Regular Meeting of the

Santa Clara County Health Authority

Utilization Management Committee

Wednesday, January 20, 2021, 6:00 - 7:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave., San Jose, CA 95119

Via Teleconference

(669) 900-6833
Meeting ID: 993 0083 8824
Passcode: umc012021
https://zoom.us/j/99300838824

AGENDA

1. Introduction	Dr. Lin	6:00	5 min
2. Public Comment Members of the public may speak to any item not on the agenda; two minutes per speaker. The committee reserves the right to limit the duration of public comment to 30 minutes.	Dr. Lin	6:05	5 min
3. Meeting Minutes Review minutes of the Q4 October 14, 2020 Utilization Management Committee (UMC) meeting. **Possible Action:** Approve Q4 2020 UMC Meeting Minutes	Dr. Lin	6:10	5 min
4. Chief Executive Officer Update Discuss status of current topics and initiatives.	Ms. Tomcala	6:15	5 min
5. Chief Medical Officer Update **a.** General Update **b.** Annual Confidentiality Agreements	Dr. Nakahira	6:20	10 min
6. UM Program Description – 2021 Annual review of UM Program Description **Possible Action:** Approve UM Program Description.	Dr. Boris	6:30	5 min
7. BHT Program Description - 2021 Annual review of BHT Program Description **Possible Action:** Approve BHT Program Description	Ms. McKelvey	6:35	5 min

8. Annual Review of UM Policies	Dr. Boris	6:40	10 min
a. HS.01 Prior Authorization			
b. HS.02 Medical Necessity Criteria			
c. HS.03 Appropriate Use of Professionals			
d. HS.04 Denial of Services Notification			
e. HS.05 Evaluation of New Technology			
f. HS.06 Emergency Services			
g. HS.07 Long-Term Care Utilization Review			
h. HS.08 Second Opinion			
i. HS.09 Inter-Rater Reliability			
j. HS.10 Financial Incentive			
k. HS.11 Informed Consent			
l. HS.12 Preventive Health Guidelines			
m. HS.13 Transportation Services			
n. HS.14 System Controls			
Possible Action: Approve annual review of UM Policies.			
9. Reports			
a. Membership	Dr. Boris	6:50	5 min
b. Over/Under Utilization by Procedure Type/Standard UM Metrics			
c. Dashboard Metrics	Mr. Perez	6:55	10 min
• Turn-Around Time – Q4 2020			
d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q4 2020	Ms. Chen	7:05	10 min
e. Cal MediConnect and Medi-Cal Annual Referral Tracking - 2020			
f. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q1 2021			
g. Inter-Rater Reliability (IRR) Report BH – 2021	Ms. McKelvey	7:15	5 min
h. Annual Physician Peer-to-Peer (HS.02.02) - 2020	Dr. Boris	7:20	5 min
i. Behavioral Health UM	Ms. McKelvey	7:25	5 min
10. Adjournment	Dr. Lin	7:30	
Next meeting: Wednesday, April 21, 2021 at 6:00 p.m.			

Notice to the Public—Meeting Procedures

- Persons wishing to address the Utilization Management Committee on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should
  notify Amy O'Brien 48 hours prior to the meeting at (408) 874-1997.
- To obtain a copy of any supporting document that is available, contact Amy O'Brien at (408) 874-1997. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave, San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com.

Santa Clara Family Health Plan™

Public Comment

Santa Clara Family Health Plan™

Meeting Minutes – October 14, 2020

Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, October 14, 2020, 6:00 – 7:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - Draft

Members Present
Jimmy Lin, MD, Internal Medicine, Chair
Ali Alkoraishi, MD, Psychiatry
Dung Van Cai, DO, Head & Neck
Ngon Hoang Dinh, OB/GYN
Laurie Nakahira, D.O., Chief Medical Officer
Indira Vemuri, Pediatric Specialist

Staff Present
Dang Huynh, Director, Utilization Management & Pharmacy
Lily Boris, MD, Medical Director
Natalie McKelvey, Manager, Behavioral Health
Amy O'Brien, Administrative Assistant

Members Absent
Habib Tobbagi, PCP, Nephrology

Staff Absent
Christine Tomcala, Chief Executive Officer
Angela Chen, Manager, Utilization Management
Luis Perez, Supervisor, Utilization Management

1. Roll Call

Jimmy Lin, MD, Chair, called the meeting to order at 6:05 p.m. Roll call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Meeting Minutes

The minutes of the July 15, 2020 Utilization Management Committee (UMC) meeting were reviewed.

It was moved, seconded, and the minutes of the July 15, 2020 Utilization Management Committee meeting were **unanimously approved.**

Motion: Dr. Cai
Seconded: Dr. Dinh
Ayes: Dr. Alkoraishi, Dr. Cai, Dr. Dinh, Dr. Lin, Dr. Nakahira, Dr. Vemuri
Absent: Dr. Tobbagi

4. Chief Executive Officer Update

This item was combined with the Chief Medical Officer Update.

5. Chief Medical Officer Update

a. General Update

Laurie Nakahira, D.O., Chief Medical Officer (CMO), Santa Clara Family Health Plan (SCFHP), delivered the Chief Executive Officer update on behalf of Christine Tomcala. Dr. Nakahira began with an update on the Plan's membership. The Plan's October 2020 membership for the Cal MediConnect line of business is 9,570 members, which is an increase of approximately 1,200 members over the last 12 months. The Plan's membership for the Medi-Cal line of business is 256,490 members, which is an increase over the last 12 months of approximately 20,000 members. This is largely attributable to the temporary disenrollment suspensions by the DHCS due to COVID.

Dr. Nakahira continued with an update on Santa Clara County's response to COVID and the impact on SCFHP. The County has now moved from the purple tier into the orange tier, and further information on the criteria and mandates under the orange tier is available on the Santa Clara County Public Health website. At this time, the majority of SCFHP's staff continues to work from home, and it is anticipated this will continue until approximately mid-2021, pending updates from the CDC and Public Health. Dr. Nakahira continued her update with the Plan's COVID statistics. The Plan's member population includes 2,343 members who tested positive for COVID, and 897 members hospitalized due to COVID. Approximately 63 members, or 17% of the Plan's member population, have died from COVID. As of October 5, 2020, SCFHP's overall call volume has decreased. Our nurse advice line has received over 333 members calling in for advice regarding COVID. Approximately, 924 members have created an MD Live account, and 775 members have completed an MD Live telehealth visit. Approximately, 54 members have filed grievances related to COVID. Hospitalizations have increased due to COVID, which includes skilled nursing homes. This situation is being closely monitored by Public Health. Dr. Nakahira continued with an overview of the Plan's member outreach calls which includes robo calls to our vulnerable population and high-risk members, as well as members over the age of 65 with co-morbidities.

Dr. Nakahira continued with an update on the Blanca Alvarado Community Resource Center (CRC), which is projected to open between late October and mid-November 2020. The CRC will offer virtual health education classes. There will be some SCFHP staff working there, such as Customer Service representatives, and members will be also be able to meet with Case Managers there if it is more convenient for them to do so.

b. Provider Relief Funds Information

Dr. Nakahira provided the committee with an update on the Department of Health and Human Services CARES Act for the provider relief fund. We are in phase 3 of the relief fund. The application period is from October 5, 2020 until November 6, 2020. Eligible providers include those who were in practice from January 1, 2020 through March 31, 2020, and who were seeing patients with Medi-Cal, Medicare, and CHIP insurance plans. Behavioral health providers and providers who treat patients in assisted living facilities and skilled nursing homes are also eligible for relief funds. Eligible providers may apply online, and Dr. Nakahira will send Committee members a link to the CARES Act website.

