

**DEPARTMENT OF MANAGED HEALTH CARE
DIVISION OF PLAN SURVEYS
CAL MEDICONNECT SURVEY**

TECHNICAL ASSISTANCE GUIDE

**UTILIZATION MANAGEMENT
ROUTINE MEDICAL SURVEY**

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this October 27, 2015 Technical Assistance Guide renders all other versions obsolete.

CAL MEDICCONNECT UTILIZATION MANAGEMENT (UM) TAG

TABLE OF CONTENTS

UTILIZATION MANAGEMENT (UM) REQUIREMENTS

Requirement UM-001:	The Health Plan develops, implements, and maintains a Utilization Management process in connection with the delivery of Medicaid-based services.	3
Requirement UM-002:	The Health Plan utilizes effective mechanisms to detect and/or manage over- and under-utilization of Medicaid-based services .	13
Requirement UM-003:	The Health Plan utilizes methodologies and processes to handle prior authorizations appropriately in connection with the delivery of Medicaid-based services.....	17
Requirement UM-004:	The Health Plan utilizes processes to evaluate and oversee utilization management activities of delegated entities in connection with the delivery of Medicaid-based services.....	28
Requirement UM-005:	The Health Plan has evidence of the delegated entities' compliance with its policies, procedures, and oversight.....	40

Requirement UM-001: The Health Plan develops, implements, and maintains a Utilization Management process in connection with the delivery of Medicaid-based services.

STATUTORY/REGULATORY CITATION(S)

Cal MediConnect Prime Contract

2.6. Long-Term Services and Supports (LTSS).

2.6.1. Contractor will ensure access to, provision of, and payment for: 1) CBAS for Enrollees who meet eligibility criteria for CBAS as defined in Section 2.6.2.1, MSSP for Enrollees who meet the eligibility criteria for MSSP pursuant to WIC, Section 9560; and, 3) IHSS for Enrollees who meet the eligibility criteria for IHSS pursuant to WIC, Section 12305.6.

2.6.1.1. Community Based Adult Services (CBAS): The Contractor shall contract for CBAS, which is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Enrollees.

2.6.1.1.1. The Contractor shall make available the CBAS benefit to Enrollees who are age 21 or older and derive their Medi-Cal eligibility from the state Plan, are Medicare beneficiaries, are either aged, blind, or disabled and who qualify based on the following criteria.

2.6.1.1.1.1. Meet medical necessity criteria as established by the state and meet “Nursing Facility Level of Care A” (NF-A) criteria, as set forth in the DHCS Code of Regulations, or above NF-A Level of Care; or

2.6.1.1.1.2. Have a moderate to severe cognitive disorder such as dementia, including dementia characterized by the descriptors of, or equivalent to, stages 5, 6, or 7 of the Alzheimer’s Type; or

2.6.1.1.1.3. Have a mild cognitive disorder such as Dementia, including Dementia of the Alzheimer’s Type, and needs assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene, or;

2.6.1.1.1.4. Have a Chronic Mental Disorder or acquired, organic, or traumatic brain injury. In addition to the presence of a Chronic Mental Disorder or acquired, organic, or traumatic brain injury, the Enrollee shall need assistance or supervision with either:

2.6.1.1.1.4.1. Two (2) of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

2.6.1.1.1.4.2. One (1) need from the above list and one (1) of the following: money management, accessing community and health resources, meal preparation, or transportation.

2.6.1.2. Multi-purpose Senior Services Program (MSSP): A program approved under the federal Medicaid Home and Community-Based, 1915(c) Waiver that provides HCBS to

Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

2.6.1.2.1. Contractor shall inform its Enrollees about the MSSP and establish a mechanism to refer Enrollees who are enrolled in Cal MediConnect and are potentially eligible for the MSSP to MSSP providers for eligibility determination.

2.6.1.2.2. Care Coordination – Contractor shall coordinate and work collaboratively with MSSP providers on care coordination activities surrounding the MSSP Waiver Participant including, but not limited to: coordination of benefits between Contractor and MSSP provider to avoid duplication of services and coordinate Care Management activities particularly at the point of discharge from the MSSP.

2.6.1.2.3. For Enrollees that may qualify for MSSP, but are on the waiting list, the Contractor may provide alternate services as identified through the development of the ICP as described in Sections 2.5.1.9 and 2.8.3.

2.6.1.3. In-Home Supportive Services (IHSS): A program that serves aged, blind, or disabled persons who are unable to perform activities of daily living and cannot remain safely in their own homes without help pursuant to Article 7 of California Welfare and Institutions Code (WIC) (commencing with Section 12300) of Chapter 3, and WIC Sections 14132.95, 14132.952, and 14132.956.).

2.6.1.3.3. Contractor and county agencies will develop and implement detailed processes for coordination and integration of IHSS which shall include, but not be limited to:

2.6.1.3.3.1. Provision of intake activities and redeterminations by IHSS social workers and allocation of IHSS hours according to WIC Section 12301.1 and how that information is coordinated and shared with the ICT.

2.6.1.3.3.2. Framework for referrals to IHSS county agencies, coordination for change of condition, discharge planning, reassessments, and the ICT.

2.6.1.4. Nursing Facilities

2.6.1.4.1. Contractor shall contract with SNFs, as defined in Title 22, CCR, Section 51121(a), in its Service Area that are licensed by California Department of Public Health (CDPH) and certified by DHCS for participation as a SNF in the Medi-Cal Program and additional Contractor credentialing standards, if any. See Section 2.10.2.3.

2.6.1.4.2. If SNFs beds are not available in the Contractor's Service Area, Contractor shall contract with qualified SNFs in areas outside of the Contractor's Service Area, in correspondence to the Contractor's projected need for SNF beds of its Enrollees.

2.7.1.1. Contractor will develop and implement a plan to ensure seamless access, coordination and delivery of Covered Services that are Medically Necessary to Enrollees who meet the medical necessity criteria.

2.11.3. Services Not Subject to Prior Approval

2.11.3.1. The Contractor will assure coverage of Emergency Medical Conditions and Urgent Care services. The Contractor must not require prior approval for the following services:

2.11.3.1.1. Any services for Emergency Medical Conditions (which includes emergency Behavioral Health care);

2.11.4. Authorization of Services. In accordance with 42 C.F.R. § 438.210, the Contractor shall authorize services as follows:

2.11.4.1. For the processing of requests for initial and continuing authorizations of Covered Services, the Contractor shall:

2.11.4.1.1. Have in place and follow written policies and procedures;

2.11.4.1.2. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and

2.11.4.1.3. Consult with the requesting Network Provider when appropriate.

2.11.4.2. The Contractor shall ensure that an authorized care coordinator is available twenty-four (24) hours a day for timely authorization of Covered Services that are Medically Necessary and to coordinate transfer of stabilized Enrollees in the emergency department, if necessary. The Contractor's guidelines for medical necessity must, at a minimum, be consistent with Medicare standards for acute services and prescription drugs and Medi-Cal standards for LTSS.

