDS; 6. Multiple chronic illness; or 7. Chronic illnesses that result in high utilization.
Corrective Action Plan (CAP)	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 Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director of the Audit & Oversight Department to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's operational departments.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
Evidence-Based	A document or recommendation created using an unbiased and transparent process of systematically reviewing, appraising, and using the best clinical research findings of the highest value to aid in the delivery of optimum clinical care to patients.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or employee of CalOptima Health or a Health Network, as applicable, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health or a Health Network, as applicable, to make an authorization decision.

Term	Definition
	OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.
Healthcare Effectiveness Data & Information Set (HEDIS)	A set of standardized performance measures designed to provide purchasers and consumers with relevant information on health plan performance and facilitate the comparison of managed care organizations. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA). It is a tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), 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.
Member	A beneficiary enrolled in a CalOptima Health program.
Over Utilization	Unnecessary health care provided with a higher volume or cost than is appropriate in delivering quality health care services.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. 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.
Under Utilization	A condition wherein the optimal healthcare resources are not being delivered in the appropriate volume to provide quality health care services.
Utilization Management	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.

Term	Definition
Utilization Management Committee (UMC)	The CalOptima Health committee provides coordination and oversight of delegated and non-delegated Utilization Management functions to ensure consistency in evaluation and delegation oversight.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.