Dr. Dinh asked Dr. Nakahira if a provider who qualified for the first 2 rounds of relief funds will also qualify for the 3rd round. Dr. Nakahira referred Dr. Dinh to the CARES Act website for further details. Dr. Dinh asked about billing modifiers, and Dr. Nakahira advised she will research this and provide clarification of this along with the link to the CARES Act website. Dr. Lin inquired as to whether telehealth will continue in 2021. Dr. Nakahira responded that CMS would like to extend telehealth, however, she has no further details.

6. Old Business/Follow-Up Items

a. General Old Business

Dr. Boris reminded the Committee that the Pharmacy Benefit Manager for the Medi-Cal line of business will transition to DHCS from Managed Care applicable to services received after January 1, 2021. Enterals and supplies are included as part of this transition. Dr. Boris referred Committee members to the website for further details. Dr. Dinh expressed concerns with next steps for providers. Dr. Huynh gave an overview of the Medi-Cal Rx program and when training for providers, as well as additional program details, will be made available on the provider portal on the Medi-Cal Rx website.

7. Medical Covered Services Prior Authorization (PA) Grid

Dr. Boris advised the Committee that the Medical Covered Services PA Grid is brought to the Committee on an annual basis for review and approval. The PA Grid pertains to both the Medi-Cal and Cal MediConnect lines of business. Dr. Boris reviewed the minor changes that were made to the grid since the last annual review in 2019. Once the Committee has approved it, the grid will be published and forwarded to CMS. Dr. Boris highlighted the most significant changes to the Grid. For example, all forms of non-emergency transportation will now require prior authorization, with the exception of ground transportation from facility to facility. In addition, prior authorizations are no longer required for colonoscopies but continue to be required for endoscopies. Dr. Lin requested clarification in regards to prior authorizations for colonoscopies, and Dr. Boris clarified that no prior authorization is needed for colonoscopies. Dr. Dinh requested clarification on prior authorization for ground transportation, and Dr. Boris clarified that emergency transportation does not require prior authorization.

It was moved, seconded and the Medical Covered Services Prior Authorization (PA) Grid was **unanimously approved**.

Motion: Dr. Cai
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Cai, Dr. Dinh, Dr. Lin, Dr. Nakahira
Absent: Dr. Tobbagi, Dr. Vemuri

Dr. Vemuri left the meeting at 6:35 pm.

8. 2021 CMC List of Durable Medical Equipment (DME) List

Dr. Boris presented an overview of the items on the 2021 CMC List of DME to the Committee. Dr. Boris advised the DME List is updated on an annual basis, and it is published on the SCFHP website.

It was moved, seconded and the 2021 CMC List of Durable Medical Equipment (DME) was **unanimously approved**.

Motion: Dr. Cai
Second: Dr. Dinh
Ayes: Dr. Alkoraishi, Dr. Cai, Dr. Dinh, Dr. Lin, Dr. Nakahira
Absent: Dr. Tobbagi, Dr. Vemuri

9. UM Policies and Procedures

a. HS. 02 Medical Necessity Criteria

b. HS. 09 Inter-Rater Reliability

Dr. Huynh presented the Committee with an overview of the relatively minor changes to the HS.02 Medical Necessity Criteria and HS.09 Inter-Rater Reliability policies.

It was moved, seconded and the UM Policies and Procedures HS.02 Medical Necessity Criteria and HS.09 Inter-Rater Reliability were **unanimously approved**.

Motion: Dr. Lin
Second: Dr. Cai
Ayes: Dr. Alkoraishi, Dr. Cai, Dr. Dinh, Dr. Lin, Dr. Nakahira
Absent: Dr. Tobbagi, Dr. Vemuri

10. Reports

a. Membership
Dr. Boris gave a brief summary of the Membership Report from January 2020 through September 2020. The majority of our members are delegated to Valley Health Plan, with the remaining majority delegated to Physicians Medical Group, Premier Care, and Kaiser Care.

b. Over/Under Utilization by Procedure Type/Standard UM Metrics
Dr. Boris presented the Committee with the UM objectives and goals. Dr. Boris summarized the results of the Medi-Cal SPD and non-SPD lines of business for the Q3 2020 12 month lookback period. Dr. Boris also summarized the Q3 2020 results of the Cal MediConnect line of business. These results resemble, but are typically higher than, the SPD results, and are attributable to a temporary claims lag. The number of discharges per thousand for the Medi-Cal population, including the SPD and non-SPD Medi-Cal population, is approximately 4-4.5 days, with the average length of stay approximately 4 days. The SPD population consists of approximately 30,000 members, and the rest are comprised of the non-SPD population. Dr. Lin asked if the average length of stay is normal, and Dr. Boris confirmed the average length of stay is normal, as is the number of discharges per thousand for the Medi-Cal population.

Dr. Boris next summarized the results for Medi-Cal and Cal MediConnect inpatient readmissions, which is an area of focus for the UM team for 2020. The lookback period ran from January through August 2020. The August numbers may be impacted by a claims lag. For our Medi-Cal population, there was a 30 day readmission rate at approximately 16% which is an area of improvement for the UM team. For our Cal MediConnect population, there was also a 30 day readmission rate at approximately 16%. These results align with the NCQA MediCare 50th percentile. Dr. Boris concluded with a summary of the ADHD Medi-Cal Behavioral Health metrics, and there are no significant changes from our July 2020 meeting.

c. Dashboard Metrics

- Turn-Around Time – Q3 2020
  Dr. Boris presented the Turn-Around Time metrics for Q3 2020 on behalf of Luis Perez. Approximately 100% of the UM staff continues to work from home. Dr. Boris summarized the Medi-Cal turn-around time results for the Committee. For July, August, and September of 2020, the turn-around times were compliant in all categories. Dr. Boris next summarized the results for the Cal MediConnect line of business. For July, August, and September of 2020, the turn-around times were also compliant in all categories.
- Call Center – Q3 2020
  Dr. Boris presented the Call Center metrics for Q3 2020 on behalf of Luis Perez. Dr. Boris reminded the Committee members these are provider calls, not member calls. The results for July, August, and September of 2020 for both the Medi-Cal and Cal MediConnect lines of business were compliant in all categories. Dr. Boris agreed with Dr. Lin that the team is very efficient.

d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q3 2020
Dr. Boris presented the Cal MediConnect and Medi-Cal Quarterly Referral Tracking report to the Committee. Dr. Boris explained that the UM team tracks the cycle of prior authorizations from the time the

prior authorization is issued through to claims payment. For the Cal MediConnect line of business, out of 2,700 authorization requests, 1,500 were paid within the first 90 days, and 1,200 outstanding claims remain. There are none that were received outside the 90 day period. This means approximately 44% received the service within the 90 day period. Overall, Cal MediConnect is at 60%. Dr. Lin advised that these numbers are low due to COVID-19 and Dr. Boris agreed.

For the Medi-Cal line of business, out of 4,000 authorization requests, 2,600 received services or were paid within 90 days, or 35%. There are none that were received outside the 90 day period. The UM team will call the 50 patients to find out why they did not get the authorized service.

e. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q3 2020

Dr. Boris presented the Committee with the results of the Q3 2020 Quality Monitoring of Plan Authorizations and Denial Letters.

