

Title: Utilization Management Overview**Policy #: UM15.001**

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Author: Dee Patrick, QM Director

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Author: Pauline Jones, Nursing Director

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Author: Florence Chan, UM Director

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Author: Jose Yasul, UM Medical Director

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Reviewer: Lynn Soloway RN, Auth & UM Director

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Author: Dennis Hsieh, CMO

Reviewed and approved by Quality Council: 6/9/16, 4/27/17, 12/14/17, 2/28/19, 6/2021, 4/2025**Presented in UM Committee:** 5/2022, 6/2024, 3/2025**Applies to:** Medi-Cal Medicare All BHC Commercial N/A**Regulatory/Accreditation:** DMHC: CMS: DHCS: Other Reg. References: NCQA: UM 11 N/A**Units:** Administration Advice Nurses All Staff Business Services Case Management Health Ed/Cultural Ling. Marketing Member Services Planning, Reg Affairs Provider Affairs Quality Management Auth/Utilization Mgmt**POLICY**

The Utilization Management (UM) Program is designed to actively manage the use of health care resources to promote efficient and quality professional care for Health Plan members. The UM program is under the direction of the CCHP Chief Medical Officer (CMO) and is an integral part of the CCHP administration.

PURPOSE

The purpose of the CCHP UM Program is to ensure the care and services received by CCHP members are effective, appropriate, timely, of high quality, consistent with community standards of care, and are coordinated and continuous across the health care spectrum.

The UM Program oversees health care delivery of services rendered to the members. This Program is designed to allow for delegation and non-delegation of the utilization management functions. Initial audit of UM plans for delegation preparedness, along with continuous oversight of delegated UM partners are performed by the CCHP UM department. Oversight of delegated partners ensures that utilization issues are identified, documented, reviewed, and acted on in an efficient, timely, consistent, and appropriate manner. Upon analysis, all utilization processes requiring modification will be addressed, implemented, and tracked on a consistent basis. CCHP UM Department shall conduct appropriate levels of utilization management activities for non-delegated partners.

Activities are designed to oversee resource utilization processes by monitoring services delivered to CCHP members, which encompasses: quality and continuity of care, appropriate and timely service, access to preventive services and member education, communication between provider and member, and promotion of continuous improvement of care and services. Provisions of these activities are

based on accepted practice standards, regulatory compliance, and clinical criteria or guidelines. The UM Program communicates, collaborates, and works in conjunction with the Quality Management program as well as other CCHP programs to ensure quality, accessible, and cost-effective care are available and rendered to members. The UM Program is reviewed and updated on annual basis and approved by the Quality Council.

CCHP through it's over and under analysis, inter-rater reliability, potential quality issues (PQI), appeals and grievances, and regular meetings of its utilization management committee continuously reviews the performance of health care personnel, and the utilization of services and facilities, and cost.

Availability

Normal business hours for the Authorization and Utilization Management (UM) Department are Monday through Saturday from 8:00am to 5:00pm, excluding Sundays and holidays. During the hours of 8:00am to 5:00pm Monday through Saturday, staff is available for all inbound call types (e.g., toll-free, direct, and other calls) and outbound communications regarding the authorization and UM processes. When making outbound or returning calls to members or practitioners regarding UM issues, staff identifies themselves by their name, title, and organization. Members can reach the UM Department by calling the Member Call Center at 1-877-661-6230, option 4. Providers can reach the UM Department by calling the Provider Call Center at 1-877-800-7423, option 3.

Afterhours and on Sundays and holidays, callers have two options. For non-urgent matters, the caller can leave a message at the above number. Communications received after normal business hours are returned on the next business day, and communications received after midnight on Monday–Friday are responded to on the same business day. For urgent matters, the caller can stay on the line and be automatically transferred to the Advice Nurse Unit, which operates 24/7. The Advice Nurse (AN) Unit is able to reach an on-call UM staff member for assistance as appropriate. This includes the UM Manager and Medical Director as needed. A toll-free number, TDD/TTY for hearing impaired, and language assistance are available and accessible to members and providers. Refer to specific Member Materials handbook and Provider Manual.