2.11.4.3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral Health services denials must be rendered by board-certified or board-eligible psychiatrists or by a licensed clinician, acting within their scope of practice, with the same or similar specialty as the Behavioral Health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

2.11.4.4. The Contractor shall assure that all Behavioral Health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). Contractor must comply with the requirements for demonstrating parity for quantitative treatment limitations between Behavioral Health and medical/surgical inpatient, outpatient and pharmacy benefits.

2.11.4.6.3. In accordance with 42 C.F.R. §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct utilization management activities for the Contractor must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

2.11.5. Utilization Management

2.11.5.1. Utilization management program: Contractor shall develop, implement, and continuously update and improve, a utilization management program that ensures appropriate processes are used to review and approve the provision of medically necessary Covered Services, excluding Part D benefits. Contractor is responsible to ensure that the utilization management program includes:

2.11.5.1.1. Qualified staff responsible for the utilization management program.

2.11.5.1.2. The separation of medical decisions from fiscal and administrative management to assure medical decisions will not be unduly influenced by fiscal and administrative management.

2.11.5.1.3. Allowances for a second opinion from a qualified health professional at no cost to the Enrollee.

2.11.5.1.4. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.

2.11.5.1.5. Communications to Network Providers of the procedures and services that require prior authorization and ensure that all contracting Network Providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

2.11.5.1.6. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor shall ensure that all contracted Network Providers and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

2.11.5.1.7. The quarterly reporting of utilization management activities into the DHCS, including a process to electronically report on the number and types of appeals, denials, deferrals, and modifications to the appropriate DHCS and CMT staff.

2.11.5.1.8. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.

2.11.5.2. These activities shall be done in accordance with Health and Safety Code Section 1363.5 and 28 CCR 1300.70(b)(2)(H) and (G) and 42 C.F.R. § 422.112, 422.152, 422.202, and 422.4.

2.11.5.3. Pre-Authorizations and Review Procedures Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

2.11.5.3.1. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

2.11.5.3.2. Qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Contractor's medical director, in collaboration with the Contractor's pharmacy and therapeutics committee (PTC) or its equivalent.

2.11.5.3.3. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

Cal MediConnect Prime Contract, Attachment A

A.2 Covered Services. Contractor agrees to provide Enrollees access to the following Covered Services:

A.2.1 All standard Medi-Cal fee-for-service benefits excluding:

A.2.1.1. ICF/MR services;

A.2.1.2. County-administered Medi-Cal Specialty Mental Health Services and and substance use disorder services. This does not include Behavioral Health services that become Medi-

Cal managed care benefits on January 1, 2014, pursuant to Welfare and Institutions Code Section 14132.03, which will be Covered Services under this contract;

A.2.1.3. State and County activities to administer IHSS, including determining eligibility, assessing, approving, and authorizing each current and new Enrollee's initial and continuing need for services, enrolling providers, conducting provider orientation, and retaining enrollment documentation, conducting criminal background checks on all potential providers, providing assistance to IHSS recipients in finding eligible providers through an established provider registry.

Health and Safety Code Section 1363.5.

(a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to Enrollees or persons designated by an Enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01.

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

- (1) Be developed with involvement from actively practicing health care providers.
- (2) Be consistent with sound clinical principles and processes.
- (3) Be evaluated, and updated if necessary, at least annually.
- (4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the Enrollee in that specified case.
- (5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.

(c) The disclosure required by paragraph (5) of subdivision (b) shall be accompanied by the following notice: "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director and/or senior Physician responsible for utilization management and/or oversight of enrollment of Cal MediConnect beneficiaries

- Utilization Management Director
- Staff assigned to oversee Cal MediConnect beneficiaries, including case managers, provider relations staff for medical groups/ IPAs handling high volume of Cal MediConnect beneficiaries, etc.

DOCUMENT(S) TO BE REVIEWED

- UM program description and UM Plan
- Policies and procedures specifically directed to the needs and requirements of Cal MediConnect Enrollees, e.g., UM policies and procedures, including org charts and committee descriptions, committee membership
- UM policies and procedures outlining development and approval of UM criteria for Medicaid-based services.
- Job Description of the Medical Director responsible for ensuring the UM Process complies with section 1367.01
- UM Committee minutes, list of committee members and medical specialties that sit on and/or consult to the committee
- Referral tracking system and reports on authorization turnaround times
- QM committee minutes and reports on UM activities and efforts to continuously improve the UM process

UM-001 - Key Element 1

1. The Plan has utilization management policies and procedures in connection with the delivery of Medicaid-based services.

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a written Utilization Management (UM) program description that ensures appropriate processes are used to review and approve the provision of medically necessary covered Medicaid-based services for Cal MediConnect Enrollees? (§2.11.5.1; §2.11.5.3.3.)			
1.2 Are the Plan’s UM written guidelines based on sound medical evidence or other applicable criterion, and are they consistently applied, and regularly reviewed and updated? (§2.11.5.3.3.)			
1.3 Does the Plan’s UM department employ qualified staff responsible for the program? (§2.11.5.1.1.)			

Assessment Questions	Yes	No	N/A
<p>1.4 Does the Plan’s UM program ensure that medical decisions are separate from fiscal and administrative management decisions? (§2.11.5.1.2.)</p>			
<p>1.5 Does the Plan’s UM program include allowances for a second opinion from a qualified health professional at no cost to the Cal MediConnect Enrollees? (§2.11.5.1.3.)</p>			
<p>1.6 Does the Plan’s UM program include established criteria for approving, modifying, deferring, or denying requested Medicaid-based services for Cal MediConnect Enrollees? (§2.11.5.1.4.)</p>			
<p>1.7 Does the Plan effectively communicate to network providers the procedures and services that require prior authorization and the procedures and timeframes for obtaining a prior authorization for Cal MediConnect Enrollees? (§2.11.5.1.5.)</p>			
<p>1.8 Does the Plan’s UM program include an established UM referral tracking system to track prior authorization requests and proper notification of providers and Cal MediConnect Enrollees? (Tracking system should include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals). (§2.11.5.1.6.)</p>			
<p>1.9 Does the Plan’s UM program processes include quarterly reporting of UM activities, including the number and types of denials, deferrals, modifications, and appeals for Cal MediConnect Enrollees? (§2.11.5.1.7.)</p>			
<p>1.10 Does the Plan’s UM program include procedures for continuously reviewing the performance and cost of UM personnel, services and facilities? (§2.11.5.1.8.)</p>			
<p>1.11 Does the Plan have written policies and procedures for the processing of requests for initial and continuing authorization of covered Medicaid-based services for Cal MediConnect Enrollees? (§2.11.4.1;§2.11.4.1.1; §2.11.5.3.3.)</p>			

Assessment Questions	Yes	No	N/A
1.12 Do the Plan's UM procedures describe a mechanism to ensure the consistent application of review criteria for authorization decisions for Medicaid based services? (§2.11.4.1.2.)			
1.13 Does the Plan's UM procedures require consultation with the requesting network provider when appropriate? (§2.11.4.1.3.)			
1.14 Are the Plan's Medicaid-based Behavioral Health utilization management practices in compliance with parity requirements of Medicaid managed care rules and the Affordable Care Act? (§2.7.1.1; 2.11.4.4; 42 USC 1396u-2(b)(8); Public Health Services Act, title XXVII, part A, subpart 2 section 2705. 2726. 42 U.S.C. 300gg-26.)			
1.15 Does the Plan ensure that compensation to individuals or entities that conduct utilization management activities for the Plan are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee? (§2.11.4.6.3.)			