Dr. Vemuri rejoined the meeting at approximately 6:35 pm.

f. Behavioral Health UM

Ms. McKelvey gave the Behavioral Health UM presentation to the Committee. Ms. McKelvey highlighted the new behavioral health vendors currently under contract or pending contract. Ms. McKelvey also highlighted the fact that the Behavioral Health team implemented the new ACES and PEARLS trauma screenings, and 1,460 screenings have been completed, largely at Valley Health Plan. Dr. Vemuri asked if SCFHP pays for these screenings. Ms. McKelvey responded that the Plan does pay for these screenings. Ms. McKelvey explained the process for providers to receive reimbursement for ACES and PEARLS trauma screenings. Dr. Vemuri expressed concern that SCFHP does not pay their providers for these screenings. A discussion ensued amongst Dr. Vemuri, Dr. Nakahira, and Dr. Boris in regards to claims reimbursements and provider incentives. Dr. Boris advised the Committee there was an issue with the billing modifier, and she and Dr. Nakahira will research this issue and report back to the Committee. Dr. Alkoraishi asked Ms. McKelvey if the trauma screenings can be broken down by age group. Ms. McKelvey replied that the reimbursement is the same no matter the age. Members under 21 are eligible for an annual screening, and providers will receive an annual provider reimbursement. Providers who screen members over the age of 21 are eligible for a once a lifetime, per provider, reimbursement. Dr. Boris assured the Committee that Ms. McKelvey will forward all pertinent information on the ACES and PEARLS trauma screenings to all Committee members.

11. UMC Meeting Calendar – 2021

Dr. Boris reviewed the 2021 UMC meeting dates and times with the Committee members.

12. Adjournment

The meeting adjourned at 6:50 p.m. The next meeting of the Utilization Management Commitment is on January 20, 2021 at 6:00 p.m.

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Jimmy Lin, MD, Chair Date

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Chief Executive Officer Update

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Chief Medical Officer Update

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UM Program Description - 2021

Santa Clara Family Health Plan

Utilization Management Program Description

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Santa Clara Family Health Plan

Introduction

Santa Clara Family Health Plan (SCFHP) has implemented a Utilization Management (UM) Plan consistent with Medicare regulations, the National Committee for Quality Assurance (NCQA) standards, the California Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) requirements to measure and monitor processes to improve the effectiveness, efficiency, and value of care and services provided to the members of SCFHP. SCFHP has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.

The UM program description is reviewed and approved by the SCFHP Utilization Management Committee (UMC) annually. SCFHP may provide recommendations for Quality Improvement (QI) activities to improve the comprehensive UM program. The SCFHP Chief Medical Officer or a medical director is involved in all UM activities, including implementation, supervision, oversight and evaluation of the UM Program. To assess the effectiveness of the UM program and to keep UM processes current and appropriate, SCFHP annually evaluates the UM Program for:

- The program structure, scope, processes, and information sources used to determine benefit coverage and medical necessity.
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioners in the program.
- Member and provider experience data

Santa Clara Family Health Plan (SCFHP) Background

Santa Clara Family Health Plan (SCFHP) is a local, public, not-for-profit health plan dedicated to improving the health and well-being of the residents of Santa Clara County. Our mission is to provide high quality, comprehensive health care coverage for those who do not have access to, or are not able to purchase, good health care at an affordable price. Working in partnership with providers, we act as a bridge between the health care system and those who need coverage. We do this by offering comprehensive, affordable medical, dental and vision coverage through our health insurance programs: Medi-Cal, a public insurance program, and Cal MediConnect, a program for individuals with both Medi-Cal and Medicare.

Since 1997, SCFHP has partnered with providers to deliver high-quality health care to our members. Through dedication to integrity, outstanding service, and care for our community, we work to ensure that everyone in our county can receive the care they need for themselves and for their families. We currently serve approximately 250,000 residents of Santa Clara County including over 8,000 of these members in the Cal MediConnect program.

Section I. Program Objectives & Principles

A. The purpose of the SCFHP Utilization Management (UM) Program is to objectively monitor and evaluate the appropriateness of utilization management services delivered to members of SCFHP. The UM Program addresses the following information about the UM structure:

1. Guide efforts to support continuity and coordination of medical services
2. Define UM staff members' assigned activities, including defining which of the UM staff has the authority to deny medical necessity coverage
3. Address process for evaluating, approving and revising the UM program and supporting policies and procedures
4. Define the UM Program's role in the QI Program, including how SCFHP collects UM information and uses it for QI related activities
5. Improve health outcomes
6. Support efforts that are taken to continuously improve the effectiveness and efficiency of healthcare services

B. The SCFHP maintains the following operating principles for the UM Program:

1. UM decisions are made on appropriateness of care and service, as well as existence of benefit coverage
2. Appropriate processes are used to review and approve provision of medically necessary covered services and are based on SCFHP policies and procedures through established criteria
3. The SCFHP does not financially reward clinicians or other individuals for issuing denials of coverage, care, or service
4. The SCFHP does not encourage UM decisions that result in under-utilization of care by members
5. Members have the right to:
    a) Participate with providers in making decisions about their individual health care
    b) Discuss candidly with providers the appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
6. The UM program and the utilization review policies and procedures are available to Members and Providers
7. SCFHP policies and procedures shall cover how Contractors, Subcontractors, or any contracted entity, authorize, modify, or deny health care services via Prior Authorization, concurrent authorization, or retrospective authorization, under the benefits provided by SCFHP
8. SCFHP policies, processes, strategies, evidentiary standards, and other factors used for UM or utilization review are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.
9. SCFHP notifies contracting health care Providers, as well as Members and Potential Enrollees upon request, of all services that require Prior Authorization, concurrent authorization or retrospective authorization and ensure that all contracting health care

Providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

10. SCFHP conducts all UM activities in accordance with CA Health and Safety Code 1367.01
11. SCFHP conducts their prior authorization requirements and complies with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d)

Section II. Program Structure

A. Program Authority

1. Board of Supervisors and the Board of Directors

The Santa Clara County Board of Supervisors appoints the Board of Directors (BOD) of SCFHP, a 12-member body representing provider and community partner stakeholders. The BOD is the final decision making authority for all aspects of SCFHP programs and is responsible for approving the Quality Improvement and Utilization Management Programs. The Board of Directors delegates oversight of Quality and Utilization Management functions to the SCFHP Chief Medical Officer (CMO) and the Quality Improvement Committee (QIC) and provides the authority, direction, guidance, and resources to enable SCFHP staff to carry out the Utilization Management Program. Utilization Management oversight is the responsibility of the Utilization Management Committee (UMC). Utilization Management activities are the responsibility of the SCFHP staff under the direction of the SCFHP Chief Medical Officer.

2. Committee Structure

The Board of Directors appoints and oversees the QIC, which, in turn, provides the authority, direction, guidance, and resources to the UMC to enable SCFHP staff to carry out the Quality Improvement and Utilization Management Programs.

SCFHP UMC meets quarterly in accordance with the SCFHP bylaws and more frequently when needed. Committee meeting minutes are maintained to summarize committee activities and decisions, and are signed and dated. The QIC provides oversight, direction and makes recommendations, final approval of the UM Program.

B. The Utilization Management Committee (UMC)

1. Composition, roles, goals, meetings, and additional information will be found in the UM Committee Charter.

2. Responsibilities of the UM Committee
   a) Develop, maintain, and execute an effective utilization review and management plan to manage the use of hospital resources in a manner that is efficient and cost effective.
   b) The Director of Utilization Management shall review the utilization review and management plan annually and revise it as necessary.
   c) Provide oversight for review and utilization of:
      i. Ancillary services
      ii. Medical necessity of admissions
      iii. Extended length of stay and high cost cases
      iv. Cases of non-covered stays
      v. Short stay inpatient stays
      vi. Observation cases.

d) Verify that utilization management functions meet the standards and requirements of all licensing and regulatory agencies, accrediting bodies, third party payers, and external review agencies.
e) Verify that admissions and discharges are appropriate using well-defined criteria.
f) Review and analyze data from the hospital-wide best practice/pathway activities, case mix index, denials, appeals/recoveries, and other sources and make recommendations for actions based on the findings.
g) Establish and approve criteria, standards, and norms for pre-admission reviews, continued stay reviews, and assist in continuing modification of such criteria, standards, and norms.
h) Recommend changes in patient care delivery if indicated by analysis of review findings.
i) Promote the delivery of quality patient care, according to developed or adopted criteria, in an efficient and cost-effective manner.
j) Refer quality concerns identified during the review process to the Quality and Compliance departments as needed for evaluation and action.