Objectives

- To facilitate accessible, appropriate, and cost-effective care to Health Plan members.
- To establish a process for collaboration and communication between network providers and with delegated and partially delegated providers to facilitate a collaborative team that promotes the proper utilization of health care services.
- To assess, monitor, and implement appropriate utilization processes for the enhancement of health care services rendered to the members.
- To evaluate historical data and trends, pertinent quality outcomes, member satisfaction, and resource utilization, in order to implement necessary process modifications to enhance UM functionality.
- To act as an intermediary between necessary disciplines for continuity of member care.
- To work in conjunction with health care providers to assess and identify long term care needs, catastrophic illness, and treatment and resources necessary for positive member outcomes.

- To continually strive for and support interdepartmental collaboration and dialogue for quality improvement focus within utilization management.

Scope

The scope of the UM Program includes, but are not limited to, all delegated and non-delegated aspects of care delivered to CCHP members. The UM Program utilizes prospective, concurrent, and retrospective review methodologies, as well as focused and claim review of high-cost inpatient and outpatient services. In addition, the UM Program identifies and implements actions to resolve:

- avoidable or inappropriate admissions due to increased technological advances or community standard practice
- delay of service, discharge, or transition to lower level of care
- chronic care needs
- inappropriate length of stay and/or skilled nursing admissions or utilization of high-cost diagnostic testing

Authority and Responsibility

The Board of Supervisors (Governing Board) has ultimate responsibility for the Health Plan's UM activities. Through the Joint Conference Committee (JCC), the Board has delegated authority of UM Program oversight functions to the CCHP Chief Medical Officer (CMO) or their designee. The CMO / designee has the authority and responsibility to ensure that an effective UM Program is supported and maintained. The CMO / designee is responsible for ensuring UM decision-making is based established sound clinical practices and appropriateness of care and services. The Plan does not compensate, reward, or incentivize the CMO, Medical Directors, Assistant Medical Directors, Medical Consultants, UM clinical or nonclinical staff, delegated and non-delegated practitioners, or decision-making individuals for unfavorable determinations or to encourage underutilization.

The CCHP CMO / designee oversight responsibilities include assurance that administrative and management decisions do not compromise the quality of care and service provided to CCHP members. The CMO / designee is responsible for providing clinical support and exercising professional judgement on matters of quality of care, peer review, and clinical and medical procedures. The CMO / designee, UM Director, and UM Manager and Supervisor act as liaison to the CCHP providers in clarifying benefit and policy issues.

Utilization Management Program Evaluation

In addition to bi-monthly UM reports, CCHP's Quality Council (QC) evaluates the UM Program on an annual basis to assess the effectiveness of the program. This evaluation includes an assessment of completed and continued program activities, comparison of industry standards and trends to Health Plan practices, review of internal and external audit findings, effectiveness of monitoring and reviewing activities, and efficiency of the UM Program in identifying and acting upon UM issues.

Feedback to Health Plan providers is accomplished through provider participation in QC, Community Provider meetings, distribution of UM activities analyses, and/or communication to Health Plan provider, in the form of reports, newsletters, conferences, and meetings.

Utilization Management Satisfaction Evaluation

HEDIS/CAHPS 4.0H and Timely Access surveys along with reviewing and evaluating Member

Services and Provider grievances and appeals allow the UM department to monitor, evaluate, and identify problem areas and improvement opportunities. Quality Management Department collects and analyzes survey results and shares findings with the Clinical Leadership Group (CLG) and QC. The Medical Director and UM Manager are participating members of the CLG and QC.

Additionally, member and provider complaints, grievances and appeals are regularly reported by Member Services and Provider Relations, respectively, to QC. UM related complaints and grievances are referred to and handled by a member of the UM management team. UM related appeals are handled by a clinical reviewer not involved in the original determination. UM related complaints and grievances are handled by the UM management team. Therefore, areas of concern are quickly identified, and as necessary, corrective action plans implemented in a timely manner. Program enhancements, such as ongoing staff and provider education and training, improved reporting data and implementation of additional program activities may be necessary to address areas of concern.

Providers are encouraged to contact the UM Department with their concerns and process improvement ideas. The UM Department regularly published articles in the provider's newsletter, Care Matters, to address concerns and process changes.