UM-001 - Key Element 2

2. Only qualified persons with appropriate clinical experience may deny or modify authorizations for Medicaid-based services.

Assessment Questions	Yes	No	N/A
2.1 Are the Plan's decisions to approve, deny or modify an authorization for a Medicaid-based service made by a health care professional that has appropriate clinical experience? (§2.11.5.3.1.)			
2.2 Does the Plan have qualified health care professionals with the appropriate clinical experience to supervise Medicaid-based service reductions, and qualified physician(s) with the appropriate clinical experience, to review all denials made on the basis of medical necessity? (Including pharmaceutical services.) (§2.11.5.3.2.)			

Assessment Questions	Yes	No	N/A
2.3 Are the Plan’s decisions to deny or modify authorization of a service made by a health care professional who has the appropriate clinical expertise? (§2.11.4.3.)			
2.4 Are the Plan’s decisions to deny or modify a behavioral health services authorization request for Cal MediConnect Enrollees rendered by a board-certified psychiatrist or by a licensed clinician with sufficient expertise in the requested service? (§2.11.4.3.)			

UM-001 - Key Element 3

3. The Plan develops and uses UM criteria for Medicaid-based services which are consistent with acceptable standards and evaluates them annually.

Assessment Questions	Yes	No	N/A
3.1 Does the Plan provide Enrollees access to all standard Medicaid based fee-for service benefits, including applicable Behavioral Health services (but excluding ICF/MR services, County-administered Medi-Cal Specialty Mental Health services, and State and County activities to administer IHSS)? (Attachment A.2.; A.2.1; A.2.1.2; A.2.1.3.)			
3.2 Does the plan disclose to the director, the enrollees and the providers the criteria by which it (and its subcontractors conducting UM/ utilization review) use to authorize, modify, or deny Medicaid-based services? (Attachment A.2.1.3 (a).)			
A. Is this criteria developed by actively practicing health care providers with the appropriate clinical experience?(Except LTSS) (Attachment A.2.1.3 (b).)			
B. Is this criteria consistent with sound clinical principles and processes?(Except LTSS) (Attachment A.2.1.3(b).)			
C. Is this criteria evaluated/updated at least annually? (Attachment A.2.1.3(b).)			

Assessment Questions	Yes	No	N/A
D. Is this criteria disclosed to the provider and Enrollee when it is used as the basis of a decision to modify, delay, or deny services in a specific case under review? (Attachment A.2.1.3(b).)			
E. Is this criteria available to the public upon request? (Attachment A.2.1.3(b).)			
F. If the criteria is disclosed to a member of the public, do the materials contain the appropriate disclosure notice? (Attachment A.2.1.3(b)(5)(c).)			

End of Requirement UM-001: The Health Plan develops, implements, and maintains a Utilization Management process in connection with the delivery of Medicaid-based services.

Requirement UM-002: The Health Plan utilizes effective mechanisms to detect and/or manage over- and under-utilization of Medicaid-based services

STATUTORY/REGULATORY CITATION(S)

Cal MediConnect Prime Contract

2.11.5. Utilization Management

2.11.5.1. Utilization management program: Contractor shall develop, implement, and continuously update and improve, a utilization management program that ensures appropriate processes are used to review and approve the provision of medically necessary Covered Services, excluding Part D benefits. Contractor is responsible to ensure that the utilization management program includes:

2.11.5.1.4. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.

2.11.5.1.5. Communications to Network Providers of the procedures and services that require prior authorization and ensure that all contracting Network Providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

2.11.5.1.7. The quarterly reporting of utilization management activities into the DHCS, including a process to electronically report on the number and types of appeals, denials, deferrals, and modifications to the appropriate DHCS and CMT staff.

2.11.5.1.8. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.

2.11.5.2. These activities shall be done in accordance with Health and Safety Code Section 1363.5 and 28 CCR 1300.70(b)(2)(H) and (G) and 42 C.F.R. § 422.112, 422.152, 422.202, and 422.4.

2.11.7. Review of Utilization Data

2.11.7.1. Contractor shall include within the utilization management program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Enrollee utilization patterns shall be reported to DHCS upon request.

2.16.3.2. The Contractor shall:

2.16.3.2.1. Establish a mechanism to detect both underutilization and overutilization of services and assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

2.16.3.3.5. Contractor shall develop an [sic] QI report for submission to DHCS and CMS on an annual basis. The annual report shall include:

2.16.3.3.5.1.1. The collection of aggregate data on utilization;

2.19.2. General Reporting Requirements. The Contractor shall:

2.19.2.6. Report rates for an under/over-utilization monitoring measure set based upon selected HEDIS use of service measures or any other standardized or DHCS-developed utilization measures selected by DHCS.

2.11.5.3.6. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

Health & Saf. Code, Section 1367.01(j)

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

28 CCR 1300.70(b)(2)(H)

(H) A plan that has capitation or risk-sharing contracts must:

2. Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible under utilization of specialist services and preventive health care services.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director and/or senior Physician responsible for utilization management and/or oversight of enrollment of Cal MediConnect beneficiaries
- Utilization Management Director
- Staff assigned to oversee Cal MediConnect beneficiaries, including case managers, provider relations staff for medical groups/ IPAs handling high volume of Cal MediConnect beneficiaries, etc.

DOCUMENT(S) TO BE REVIEWED

- UM program description and UM Plan
- UM Committee minutes, list of committee members and medical specialties that sit on and/or consult to the committee
- Referral tracking system and reports on authorization turnaround times

- QM committee minutes and reports on UM activities and efforts to continuously improve the UM process
- Policies and procedures related to the detection of over and under-utilization of Medicaid-based services

UM-002 - Key Element 1

1. The Health Plan has mechanisms for managing and detecting and managing over- and under-utilization of Medicaid-based services.

Assessment Questions	Yes	No	N/A
1.1 Does the Plan systemically and routinely analyze UM data to monitor for potential over and under-utilization of Medicaid-based services? (§2.11.5.1.8.; §2.11.7.1.; §2.16.3.2.)			
1.2 Does the Plan regularly report the results of over and under-utilization monitoring activities to the UM and/ or QI Committees and discuss the findings? (§2.16.7.; Health & Saf. Code, Section 1367.01(j).)			
1.3 Does the Plan identify, communicate, and implement corrective actions when potential over and under-utilization issues are identified? (§2.16.7.; Health & Saf. Code, Section 1367.01(j).)			
1.4 Does the Plan have a mechanism to detect both underutilization and overutilization of services to Enrollees with special health care needs? (§2.16.3.2.)			
1.5 Does the Plan’s annual QI report include a collection of aggregate data on utilization? (§2.16.3.3.5.; §2.16.3.3.5.1.1.)			
1.6 If the Plan has capitation or risk sharing contracts, does the Plan have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix)? (28 CCR 1300.70(b)(2)(H).)			
1.7 Does the Plan meet its general reporting requirements to report rates of under/over utilization?			