3. Conflict of Interest

No person who holds a direct financial interest in an affiliated health care entity is eligible for appointment to the Utilization Management Committee. SCFHP does not consider employment by the Plan to constitute a direct financial interest in an affiliated entity. No committee member may participate in the review of a case in which either he or she or any of his or her professional associates have been professionally involved, except to provide additional information as requested.

C. The Quality Improvement Committee (QIC)

1. Functional responsibilities for the UM Program
   a) Annual review, revision and approval of the UM Program Description
   b) Oversight and monitoring of the UM Program, including:
      a. Review and approval of the sources of medical necessity criteria
      b. Recommend policy decisions
      c. Monitor for over and under-utilization of health services
      d. Design and implement interventions to address over and under-utilization of health services
      e. Guide studies and improvement activities
      f. Oversight of annual program evaluation and review
      g. Review results of improvement activities, HEDIS measures, other studies and profiles and recommend necessary actions

D. Health Services Department

The Health Services Department at SCFHP is responsible for coordination of programs including the UM Program. The UM staff administer the UM Program. Non-clinical staff may receive and log utilization review requests in order to ensure adequate information is present. Some utilization requests are approved by the non-clinical staff. Appropriately qualified and trained clinical staff use evidence-based criteria or generally accepted medical compendia and professional practice guidelines to conduct utilization reviews and make UM determinations relevant to their positions and their scope. Potential denials are referred to licensed physicians and pharmacists for review. The CMO and Medical Director (MD), conduct reviews that require additional clinical interpretation or are potential denials. The medical directors apply medical necessity criteria that are reviewed and adopted on an annual basis. The CMO or qualified designee, including medical directors and pharmacists, are the only staff members that make medical necessity and coverage denial decisions.

1. Communication Services

The UM Staff shall provide the following communication services for members and practitioners:

a) UM personnel are available during normal business hours for inbound collect or toll-free calls regarding UM issues. The UM Department shall operate during normal health plan business hours.
b) Telephone lines are staffed with individuals who have access to most information/resources needed to provide a timely response. Callers have the option of leaving a voice mail message either during or after business hours
c) UM staff can receive inbound communication regarding UM issues after normal business hours. These calls are returned promptly the same or next business day.
d) UM staff are identified by name, title and organization name when initiating or returning calls regarding UM issues
e) The UM department has both local and toll-free telephone and telefax numbers and offers TDD/TTY services for deaf, hard of hearing or speech impaired members. Language assistance/interpretation is also available for members to discuss UM issues at no cost to the member

2. Roles / UM Staff Assigned Activities

a) Chief Medical Officer (CMO)

The Chief Medical Officer is a physician who holds an active, unrestricted California license and is designated with responsibility for development, oversight and implementation of the UM Program. The CMO shall serves as a voting committee member of the QIC, and makes periodic reports of committee activities, UM Program activities and the annual program evaluation to the BOD. The CMO works collaboratively with SCFHP community partners to continuously improve the services that the UM Program provides to members and providers. The CMO is the senior level physician for medical determinations and his/her role includes:

- Setting UM medical policies
- Supervising operations
- Reviewing UM cases
- Participating in UMC
- Evaluation of the UM program

b) Medical Directors (MD)

The Medical Directors are licensed physicians with authority and responsibility for providing professional judgment and decision making regarding matters of UM. Medical Director responsibilities include, but are not limited to, the following:

1. Support processes where medical decisions are rendered by, and are not influenced by fiscal or administrative management considerations. The decision to deny services based on medical necessity is made only by Medical Directors
2. Ensure that the medical care provided meets the standards of practice and care
3. Ensure that medical protocols and rules of conduct for plan medical personnel are followed
4. Develop and implement medical policy.
5. A medical director is designated to be involved with UM activities, including implementation, supervision, oversight and evaluation of the UM program
6. Any changes in the status of the CMO or Medical Directors shall be reported to the Department of Health Care Services (DHCS) within ten calendar working days of the change.
7. The SCFHP may also use external specialized physicians to assist with providing specific expertise in conducting reviews. These physicians hold current, unrestricted licenses in the state of California and are board-certified by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) in specific areas of medical expertise. The CMO is responsible for managing access and use of the panel organization of specialized physicians. An example of external specialist physicians would be psychiatry or psychology for making determinations regarding mental health care.

c) UM Director and UM Manager

The UM Director and UM Manager are responsible for the day-to-day management of the UM department, the overall UM Department operations and for coordination of services between other departments. These responsibilities include:

1. Develop and maintain the UM Program in collaboration with the Medical Director and other Health Services leadership including Behavioral Health, Case Management, Long Term Support Services (LTSS), Pharmacy, and Quality.
2. Coordinate UM activities with other SCFHP units.
3. Maintain compliance with the regulatory standards and requirements.
4. Monitor utilization data for over and under utilization.
5. Coordinate interventions with Medical Director(s) and staff to address under and over utilization concerns when appropriate.
6. Monitor utilization data and activities for clinical and utilization studies.
7. Maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans and community partners, sharing information about requirements and successful evaluation strategies
8. Implement the annual UM Program evaluation and Member and Provider Satisfaction Surveys

d) UM Supervisor

Responsible for the daily operational management of the UM department activities, including: authorization processing, letter creation, provider outreach and education, productivity and quality monitoring oversight, training and development, and the daily supervision of non-clinical UM Care Coordinators.

e) Pharmacy Director

The Pharmacy Director, or designee, is a unrestricted California licensed pharmacist (RPh) responsible for coordinating daily operations, and revewing and managing pharmacy utilization reports to identify trends and patterns. The Pharmacy Director provides clinical expertise relative to the Pharmacy, Quality, and Utilization Management components of SCFHP management. The scope of responsibilities of the Pharmacy Director includes:

1. Render pharmaceutical service decisions (approve, defer, modify or deny) pursuant to criteria established for the specific line of business by the CMO and the SCFHP Pharmacy and Therapeutics Committee or generally accepted medical compendia and professional practice guidelines
2. Assure that the SCFHP maintains a sound pharmacy benefits program.
3. Manage the SCFHP Formulary on an ongoing basis
4. Manage the Drug Utilization Review program
5. Monitor compliance with delegation requirements and the performance of thePharmacy Benefits Management
6. Provide clinical expertise and advice for the on-going development of pharmacy benefits.
7. Review medication utilization reports to identify trends and patterns in medication utilization

8. Develop and manage provider and client education programs to improve medication prescribing patterns and to increase patient compliance
9. Ensure compliance with Federal and State regulatory agencies
10. Manage the contract with, and delegated activities of, the pharmacy benefits management organization

f) Utilization Review and Discharge Planning Registered Nurses

Registered Nurses, with an unrestricted California license, are responsible for the review and determinations of medical necessity coverage decisions. Nurses may provide prospective, concurrent and retrospective inpatient or outpatient medical necessity coverage determinations using established and approved medical criteria, tools and references as well as their own clinical training and education. Utilization Review Nurses also work collaboratively with case managers and assist with member discharge planning. All cases that do not satisfy medical necessity guidelines for approval are referred to a Medical Director for final determination. The CMO or Medical Director(s) are available to the nurses for consultation and to make medical necessity denials.

g) Utilization Management Review Nurse

Under the guidance and direction of the UM Manager or UM Director, Registered Nurses or Licensed Vocational Nurses are responsible for performing prospective and retrospective pre-service clinical review for inpatient and outpatient authorization requests in compliance with all applicable state and federal regulatory requirements, SCFHP policies and procedures, and applicable business requirements. Following regulatory or evidence-based guidelines, the nurses assess for medical necessity of services and/or benefit coverage which result in approved determination for services or the need to collaborate with Medical Directors for potential denial considerations.