Assessment Questions	Yes	No	N/A
(§2.7.1.1.; §2.19.2.6.)			

End of Requirement UM-002: The Health Plan utilizes effective mechanisms to detect and/or manage over- and under-utilization of Medicaid-based services

Requirement UM-003: The Health Plan utilizes methodologies and processes to handle prior authorizations appropriately in connection with the delivery of Medicaid-based services

STATUTORY/REGULATORY CITATION(S)

Cal MediConnect Prime Contract

2.11.3. Services Not Subject to Prior Approval

2.11.3.1. The Contractor will assure coverage of Emergency Medical Conditions and Urgent Care services. The Contractor must not require prior approval for the following services:

2.11.3.1.1. Any services for Emergency Medical Conditions (which includes emergency Behavioral Health care);

2.11.4.2. The Contractor shall ensure that an authorized care coordinator is available twenty-four (24) hours a day for timely authorization of Covered Services that are Medically Necessary and to coordinate transfer of stabilized Enrollees in the emergency department, if necessary. The Contractor's guidelines for medical necessity must, at a minimum, be consistent with Medicare standards for acute services and prescription drugs and Medi-Cal standards for LTSS.

2.11.4.5. The Contractor must notify the requesting Network Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Title 22 CCR § 53261, and must:

2.11.4.5.1. Be produced in a manner, format, and language that can be easily understood;

2.11.4.5.2. Be made available in Threshold Languages, upon request; and

2.11.4.5.3. Include information, in Threshold Languages about how to request translation services and alternative formats. Alternative formats shall include materials which can be understood by persons with limited English proficiency.

2.11.4.6. The Contractor must make authorization decisions in the following timeframes:

2.11.4.6.1. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.11.4.6.1.1. The Enrollee or the Provider requests an extension, or

2.11.4.6.1.2. The Contractor can justify (to the satisfaction of DHCS and/or CMS upon request) that:

2.11.4.6.1.2.1. The extension is in the Enrollee's interest; and

2.11.4.6.1.2.2. There is a need for additional information where:

2.11.4.6.1.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.11.4.6.1.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.4.6.2. For expedited service authorization decisions, where the provider indicates or the Contractor determines that following the standard timeframe in Section 2.11.4.7.1 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.11.4.6.2.1. The Enrollee or the provider requests an extension; or

2.11.4.6.2.2. The Contractor can justify (to DHCS and/or CMS upon request) that:

2.11.4.6.2.2.1. The extension is in the Enrollee's interest; and

2.11.4.6.2.2.2. There is a need for additional information where:

2.11.4.6.2.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.11.4.6.2.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.5.1.6. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor shall ensure that all contracted Network Providers and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

2.11.5.3. Pre-Authorizations and Review Procedures Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

2.11.5.3.4. Reasons for decisions are clearly documented

2.11.5.3.5. Notification to Enrollees regarding denied, deferred or modified referrals is made as specified in Section 2.11.5.1.6.

2.11.5.3.6. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

2.11.5.3.9. Contractor must notify the requesting provider or Enrollee of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

2.11.6. Timeframes for Authorization

2.11.6.1. Emergency and Urgently Needed Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

2.11.6.2. Concurrent review of authorization for treatment regimen already in place: Within five (5) business days or less, consistent with urgency of the Enrollee's medical condition

and in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.

2.11.6.3. Retrospective review: Within thirty (30) calendar days in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.

2.11.6.5. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Enrollee or the Enrollee's provider requests an extension, or the Contractor can provide justification upon request by the state for the need for additional information and how it is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.6.6. Expedited Authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires and not later than seventy-two (72) hours after receipt of the request for services. The Contractor may extend this period by up to fourteen (14) calendar days if the Enrollee requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.6.7. LTSS Authorization as follows:

2.11.6.7.1. Must include the PCP or case manager signature on any nursing facility authorization or reauthorization request.

2.11.6.7.2. Must include the PCP or case manager signature on any CBAS authorization or reauthorization request.

2.11.6.7.3. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for MSSP to MSSP providers for authorization into the MSSP. MSSP providers and the Contractor shall collaborate and coordinate MSSP care management services (see Section 2.6.3) [SIC, section 2.16.3].

2.11.6.7.4. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for IHSS to County Social Services Agency responsible for IHSS service authorization. County IHSS eligibility worker shall participate on the ICT whenever IHSS services are involved in the care of the Enrollees.

42 USC 1396u-2(b)(8)

(8) Compliance with certain maternity and mental health requirements. Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage.

Public Health Services Act, title XXVII, part A, subpart 2
SEC. 2705. 2726. 42 U.S.C. 300gg–26. PARITY IN MENTAL HEALTH AND
SUBSTANCE USE DISORDER BENEFITS.

(a) IN GENERAL.—

(1) AGGREGATE LIFETIME LIMITS.—In the case of a group health plan o(or health insurance coverage offered in connection with such a plan) or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) NO LIFETIME LIMIT.—If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) LIFETIME LIMIT.—If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable lifetime limit”), the plan or coverage shall either—(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or (ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit is less than the applicable lifetime limit.

(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) ANNUAL LIMITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan). or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) NO ANNUAL LIMIT.—If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(B) ANNUAL LIMIT.—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable annual limit”), the plan or coverage shall either— (i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or (ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) **RULE IN CASE OF DIFFERENT LIMITS.**—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) **FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.**—

(A) **IN GENERAL.**—In the case of a group health plan (or health insurance coverage offered in connection with such a plan); or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. (B) **DEFINITIONS.**—In this paragraph:

(i) **FINANCIAL REQUIREMENT.**—The term “financial requirement” includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

(ii) **PREDOMINANT.**—A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) **TREATMENT LIMITATION.**—The term “treatment limitation” includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) **AVAILABILITY OF PLAN INFORMATION.**—The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(5) **OUT-OF-NETWORK PROVIDERS.**—In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use

disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(b) CONSTRUCTION.—Nothing in this section shall be construed—(1) as requiring a group health plan o(or health insurance coverage offered in connection with such a plan). or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits; or (2) in the case of a group health plan o(or health insurance coverage offered in connection with such a plan). or a health insurance issuer offering group or individual health insurance coverage that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- UM Director and/or Managers
- Medical Director and/or senior Physician responsible for UM

DOCUMENT(S) TO BE REVIEWED

- UM policies and procedures, including UM decision timeframe requirements, UM criteria, policies regarding denial letters, including threshold language requirements
- Policies and procedures on LTSS referrals and authorization process
- Organization charts, committee descriptions and key staff job descriptions of staff involved in UM review
- Sample UM denial, deferral and modification letter templates
- Criteria plan uses to determine medical necessity
- Reports on referral turnaround times for routine, expedited, concurrent, pharmacy, and retrospective
- Description of treatment authorization processes

UM-003 - Key Element 1

1. The Plan has established and implemented written policies and procedures regarding the timeliness of UM Decisions and ensures they are consistently applied.

Assessment Questions	Yes	No	N/A
1.1 Does the Plan ensure that decisions for routine authorizations of Medicaid-based services are made in a timely fashion, not to exceed five business days after the Plan’s receipt of the information reasonably necessary to make the determination? (§2.11.6.5.; §2.11.4.6.1.)			

Assessment Questions	Yes	No	N/A
<p>1.2 Does the Plan ensure that decisions for routine authorizations (excluding LTSS) for Medicaid-based services are generally completed within five working days, and do not exceed 14 calendar days after the receipt of the request for service. unless: a) the Enrollee or provider requests an extension; or b) the Plan can justify that the extension is in the best interest of the Enrollee and there is need for additional information that could be received within 14 additional calendar days which has reasonable likelihood to lead to the approval of the request?</p> <p>(§2.11.6.5.; §2.11.4.6.1.; §2.11.4.6.1.1.; §2.11.4.6.1.2.; §2.11.4.6.1.3.; §2.11.4.6.1.2.1.; §2.11.4.6.1.2.2.)</p>			
<p>1.3 Does the Plan ensure that any decision on routine authorizations for Medicaid-based services (excluding LTSS) delayed beyond the time limit outlined in the three way contract, is considered a denial, and is immediately processed as such?</p> <p>(§2.11.6.5.)</p>			
<p>1.4 Does the Plan ensure that any decisions on expedited authorizations for Medicaid-based services (excluding LTSS) where the provider or Plan indicate that following the standard timeframe could seriously jeopardize the Cal MediConnect Enrollee’s life, health, or ability to maintain or regain maximum function do not exceed 72 hours after the receipt of the request for service, with a possible extension not to exceed 14 additional calendar days only if: a) the Enrollee or provider requests an extension; or b) the Plan can justify that the extension is in the best interest of the Enrollee and there is need for additional information that could be received within 14 calendar days which has reasonable likelihood to lead to the approval of the request?</p> <p>(§2.11.6.6.; §2.11.4.6.2.)</p>			
<p>1.5 Does the Plan ensure that any decision on expedited authorizations for Medicaid-based services for Cal MediConnect Enrollees delayed beyond either time limit, whichever one is shorter, is considered a denial, and is immediately processed as such? (Does not apply to LTSS)</p> <p>(§2.11.6.6.)</p>			

Assessment Questions	Yes	No	N/A
1.6 Does the Plan ensure that any decisions on concurrent review of authorization for treatment regimen already in place for Medicaid-based services for Cal MediConnect Enrollees do not exceed five business days, or less consistent with the Enrollee's medical condition? (Applies to Behavioral Health only) (§2.11.6.2.)			
1.7 Does the Plan ensure that any decisions on retrospective review of claims or previously provided care for Medicaid-based services for Cal MediConnect Enrollees do not exceed 30 calendar days? (§2.11.6.3.)			
1.8 Does the Plan ensure that decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services? (Behavioral Health only) (§2.11.5.3.6.)			

UM-003 - Key Element 2

2. The Plan establishes and implements appropriate UM-related guidelines for Medicaid based services (except LTSS), and communicates these to providers and beneficiaries.

Assessment Questions	Yes	No	N/A
2.1 Does the Plan ensure that the requesting provider is notified either verbally or in writing of any decision to approve, deny, modify or delay a service authorization request or to authorize a Medicaid-based service in an amount, duration or scope that is less than requested for any Cal MediConnect Enrollee? (§2.11.4.5; §2.11.5.3.9.)			
2.2 Does the Plan ensure that the Cal MediConnect Enrollee is notified in writing of any decision to approve, deny, modify or delay a service authorization request or to authorize a service in the amount, duration or scope that is less than requested? (§2.11.4.5; §2.11.5.3.9.)			
2.3 Does the Plan ensure that any notification to deny, modify, or delay a service authorization request is in a format and language that the Enrollee can easily understand? (§2.11.4.5.1.)			

Assessment Questions	Yes	No	N/A
2.4 Does the Plan ensure that any notification to deny, modify, or delay a service authorization request for any Cal MediConnect Enrollee is available in threshold languages upon request? (§2.11.4.5.2.)			
2.5 Does the Plan ensure that any notification to deny, modify, or delay a service authorization request for any Cal MediConnect Enrollee include information, in threshold languages on how to request translation services and alternative formats which include materials that can be understood by persons with limited English proficiency? (§2.11.4.5.3.)			
2.6 Does the Plan ensure that the reason for the decision is clearly documented? (§2.11.5.3.4.)			

UM-003 - Key Element 3

3. The Plan authorizes and communicates UM decisions to providers and beneficiaries within the timeframes outlined in the three way contract.

Assessment Questions	Yes	No	N/A
3.1 Does the Plan authorize services within five working days from receipt of the information reasonably necessary to render a decision but, no longer than fourteen (14) calendar days from the receipt of the request? (§2.11.6.5.)			
3.2 Does the Plan defer and extend the time limit an additional fourteen calendar days when the Enrollee or the Enrollee’s provider requests an extension, or when the Plan can provide justification for the need for additional information which is in the Enrollee’s interest? (§2.11.6.5.)			
3.3 Does the Plan authorize services within seventy-two hours after the request for services when the standard decision timeframe could seriously jeopardize the Enrollee’s life or health or ability to attain, maintain, or regain maximum function ? (§2.11.6.6.)			

Assessment Questions	Yes	No	N/A
3.4 Does the Plan provide notice of decisions related to expedited authorization requests within seventy-two hours of after receipt of the request for services? (§2.11.6.6.)			
3.5 Does the Plan extend this period by up to fourteen calendar days if the Enrollee requests an extension, or if the Plan needs additional information and the extension is in the Enrollee's interest? (§2.11.6.6.)			
3.6 Does the Plan consider any decisions delayed beyond the required time limits a denial and immediately process them as such? (§2.11.6.6.)			
3.7 Does the Plan notify Enrollees regarding denied, deferred or modified requests for authorization ? (§2.11.5.3.5.)			
3.8 Does the Plan the requesting provider or Enrollee of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested requests for authorization orally or in writing? (§2.11.5.3.9.)			

UM-003 - Key Element 4

4. The Plan has established and implemented guidelines for Long Term Services and Supports authorizations.

Assessment Questions	Yes	No	N/A
4.1 Does the Plan have policies and procedures for LTSS authorizations for Cal MediConnect Enrollees? (§2.11.6.7.)			
4.2 Is the PCP or case manager signature on nursing facility authorization or re-authorization requests for Cal MediConnect Enrollees? (§2.11.6.7.1.)			