h) Non-Clinical Staff

Non-clinical staff in multiple roles perform a variety of basic administrative and operational functions. Clinical staff provides oversight to the non-clinical staff. Roles and responsibilities include:

1. Processing selected approvals that do not require clinical interpretation as indicated in the Care Coordinator Guidelines
2. Complete intake functions with the use of established scripted guidelines.
3. Assists with mailings and data collection

i) Behavioral Health Staff Assigned Activities

1. Medical Director or CMO
    i. Reviews denials, changes in requested service.
        a) If there is a change in the authorization request for a behavioral health related inpatient or partial hospitalization stay for a member, this is

considered a denial. The denial will be reviewed by the SCFHP MD or CMO who shall consult with a SCFHP psychiatrist as needed.

ii. Involved in the implementation of the behavioral health care aspects of the UM Program

iii. Establishes UM policies and procedures relating to behavioral healthcare

iv. Reviews and decides UM behavioral healthcare cases

v. Participates in UM Committee meetings

2. Psychiatrist
    i. SCFHP contracts with a board certified psychiatrist to provide consultation and participation in the following:
        a. Implementation of the behavioral health care aspects of the UM Program
        b. Establishing UM policies and procedures related to behavioral healthcare
        c. Participates in UM Committee meetings
        d. Development and approval of behavioral health criteria
        e. Review and decides UM behavioral healthcare cases
        f. Oversight of UM referrals and cases

3. Behavioral Health Director or Manager
    i. The BH Director or Manager is a clinician with the responsibility to facilitate the review of all referrals to the BH department for appropriate triage and assignment. The priority for assignment will be for psychiatrically hospitalized members, frequent emergency room (medical and psychiatric ER), emergent or urgent situations of a life-threatening nature, care coordination with Specialty Mental Health members. All other referrals from internal and external sources will be prioritized as staff time is available.
    ii. The BH Director or Manager is responsible to oversee Quality Improvement monitoring to continuously assess application of utilization management criteria, turn-around-times, appropriate level of care, etc. The Director or Manager drives compliance with behavioral health related HEDIS measures to support member access to preventive services and management of chronic conditions.

4. Behavioral Health Case Manager (s)
    i. The BH case manager will review all psychiatric hospitalizations and partial hospitalizations for medical necessity and to provide coordination of care upon discharge. The BH case manager will contact the hospital case manager to ensure that a plan is developed for aftercare. If the hospitalization is reviewed retrospectively, the BH case manager will contact the member or member's

parents to arrange for coordination of aftercare. The BH case manager will work to ensure that members receive follow-up care by a behavioral health practitioner within 30 days following a hospital discharge.

j) Pharmacy Staff

SCFHP staff is composed of clinical pharmacist(s), pharmacy technician(s), and medical director(s). Pharmacy staff roles and responsibilities include but are not limited to:

1. Review of all prior authorization requests for non-formulary medication therapy
2. Delegation oversight of the Pharmacy Benefit Manager
3. Quality Improvement monitoring to continuously assess application of criteria, turn-around-times, step therapy, etc.
4. Provides education to the contracted network staff as necessary
5. Drives compliance with medication related HEDIS measures to support member access to preventive services and management of chronic conditions

E. UM Program Evaluation

Members of the UM Program management team (CMO, Medical Director, UM and BH Director/Manager) annually evaluate and update the UM Program and develop the annual UM program evaluation to ensure the overall effectiveness of UM Program objectives, structure, scope and processes. The evaluation includes, at a minimum:

a) Review of changes in staffing, reorganization, structure or scope of the program
b) Analysis of annual aggregated data related to UM processes and activities
c) Resources allocated to support the program
d) Review of completed and ongoing UM work plan activities
e) Assessment of performance indicators
f) Review of delegated arrangements activities
g) Recommendations for program revisions and modifications

The UM management team presents a written program description and program evaluation to the UMC which is then taken to QIC. The QIC reviews and approves the UM Program description and evaluation on an annual basis. The review and revision of the program may be conducted more frequently as deemed appropriate by the QIC, CMO, CEO, or BOD.

The QIC's recommendations for revision are incorporated into the UM Program description, as appropriate, which is reviewed and approved by the BOD and submitted to DHCS, CMS on an annual basis.

F. Quality Improvement Integration

The UM Program includes a wide variety of quality assurance activities to support positive member outcomes and continuous quality improvement. The CMO guides these activities in collaboration with the Director of Compliance with the oversight of the QIC. Performance results are analyzed and

reviewed with opportunities for improvement identified for intervention and performance management.

1. Quality Improvement UM Program activities:

a. HEDIS measurement and reporting
b. Under and Over Utilization monitoring as exampled by:
    1. Readmission rates
    2. Access to preventive health services
    3. Bed days
    4. Length of Stay
c. Appeal, denial, deferral, modification and grievance monitoring
d. Provider profile measurement
e. Potential quality issue referrals
f. Quality Improvement Work Plan indicators
g. Quality improvement projects
h. Inter-rater reliability assessments
i. Focused ad hoc analyses
j. Regulatory compliance
k. Delegation oversight
l. Member and provider satisfaction with the UM process
m. Member and provider education
n. Member notifications for denial reason
o. UM turnaround times
p. Nurse Advice Line utilization and trends
q. Monitoring of groups with shared savings/capitation agreements
    1. SCFHP monitors groups with CAP agreements for under-utilization so that members receive optimal care regardless of risk agreement with provider group or plans.

2. UM Data Sources

Sources are used for quality monitoring and improvement activities, including those both directly administered by SCFHP and their delegates

a. Claims and encounter data
b. Medical records
c. Medical utilization data
d. Behavioral Health utilization data
e. Pharmacy utilization data
f. Appeal, denial, and grievance information
g. Internally developed data and reports
h. Audit findings
i. Other clinical or administrative data

Actual unit cost and utilization rates by treatment type category are compared to budgeted and benchmark figures. If any significant over or underutilization trend is noted, additional, more detailed reports are reviewed. Reports are structured so that they are available on a patient specific, provider or

group specific, service specific, or diagnosis specific basis. Data can be reported in summary or at an individual claim level of detail. The utilization reporting system allows for focused problem identification and resolution.

SCFHP's Pharmacy Benefit Coordinator routinely monitors and analyzes pharmacy use in each product line to detect potential underutilization and overutilization. Pharmacy utilization is also monitored by individual physicians and across practice and provider sites. Appropriate clinical interventions and/or other strategies are implemented when required and monitored for effectiveness.

3. Utilization Management Performance Monitoring

a. Areas to monitor

The Director of UM monitors the consistency of the UM staff in handling approval, denial and inpatient decisions. Turnaround time of UM decisions, including verbal and written notification is also monitored. CMO and Medical Director decisions are periodically reviewed by a physician for consistency of medical appropriateness determinations. Telephone service, as related to the percentage of calls that go into the hold queue, abandonment rate and average speed of answer are tracked. Additional monitoring of the UM Program is performed through comments from the Member Satisfaction Survey, the Provider Satisfaction Survey, and the quarterly appeals reports Product-line specific, high level, summary cost and utilization data is reviewed and analyzed monthly but not limited to the following areas:

1. Discharges/1,000
2. Percentage of members receiving any mental health service
3. Hospital outpatient services/1,000
4. ED visits/1,000 (not resulting in admission)
5. Primary Care visits/1,000
6. Specialty Care visits/1,000
7. Prescription Drug services
8. Denials
9. Deferrals
10. Modifications
11. Appeals

Actual unit cost and utilization rates by treatment type category are compared to budgeted and benchmark figures. If any significant over or underutilization trend is noted, additional, more detailed reports are reviewed. Reports are structured so that they are available on a patient specific, provider or group specific, service specific, or diagnosis specific basis. Data can be reported in summary or at an individual claim level of detail. The utilization reporting system allows for focused problem identification and resolution.

The Plan's Pharmacy Benefit Manager routinely monitors and analyzes pharmacy use in each product line to detect potential underutilization and overutilization. Appropriate clinical

interventions and/or other strategies are implemented when required and monitored for effectiveness.

b. Access to UM Staff

UM staff is available during normal business hours to answer questions regarding UM decisions, authorization of care and the UM program. The department has both local and toll-free telephone and telefax numbers and offers TDD/TTY services for deaf, hard of hearing or speech impaired members. Language assistance/interpretation is also available for members free of charge to discuss UM issues. Telephone lines are staffed with professionals who have access to most information/resources needed to provide a timely response. Callers have the option of leaving a voice mail message either during or after business hours. These calls are returned promptly the same or next business day. Staff is also a resource for other Plan Departments for UM and Case Management questions.

G. Appeal Procedures

The SCFHP maintains procedures by which a member, authorized representative and provider can appeal a UM organization determination that results in a denial, termination, or limitation of a covered service. The UM Program procedure for appeals includes provisions for timely and appropriate notification of pre-service, post-service and expedited appeals along with an option for external level review. Appeals are administered in accordance with SCFHP policies and procedures, and regulatory standards.

Detailed information about SCFHP appeal policies and procedures are housed within the appeal and grievance committee and unit.

H. Delegation of Utilization Management Activities

When SCFHP delegates Utilization Management decisions or other UM related activities, the contractual agreements between the SCFHP and this delegated group specify the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities to the SCFHP, how performance is evaluated; and corrective action plan expectations, if applicable. The SCFHP conducts a pre-contractual evaluation of delegated functions to assure capacity to meet standards and requirements. The SCFHP's Delegation Oversight Manager is responsible for the oversight of delegated activities. Delegate work plans, reports, and evaluations are reviewed by the SCFHP and the findings are summarized at QIC meetings, as appropriate. The Delegation Oversight Manager monitors all delegated functions of each of our delegates through reports and regular oversight audits. The QIC annually reviews and approves all delegate UM programs. Depending on the delegated functions the audit may include aspects of the following areas: utilization management, credentialing, grievance and appeals, quality improvement and claims.

As part of delegation responsibilities, delegated providers must:

- Develop, enact, and monitor a UM Program description that addresses all State, Federal, health plan and accreditation requirements.

- Provide encounter information and access to medical and behavioral health records pertaining to SCFHP members.
- Provide a representative to the QIC.
- Submit quarterly reports, annual evaluations, and work plans.
- Cooperate with annual audits and complete any corrective action judged necessary by the SCFHP.

SCFHP does not delegate the management of complaints, grievances and appeals. SCFHP conducts a pre-delegation review to measure resources of the potential delegate

Section III. Program Scope, Processes & Information Sources

The UM Program consists of comprehensive and systematic functions, services, and processes that provide care management to members, and include medical necessity determinations regarding the appropriateness of health care services in accordance with definitions contained in the member certificate of coverage. The UM Program also encompasses delegated utilization management functions, activities, and processes for behavioral health and pharmacy services.

A. Clinical Review Criteria

The UM Program is conducted under the administrative and clinical direction of the CMO and UMC. Therefore, it is SCFHP's policy that all medical appropriateness and necessity criteria are developed, and approved by the physician entities prior to implementation. Part of this review process may also include input from appropriate participating subspecialists. As part of the review of the UM Program, all criteria are reviewed and updated as needed, but no less than annually. Providers are advised annually that criteria are available upon request, by mail, fax, or email. Internally developed criteria and a general list of services that require prior authorization are also available on SCFHP's web site. MCG® criteria are available to providers upon request with the UM Department. The individual needs of the member and the resources available within the local delivery system are considered when applying medical necessity criteria.

1. Adoption of criteria

When adopting medical necessity criteria, SCFHP (with direct oversight by the CMO) will:

a. Have written UM decision-making criteria that are objective and based on medical evidence. The criteria include medical, long term services and support (LTSS), and behavioral healthcare services requiring review.
b. Have written policies for applying the criteria based on individual needs. SCFHP considers the clinical variables for review including:
    a. Age
    b. Comorbidities
    c. Complications
    d. Treatment progress
    e. Psychosocial factors

f. Home environment: when applicable

c. Have written policies for applying the criteria based on an assessment of the local delivery system. The medical, behavioral health, and LTSS units evaluate the local delivery systems in meeting member's needs.
d. Involve appropriate practitioners in developing, adopting and reviewing criteria via the practitioner involvement in UMC.
e. Annually review the UM criteria and the procedures for applying them, and updates the criteria when appropriate. SCFHP reviews UM criteria against current clinical and medical evidence and updates them when appropriate.

2. **Hierarchy of criteria**

Utilization review determinations are derived from a consistently applied, systematic evaluation of utilization management decision criteria. The criteria are selected based on nationally recognized and evidence-based standards of practice for medical services and are applied on an individual needs basis. A hierarchy of criteria for UM decision shall be outlined by UM Policies & Procedures.

Other applicable publicly available clinical guidelines from recognized medical authorities are referenced, when indicated. Also when applicable, government manuals, statutes, and laws are referenced in the medical necessity decision making process. The QIC annually reviews the Care Coordinator Guidelines and criteria and applicable government and clinical guidelines for changes and updates.

Additionally, the SCFHP has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in benefit plans in order to keep pace with changes and to ensure that members have equitable access to safe and effective care.

B. Medical Necessity

The UM Program is conducted under the administrative and clinical direction of the CMO and the UMC. Therefore, it is the policy of SCFHP that all medical appropriateness/necessity criteria are developed, reviewed and approved by the physician entities prior to implementation.

Part of this review process may also include input from appropriate participating subspecialists. As part of the review of the UM Program, all criteria are reviewed and updated as needed, but no less than annually. Providers are advised annually that criteria are available upon request. Internally developed criteria and a general list of services that require prior authorization are also available on the web site for SCFHP.

Specific MCG criteria are available to providers by contacting the UM department or the physician reviewer. The individual needs of the member and the resources available within the local delivery system are considered when applying medical necessity criteria.

Members may request a copy of the medical necessity criteria. When the disclosure of UM criteria is made to the public, the disclosure will 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."

The Medicare Model Evidence of Coverage (EOC) defines medically necessary services or supplies as those that are: "1) Proper and needed for the diagnosis or treatment of your medical condition; 2) Used for the diagnosis, direct care, and treatment of your medical condition; 3) Not mainly for your convenience or that of your doctor; and those that 4) Meet the standards of good medical practice in the local community."

1. Medical Necessity Determinations

Medical necessity determinations are made based on information gathered from many sources. As each case is different, these sources may include some or all of the following:

a) Primary care physician
b) Specialist physician
c) Hospital Utilization Review Department
d) Patient chart
e) Home health care agency
f) Skilled nursing facility
g) Physical, occupational or speech therapist
h) Behavioral health/chemical dependency provider
i) Patient or responsible family member

The information needed will often include the following:

a) Patient name, ID#, age, gender
b) Brief medical history
c) Diagnosis, comorbidities, complications
d) Signs and symptoms
e) Progress of current treatment, including results of pertinent testing
f) Providers involved with care
g) Proposed services
h) Referring physician's expectations
i) Psychosocial factors, home environment

The Utilization Review Nurses will use this information, along with good nursing judgment, departmental policies and procedures, needs of the individual member and characteristics of the local delivery system, including the availability of the proposed services within the network service area, or case conference discussions with a SCFHP Medical Director, to make a decision.