Assessment Questions	Yes	No	N/A
4.3 Is the PCP or case manager signature on CBAS authorization or re-authorization requests for Cal MediConnect Enrollees? (§2.11.6.7.2.)			
4.4 If the Plan identifies a need for services during the HRA or ICT discussions, does the Plan refer potentially eligible Enrollees to MSSP and/ or IHSS? (§2.11.6.7.3.; §2.11.6.7.4.)			

End of Requirement UM-003: The Health Plan utilizes methodologies and processes to handle prior authorizations appropriately in connection with the delivery of Medicaid-based services.

Requirement UM-004: The Health Plan utilizes processes to evaluate and oversee utilization management activities of delegated entities in connection with the delivery of Medicaid-based services.

STATUTORY/REGULATORY CITATION(S)

Cal MediConnect Prime Contract

2.2.4. Delegation Oversight

2.2.4.1. Contractor shall provide ongoing delegation oversight of the structures, processes, and outcomes of First Tier, Downstream, and Related Entities operations.

2.2.4.2. Contractor shall continually assess its First Tier, Downstream, and Related Entities' ability to perform delegated activities through initial reviews, on-going monitoring, performance reviews, analysis of data, and utilization of available benchmarks, if available.

2.2.4.3. Contractor's Quality Improvement (QI) department shall maintain documentation of oversight activities.

2.2.4.4. Contractor's delegation oversight and monitoring activities shall emphasize results. To that end, Contractor shall identify areas requiring improvement and shall monitor the performance of the First Tier, Downstream, and Related Entities to ensure that such improvement occurs.

2.2.4.5. Contractor delegates activities to its First Tier, Downstream, and Related Entities in accordance with terms and conditions, contracts, applicable regulations, and this contract.

2.2.4.6. Contractor shall provide delegation oversight of its First Tier, Downstream, and Related Entities that includes the following:

2.2.4.6.1. Desktop and annual on-site revises;

2.2.4.6.2. Monitoring; and

2.2.4.6.3. Continuous improvement activities.

2.9.9. Subcontracting Requirements

2.9.9.1. The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

2.9.9.2. Contractor may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. Contractor shall evaluate the prospective First Tier, Downstream or Related Entity's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements per 42 C.F.R. §§ 422.504(i), 423.505(i), 438.230(b)(3), (4) and Title 22 CCR Section 53867 and this Contract.

2.9.9.3. All contracts entered into with First Tier, Downstream and Related Entities shall be in writing and in accordance with the requirements of the 42 C.F.R. § 438.230(b)(2), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 28, CCR Section 1300 et seq.; WIC Section 14200 et seq.; Title 22, CCR Section 53800 et seq.; and other applicable federal and state laws and regulations, including the required

contract provisions between the Contractor and First Tier, Downstream and Related Entities in Appendix C.

2.9.9.4. The Contractor remains fully responsible for functions delegated and for ensuring adherence to the legal responsibilities under the Contract, as described in Appendix C, except that the Contractor's legal responsibilities under this Contract for the provision of LTSS shall be limited as set forth in WIC Sections 14186 through 14186.4.

2.9.9.5. The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and state financial and program reporting requirements as the Contractor. Additional required contract provisions between the Contractor and First Tier, Downstream and Related Entities is contained in Appendix C.

2.9.9.6. The Contractor must:

2.9.9.6.1. Establish contracts and other written agreements between the Contractor and First Tier, Downstream and Related Entities for Covered Services not delivered directly by the Contractor or its employees;

2.9.9.6.2. Contract only with qualified or licensed providers who continually meet federal and state requirements, as applicable, and the qualifications contained in Appendix C.

2.9.9.6.3. This section does not apply to the California Department of Social Services or any other state department contracting with the Contractor for the provision of services under the Demonstration.

2.11.3. Services Not Subject to Prior Approval

2.11.3.1. The Contractor will assure coverage of Emergency Medical Conditions and Urgent Care services. The Contractor must not require prior approval for the following services:

2.11.3.1.1. Any services for Emergency Medical Conditions (which includes emergency Behavioral Health care);

2.11.4.3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral Health services denials must be rendered by board-certified or board-eligible psychiatrists or by a licensed clinician, acting within their scope of practice, with the same or similar specialty as the Behavioral Health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

2.11.4. Authorization of Services. In accordance with 42 C.F.R. § 438.210, the Contractor shall authorize services as follows:

2.11.4.1. For the processing of requests for initial and continuing authorizations of Covered Services, the Contractor shall:

2.11.4.1.1. Have in place and follow written policies and procedures;

2.11.4.1.2. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and

2.11.4.1.3. Consult with the requesting Network Provider when appropriate.

2.11.5.1. Utilization management program: Contractor shall develop, implement, and continuously update and improve, a utilization management program that ensures appropriate processes are used to review and approve the provision of medically necessary Covered Services, excluding Part D benefits. Contractor is responsible to ensure that the utilization management program includes:

2.11.5.1.1. Qualified staff responsible for the utilization management program.

2.11.5.1.2. The separation of medical decisions from fiscal and administrative management to assure medical decisions will not be unduly influenced by fiscal and administrative management.

2.11.5.1.3. Allowances for a second opinion from a qualified health professional at no cost to the Enrollee.

2.11.5.1.4. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.

2.11.5.1.5. Communications to Network Providers of the procedures and services that require prior authorization and ensure that all contracting Network Providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

2.11.5.1.6. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor shall ensure that all contracted Network Providers and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

2.11.5.1.7. The quarterly reporting of utilization management activities into the DHCS, including a process to electronically report on the number and types of appeals, denials, deferrals, and modifications to the appropriate DHCS and CMT staff.

2.11.5.1.8. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.

2.11.5.2. These activities shall be done in accordance with Health and Safety Code Section 1363.5 and 28 CCR 1300.70(b)(2)(H) and (G) and 42 C.F.R. § 422.112, , 422.152, 422.202, and 422.4.

2.11.5.3. Pre-Authorizations and Review Procedures Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

2.11.5.3.1. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

2.11.5.3.2. Qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of

and pursuant to criteria established by the Contractor's medical director, in collaboration with the Contractor's pharmacy and therapeutics committee (PTC) or its equivalent.

2.11.5.3.3. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

2.11.5.3.4. Reasons for decisions are clearly documented.

2.11.5.3.5. Notification to Enrollees regarding denied, deferred or modified referrals is made as specified in Section 2.11.5.1.6.

2.11.5.3.6. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

2.11.5.3.7. Prior Authorization requirements shall not be applied to Emergency Services, urgently needed services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

2.11.5.3.8. Records, including any Notice of Action (NOA), shall meet the retention requirements described in Section 5.4 Records Retention, Inspection, and Audit.

2.11.5.3.9. Contractor must notify the requesting provider or Enrollee of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

2.11.6. Timeframes for Authorization

2.11.6.1. Emergency and Urgently Needed Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

2.11.6.2. Concurrent review of authorization for treatment regimen already in place: Within five (5) business days or less, consistent with urgency of the Enrollee's medical condition and in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.