If the decision is outside the scope of the Utilization Review Nurse's authority, the case is referred to the Medical Director for a determination. The Medical Director, pharmacists, or designated behavioral health practitioner as appropriate, are the only plan representatives with the authority to deny payment for services based on medical necessity and appropriateness. Psychiatrists, doctoral-level clinical psychologists, or certified addiction medicine specialists have the authority to deny payment for behavioral health care services based on medical necessity

and appropriateness. Alternatives for denied care or services are given to the requesting provider and member and are based on the criteria set used or individual case circumstances. In making determinations based on contract benefit exclusions or limitations, the Member Handbook and Group Services Agreement are used as references.

2. Inter-Rater Reliability

The UM Manager monitors the consistency of the UM/BH/MLTSS/Pharmacy staff in handling pre-service approval, denial and inpatient concurrent review decisions. The Inter-Rater Reliability (IRR) testing process evaluates the consistent application amongst the Health Services teams (UM, BH, MLTSS, pharmacy staff), including all staff who apply medical necessity criteria, including medical directors, registered and licensed vocational nursing staff, pharmacists, pharmacy technicians, and non-clinical staff. Please refer to IRR Policy HS.09.01.

All staff is assessed through the established IRR process at least annually. All new hires are reviewed monthly for the first 90 days and then again annually.

C. Timeliness of UM Decisions

SCFHP maintains a policy and procedure (P&P) that meets state, federal, and NCQA (National Committee for Quality Assurance) regulations and guidelines for meeting timeliness standards of UM decisions and notification. The P&P is comprehensive and includes non-behavioral and behavioral UM decision and notification timeframes, it is reviewed at least annually. The operations dashboard is updated monthly and staff is monitored and evaluated on meeting timeliness standards.

D. Clinical Information

When determining coverage based on medical necessity for non-behavioral, behavioral, and pharmacy decisions, SCFHP obtains relevant clinical information and consults with the treating practitioner where necessary. The reviewing medical director or pharmacist shall document any consults conducted and will acknowledge the clinical information considered when making a decision to deny, delay or modify a request for service or care.
Clinical information may include, but is not limited to:

- Office and hospital records.
- A history of the presenting problem.
- Physical exam results.
- Diagnostic testing results.
- Treatment plans and progress notes.
- Patient psychosocial history.
- Information on consultations with the treating practitioner.
- Evaluations from other health care practitioners and providers.
- Operative and pathological reports.
- Rehabilitation evaluations.
- A printed copy of criteria related to the request.
- Information regarding benefits for services or procedures.

- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from family members.
- Behavioral Health Assessment

E. Transplants

It is SCFHP's policy that all requests for organ transplants be reviewed by the Medical Director or designee. Members are directed to the most appropriate Center of Excellence transplant facility for evaluation based on benefits. The Case Manager coordinates with the facility transplant coordinator to send the transplant recommendation to SCFHP, as appropriate, prior to approval by the Plan. Renal and corneal transplants are excluded from SCFHP review. The Plan's determination of medical necessity will be based on the Transplant Team determination, thus providing an outside, impartial, expert evaluation. Once the member has been approved, the member is enrolled in the United Network for Organ Sharing (UNOS). The patient's acceptance into UNOS serves as the Plan's medical necessity determination. All members that are approved for transplant are followed closely by Case Management as well as Paramount's interdepartmental transplant team, consisting of Medical Directors, Case Managers and Financial, Claims and Actuarial representatives. The purpose of the team is to ensure ongoing medical necessity for transplant, employer group high dollar alert (if self-insured), and reinsurance notification and to ensure appropriate claims payment.

F. New Technology Assessment

SCFHP investigates all requests for new technology or a new application of existing technology to determine whether the new technology is investigational in nature. If further information is needed, the Plan utilizes additional sources, including Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This includes medical and behavioral health procedures and devices. Pharmaceuticals are investigated by the Pharmacy and Therapeutics Committee. If the new technology, pharmaceutical or new application of an existing technology or pharmaceutical is addressed in the above documents, the information is taken into consideration by the Medical Director at the time of benefit determination. If the new technology, pharmaceutical or new application of an established technology/pharmaceutical is not addressed in the above documents, the Medical Director will confer with an appropriate board certified specialist consultant for additional information.. The decision will be based on safety, efficacy, cost and availability of information in published literature regarding controlled clinical trials. If a decision cannot be made, a committee of specialists (including medical, pharmacy, and behavioral health practitioners) may be convened to review the new medical technology/pharmaceutical and make a recommendation to the Medical Advisory Council.

G. Emergency Services/Post--Stabilization Care

No referrals are required for treatment of an emergency medical condition that manifests itself by such acute symptoms of sufficient severity, including severe ~~pain, that~~pain that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman, or her unborn child, in serious jeopardy
b. Serious impairment to bodily functions
c. Serious dysfunction of any bodily organ or part.

Emergency Room services are also covered if referred by an authorized Plan representative, PCP or Plan specialist. Plan notification (referral) is not required for payment of Emergency Room services for an emergency medical condition.

SCFHP properly arranges for the transfer of members after the member has been stabilized subsequent to an emergency psychiatric or medical condition but the provider believes further medically necessary health care treatment is required and the member cannot be safely discharged.

SCFHP ~~does not~~ require prior authorization for post-stabilization care

- The Plan shall fully document all requests for authorizations and responses to such requests for post stabilization medically necessary care which shall include the date and time of receipt, the name of the health care practitioner making the request and the name of the SCFHP representative responding to the request.
- The P~~p~~lan shall have procedure in place if the P~~p~~lan is unable to provide a determination (approval or denial) within 30 minutes of the request.
- All non-contracting hospitals are able to locate a contact number at which the hospital can obtain authorization from the Plan's web site, annual communication from the plan, and the Department of Managed Health Care's web page for 24/7 Contact of health plans requiring prior authorization for post-stabilization care.~~SCFHP by the information on the back of the member's identification card or by the website of the Plan~~
- SCFHP has mechanisms in place to support that a patient is not transferred to a contracting facility unless the provider determines no material deterioration of the patient is likely to occur upon transfer

H. Determination Information Sources

UM personnel collect relevant clinical information from health care providers to make prospective, concurrent and retrospective utilization review for medical necessity and health plan benefit coverage determinations. Clinical information is provided to the appropriate clinical reviewers to support the determination review process. Examples of relevant sources of patient clinical data and information used by clinical reviewers to make medical necessity and health plan benefit coverage determinations include the following:

1. History and physical examinations
2. Clinical examinations
3. Treatment plans and progress notes
4. Diagnostic and laboratory testing results
5. Consultations and evaluations from other practitioners or providers
6. Office and hospital records
7. Physical therapy notes
8. Telephonic and fax reviews from inpatient facilities
9. Information regarding benefits for services or procedures
10. Information regarding the local delivery system
11. Patient characteristics and information
12. Information from responsible family members

I. Health Services

The scope of health services and activities include utilization management, utilization review determinations, referral management, discharge planning, and complex case management.

1. Utilization Determinations

Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria. Qualified health care professionals supervise utilization review decisions of assigned UM staff and participate or lead UM staff training. These professionals also monitors all UM staff for consistent application of UM criteria for each level and type of UM decision, monitors all documentation for adequacy and is available to UM staff on site or by telephone. Under the supervision of a licensed medical professional, non-clinical staff collects administrative data or structured clinical data to administratively authorize cases that do not require clinical review.

Only a Medical Director, with a current California license to practice without restriction, makes medical necessity denial determinations. A Medical Director (medical or behavioral health) and/or an appropriately licensed pharmacist is available to discuss UM denial determinations with providers, and providers are notified about determination processes in the denial letter.

When applying medical necessity criteria, SCFHP shall

a. Consider individual needs of members
    i. Age
    ii. Comorbidities
    iii. Complications

iv. Progress of treatment
v. Psychosocial situation
vi. Home environment, as applicable

b. Assessment of the local delivery system

i. Availability of inpatient outpatient and transitional facilities
ii. Availability of outpatient services in lieu of inpatient services such as surgery centers vs. inpatient surgery
iii. Availability of highly specialized services, such as transplant facilities or cancer centers
iv. Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge
v. Local hospitals' ability to provide all recommended services within the estimated length of stay

In accordance with the DHCS contract only qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made on the basis of medical necessity. Additionally, a qualified physician or 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 Medical Director, in collaboration with the Pharmacy and Therapeutics Committee (P&T) or generally accepted medical compendia and professional practice guidelines.