2.11.6.3. Retrospective review: Within thirty (30) calendar days in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.

2.11.6.4. Non Part D covered pharmaceuticals: Twenty-four (24) hours on all drugs that require prior authorization in accordance with WIC Section 14185 or any future amendments thereto.

2.11.6.5. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Enrollee or the Enrollee's provider requests an extension, or the Contractor can provide justification upon request by the state for the need for additional information and how it is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.6.6. Expedited Authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the

Contractor must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires and not later than seventy-two (72) hours after receipt of the request for services. The Contractor may extend this period by up to fourteen (14) calendar days if the Enrollee requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.6.7. LTSS Authorization as follows:

2.11.6.7.1. Must include the PCP or case manager signature on any nursing facility authorization or reauthorization request.

2.11.6.7.2. Must include the PCP or case manager signature on any CBAS authorization or reauthorization request.

2.11.6.7.3. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for MSSP to MSSP providers for authorization into the MSSP. MSSP providers and the Contractor shall collaborate and coordinate MSSP care management services (see Section 2.6.3) [SIC, section 2.16.3].

2.11.6.7.4. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for IHSS to County Social Services Agency responsible for IHSS service authorization. County IHSS eligibility worker shall participate on the ICT whenever IHSS services are involved in the care of the Enrollees.

2.11.7. Review of Utilization Data

2.11.7.1. Contractor shall include within the utilization management program mechanisms to detect both under- and over-utilization of health care services.

Contractor's internal reporting mechanisms used to detect Enrollee utilization patterns shall be reported to DHCS upon request.

2.11.8. Delegating Utilization Management Activities

2.11.8.1. Contractor may delegate utilization management activities. If Contractor delegates these activities, Contractor shall comply with Section 2.11.5.

2.16.3.3. Delegation of Quality Improvement Activities

2.16.3.3.1. Contractor is accountable for all QI functions and responsibilities (e.g. utilization management, credentialing and site review) that are delegated to First Tier, Downstream, and Related Entities.

2.16.3.3.2. Contractor shall maintain a system to ensure accountability for delegated QI activities, that at a minimum:

2.16.3.3.2.3. Includes the continuous monitoring, evaluation and approval of the delegated functions.

28 CCR 1300.70(b)(2)(H)

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.

(H) A plan that has capitation or risk-sharing contracts must:

1. Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations; the plan shall have systems in place to monitor QA functions.
2. Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible under utilization of specialist services and preventive health care services.

28 CCR 1300.70(b)(2)(G)

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.

If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

- (1) Inform each provider of the plan's QA program, of the scope of that provider's QA responsibilities, and how it will be monitored by the plan.
- (2) Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise and budgetary resources.
- (3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.
- (4) Require that standards for evaluating that enrollees receive health care consistent with professionally recognized standards of practice are included in the provider's QA program, and be assured of the entity's continued adherence to these standards.
- (5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.
- (6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- UM or QI Director
- Director of Compliance or Audits
- Director of delegated entities (or equivalent), if necessary

DOCUMENT(S) TO BE REVIEWED

- Plan to delegate contract or Delegation Agreement
- Materials provided by the Plan to the delegate to delineate responsibilities and monitoring activities
- Delegated entity UM Program description, policies and procedures, and criteria, as applicable
- Plan audit tool and sample audits of delegated entities
- Delegate UM reports
- Minutes of meetings where Plan presents audit findings for delegated entity audit
- Corrective action plans submitted and reviewed as necessary
- Provider service agreement and amendments addenda as applicable

UM-005 - Key Element 1:

1. Delegation Oversight: The Plan has policies and procedures for conducting regular oversight and monitoring its delegated entities to ensure compliance with its established UM standards.

Assessment Questions	Yes	No	N/A
1.1 Is there a delegation agreement between the Plan and the entity to which the Plan has delegated management (of UM, QI, benefits, etc.) that includes, but is not limited to a description of the delegated services, activities and administrative responsibilities? (§2.9.6.1.)			
1.2 Does the Plan have policies and procedures for monitoring its delegated entities including desktop and annual on-site reviews, monitoring, performance reviews, analysis of data, utilization of available benchmarks (if available) and continuous improvement activities? (§2.2.4.2.; §2.2.4.6.; §2.2.4.6.1.; §2.2.4.6.2.; §2.2.4.6.3.; §2.16.3.3.2.3.)			
1.3 Does the Plan conduct regular oversight of the UM Program for each of its delegated entities for compliance with its established UM standards? (§2.11.8.1.; §2.11.5.)			
1.4 Does the Plan retain responsibility for reviewing the overall quality of care delivered to plan enrollees (even if providers have quality assurance programs)? (§2.11.5.2.; 28 CCR 1300.70(b)(2)(G).)			

Assessment Questions	Yes	No	N/A
<p>1.8 If the Plan has capitation or risk-sharing contracts, does it have a mechanism to detect and correct under-utilization of Medicaid-based services by an at-risk provider (as determined by its patient mix)?</p> <p>(§2.11.5.2.; 28 CCR 1300.70 (b)(2)(H).)</p>			

UM-004 - Key Element 2:

2. UM Program: Each delegate has a written description of the UM Program that includes structure, scope, criteria, processes, and policies.

Assessment Questions	Yes	No	N/A
<p>2.1 Does the Plan ensure that each delegate has a written UM program description that ensures appropriate processes are used to review and approve the provision of medically necessary covered services for Cal MediConnect Enrollees (excluding Part D benefits)?</p> <p>(§2.16.3.3.1.; §2.11.5.1.)</p>			
<p>2.2 Does the Plan ensure that each delegate UM program description includes a <u>description of the staff responsible</u> for the UM program and their qualifications and the separation of medical decisions from fiscal and administrative management?</p> <p>(§2.11.5.1.1.; §2.11.5.1.2.)</p>			
<p>2.3 Does the Plan ensure that each delegate UM program description include established <u>criteria</u> for approving, modifying, deferring, or denying requested services for Cal MediConnect Enrollees and allow for a second opinion from a qualified health professional at no cost?</p> <p>(§2.11.5.1.3.; §2.11.5.1.4.)</p>			
<p>2.4 Does the Plan ensure that each delegate UM program description include <u>procedures for delegates to communicate</u> to Network Providers the procedures and services that require prior authorization and ensure that all contracting Network Providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services?</p> <p>(§2.11.5.1.5.)</p>			

Assessment Questions	Yes	No	N/A
2.5 Does the Plan ensure that each delegate UM program description <u>include an established UM referral tracking system</u> to track the timeliness of authorization request processing and to ensure proper notification of providers and Cal MediConnect Enrollees and the delegate has a UM plan that includes quarterly reports of UM activities? (§2.11.5.1.6.)			
2.6 Does the Plan ensure that each delegate UM program description or UM Plan includes <u>procedures for continuously reviewing</u> the performance of UM functions? (§2.11.5.1.8.)			
2.7 Does the Plan ensure that each delegate’s UM policies and <u>procedures require consultation</u> with the requesting network provider when appropriate? (§2.11.4.1.3.)			

UM-004 - Key Element 3:

3. Delegation Oversight: The Plan oversees each delegate to ensure that medical necessity and behavioral health determinations are made by appropriate professionals and that criteria/guidelines are developed and utilized appropriately.

Assessment Questions	Yes	No	N/A
3.1 Does the Plan ensure that each delegate’s UM policies and procedures specify that any decision to deny or modify a service that is less than requested must be made by a health care professional who has appropriate clinical experience in treating the Cal MediConnect Enrollee’s medical condition? (§2.11.5.1; §2.11.5.3.1.)			

Assessment Questions	Yes	No	N/A
<p>3.2 Does the Plan ensure that each delegate’s UM policies and procedures specify that any <u>decision to deny or modify</u> Medicaid-based behavioral health services for Cal MediConnect Enrollees <u>must be rendered by a board-certified psychiatrist, or by a licensed clinician with sufficient expertise in the requested service?</u></p> <p>(§2.11.5.1; §2.11.4.3.)</p>			
<p>3.3 Does the Plan ensure that each delegate <u>utilizes UM criteria/guidelines</u> when determining the <u>necessity</u> of Medicaid-based services for Cal MediConnect Enrollees and that the criteria/guidelines are based on sound medical evidence, or criteria outlined in the three way contract?</p> <p>(§2.11.5.1; §2.11.5.3.3.)</p>			
<p>3.4 Does the Plan ensure that each delegate <u>conducts a regular review and update of the written criteria/guidelines</u> for making medical necessity determinations for Cal MediConnect Enrollees? (Excluding LTSS)</p> <p>(§2.11.5.1; §2.11.5.3.3.)</p>			
<p>3.5 Does the Plan ensure that each delegate <u>conducts regular assessments</u> that the <u>UM criteria</u> are <u>consistently applied</u>?</p> <p>(§2.11.5.3.3)</p>			

UM-004 - Key Element 4:

4. Delegation oversight: The plan oversees each delegate to ensure that authorizations are processed in a timely manner.

Assessment Questions	Yes	No	N/A
<p>4.1 Does the Plan ensure that each delegate makes decisions on routine authorizations to approve, modify, or deny requests by providers in a timely fashion, not to exceed five business days after the Plan’s receipt of the information reasonably necessary to make the determination but no longer than 14 calendar days from the receipt of the request?(Does not apply to LTSS)</p> <p>(§2.11.6.5.)</p>			

Assessment Questions	Yes	No	N/A
<p>4.2 Does the Plan ensure that each delegate makes decisions on expedited authorizations within 72 hours after the receipt of the request for service? (Does not apply to LTSS)</p> <p>(§2.11.6.6.; §2.11.4.6.2.)</p>			
<p>4.3 Does the Plan ensure each delegate allows for an extension of expedited requests; not to exceed 14 additional calendar days only if: a) the Enrollee or provider requests an extension; or b) the Plan can justify that the extension is in the best interest of the Enrollee? (Does not apply to LTSS)</p> <p>(; §2.11.6.5.; §2.11.4.6.1.)</p>			
<p>4.4 Does the Plan ensure that each delegate’s decision on retrospective review of claims or previously provided care for Cal MediConnect Enrollees do not exceed 30 calendar days?</p> <p>(§2.11.5.1.; §2.11.6.3.)</p>			
<p>4.5 Does the Plan ensure that each delegate notify the requesting provider either verbally or in writing of any decision to approve, deny, modify or delay a service authorization request or to authorize a service in the amount, duration or scope that is less than requested for any Cal MediConnect Enrollee?</p> <p>(§2.11.5.1.; §2.11.5.3.9.)</p>			
<p>4.6 Does the Plan ensure that each delegate notify the Cal MediConnect Enrollee in writing of any decision to approve, deny, modify or delay a service authorization request or to authorize a service in the amount, duration or scope that is less than requested for any Cal MediConnect Enrollee?</p> <p>(§2.11.5.1.; §2.11.5.3.9.; §2.11.4.5.)</p>			
<p>4.7 Does the Plan ensure that each delegate notification to deny, modify, or delay a service authorization request for any Cal MediConnect Enrollee is in a format and language that is easily understood and is available in threshold languages upon request?</p> <p>(§2.11.5.1.; §2.11.4.5.1.)</p>			

Assessment Questions	Yes	No	N/A
<p>4.8 Does the Plan ensure that each delegate notification to deny, modify, or delay a service authorization request for any Cal MediConnect Enrollee include information, in threshold languages on how to request translation services and alternative formats which include materials that can be understood by persons with limited English proficiency?</p> <p>(§2.11.5.1.; §2.11.4.5.3.)</p>			
<p>4.9 Does the Plan ensure that each delegate has policies and procedures for LTSS authorizations and referrals for Cal MediConnect Enrollees and that those authorizations require the proper signatures?</p> <p>(§2.11.5.1; §2.11.6.7.)</p>			

End of Requirement UM-004: The Health Plan utilizes processes to evaluate and oversee utilization management activities of delegated entities in connection with the delivery of Medicaid-based services.

Requirement UM-005: The Health Plan has evidence of the delegated entities' compliance with its policies, procedures, and oversight.

STATUTORY/REGULATORY CITATION(S)

2.11.7. Review of Utilization Data

2.11.7.1. Contractor shall include within the utilization management program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Enrollee utilization patterns shall be reported to DHCS upon request.

2.11.5.3.3. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

2.11.8. Delegating Utilization Management Activities

2.11.8.1. Contractor may delegate utilization management activities. If Contractor delegates these activities, Contractor shall comply with Section 2.11.5.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- UM Director and/or Managers
- Medical Director and/or senior Physician responsible for UM
- UM Director and/or Managers responsible for the delegated entities

DOCUMENT(S) TO BE REVIEWED

- Policies or materials provided by the Plan to the delegate, related to oversight of delegated UM activities
- Plan audit tool
- Sample audits of delegated entities
- Delegate UM reports

UM-005 - Key Element 1

1. UM Program: The plan maintains evidence that the delegated entities are subject to Plan oversight and the delegated entities comply with Plan’s Medicaid-based policies and procedures

Assessment Questions	Yes	No	N/A
5.1 Does the Plan maintain written records demonstrating that each of its delegated entities’ comply with UM policies, procedures, and oversight? (§2.11.8.1.; §2.11.5.)			
5.2 Does the Plan ensure that each delegate routinely analyzes UM data and monitors for potential over and underutilization of services for Cal MediConnect Enrollees? (§2.11.5.1.8; §2.11.7.1; §2.16.3.2.)			
5.3 Does the Plan maintain reports and documentation provided by entities delegated to perform UM activities for ten (10) years from the end of the final contract period or completion of audit, whichever is later. (§5.4.1.)			

End of Requirement UM-005: The Health Plan has evidence of the delegated entities’ compliance with its policies, procedures, and oversight.