UM decisions are not based on the outcome of individual authorization decisions or the number and type of non-authorization decisions rendered. UM decision making is based only on appropriateness of care and service and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. UM staff involved in clinical and health plan benefit coverage determination process are compensated solely based on overall performance and contracted salary, and are not financially incentivized by the SCFHP based on the outcome of clinical determination.

Board certified physician advisors are available to the UM Program for consultation on clinical issues as well as consultation for potential denials. The UM Program maintains a list of board-certified physician specialists identified for consultation and documents their involvement in member authorization and appeal records when appropriate.

For each non-medical necessity denial, the UM Department documents within it's UM system the reason for and the specific benefit provision, administrative procedure or regulatory limitation used to classify the denial. The UM staff references the sources (e.g. Certificate of Coverage or Summary of Benefits) of the administrative denial. The Plan includes this information in the denial notice sent to the member or the member's authorized representative and the practitioner.

Decisions affecting care are communicated in writing to the provider and member in a timely manner in accordance with regulatory guidelines for timeliness. Notification communication includes appeal rights and procedures. Member notifications comply with appropriate contractual and regulatory guidance for each member's line of business. Member correspondence about authorization decisions includes a statement in each SCFHP threshold language instructing the member how to obtain correspondence in their preferred language.

The UM Program appeals and reconsideration policies and procedures assure members and providers that the same staff involved in the initial denial determination will not be involved in the review of the appeal or reconsideration. Additionally, there is separation of medical decisions from fiscal and administrative management to ensure medical decisions will not be unduly influenced by fiscal and administrative management.

The UM Program includes the following utilization review processes:

a) Prospective Review

Prospective (pre-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted prior to the delivery of a health care service or supply to a member. A prospective review decision is based on the collection of medical information available to the health care provider prior to the time the service or supply is provided.

b) Concurrent Review

Concurrent review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted during a member's ongoing stay in a facility or course of outpatient treatment. The frequency of review is based on the member's medical condition with respect to applicable care guidelines.

c) Retrospective Review

Retrospective (post-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted after the health care service or supply is provided to a member. A retrospective review decision is based on the medical information available to the health care provider at the time the service or supply was provided.

d) Standing Referrals

SCFHP has established and implemented a procedure by which a member may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, and the plan medical director or his or her designee, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or independent practice association. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the member.

e) Terminal Illness

In the circumstances where SCFHP denies coverage to member with a terminal illness, which refers to an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider, SCFHP shall provide to the member within five business days all of the following information:

1. A statement setting forth the specific medical and scientific reasons for denying coverage
2. A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine
3. Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the member to request a conference as part of the plan's grievance system

f) Communications

Decisions to approve, modify, or deny requests by practitioners for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting practitioner verbally as appropriate and in writing. See pages 17 through 21 for notification timelines.

In the case of concurrent review, care shall not be discontinued until the member's treating practitioner has been notified of SCFHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

Communications regarding decisions to approve requests by practitioners prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to practitioners initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for SCFHP's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider to contact the professional responsible for the denial, delay, or modification with ease. Responses shall also include information as to how the member may file a grievance with the Plan.

For non-behavioral, behavioral, and pharmacy communication to members for denial, delay, or modification of all or part of the requested service shall include the following:

a) Be written in a language that is easily understandable by a layperson
b) Specify the specific health care service requested
c) Provide a clear and concise explanation of the reasons for the Plan's decision to deny, delay, or modify health care services. Reason shall be written in layperson terms, easily understandable by the member
d) Specify a description of the criteria or guidelines used for the Plan's decision to deny, delay, or modify health care services
e) Specify the clinical reasons for the Plan's decision to deny, delay, or modify health care services
f) Include information as to how he/she may file a grievance to the Plan

g) Include information as to how he/she may request an independent medical review
h) Include a statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the decision was based , upon request

g) Referral Management

1. In-network

SCFHP network physicians are the primary care managers for member healthcare services. The network primary care physicians provide network specialist and facility referrals directly to members without administrative pre-authorization from the UM Program, and primary care physicians may coordinate prior authorization for utilization review on a number of services such as DME, home health, and nutritional supplements. These referrals are primarily for routine outpatient and diagnostic services and are tracked by the UM Program from claims and encounter data. All elective inpatient surgeries and non-contracted provider referrals require prior authorization. The UM Program care management system tracks all authorized, denied, deferred, and modified service requests and include timeliness records. These processes are outlined in the Provider Manual and in internal policies and procedures.

2. Emergency Services

No referrals or prior authorization requests are required for treatment of an emergency medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

i. Placing the health of the individual or, with respect to a
ii. Pregnant woman, the health of the woman, or her unborn child,
iii. In serious jeopardy
iv. Serious impairment to bodily functions
v. Serious dysfunction of any bodily organ or part

Emergency Room services are also covered if referred by an authorized Plan representative, PCP or Plan specialist. Plan notification (referral) is not required for payment of Emergency Room services for an emergency medical condition.

3. Out of Network

Requests for out-of-network Referrals are reviewed individually and determinations are made based on the patient's medical needs and the availability of services within the Provider Network to meet these needs. A physician reviewer shall assess any requests for out of network referrals.

4. Specialist Referrals

The Primary Care Physician (PCP) may request a consultation from a participating specialist physician at any time. No referral is required from SCFHP prior to consultation with any participating specialists.

5. Tertiary Care Services

All referrals to Plan tertiary care centers are reviewed on an individual basis. The member's medical needs and the availability of the requested services within the non-tertiary care network are taken into consideration.

6. Second Opinions

A request for a second opinion may be initiated by a member or a treating healthcare provider of a member, and at no charge to the member. The processing of a request for a second opinion will be treated with the same criteria for turn-around-time as other UM referral requests. If a second opinion is not available within the Member's network, an out-of-network opinion will be arranged, at no cost other than normal co-payments, to the member. The member Evidence of Coverage provides all members with notice of the policy regarding the manner in which a member may receive a second medical opinion. The second opinion policy is reviewed, revised and approved annually.

7. Predetermination of Benefits/Outpatient Certification

Certain procedures, durable medical equipment and injectable medications are prior authorized. SCFHP uses MCG criteria for Imaging, Procedures and Molecular Diagnostics. When MCG criteria does not exist within SCFHP's purchased products, criteria are developed internally by the Utilization Management Committee, Pharmacy and Therapeutics Committee, or a workgroup as appropriate. Additionally, potentially cosmetic surgery and other procedures may be reviewed prospectively, at the request of providers and members, to issue coverage determinations.

8. Authorization Tracking

SCFHP tracks a defined sub-set of outpatient authorizations for completion of the authorization to claims paid cycle. This allows for monitoring of possible barriers leading to member non-compliance with prescribed care. In addition, the plan tracks authorizations while in process for timeliness and compliance with regulations and guidelines.

h) Discharge Planning

Discharge planning is a component of the UM process that assesses necessary services and resources available to facilitate member discharge to the appropriate level of care. UM nurses work with facility discharge planners, attending physicians and ancillary service providers to assist in making necessary arrangements for member post-discharge needs. Behavioral health case managers will work with psychiatric hospital facilities to facilitate member discharge to the most appropriate level of care and community case management. Long Term Services and Supports case managers assist members discharging from long term care.

i) UM Documents

In addition to this program description other additional documents important in communicating UM policies and procedures include:

1. The Provider Manual provides an overview of operational aspects of the relationship between the SCFHP, providers, and members. Information about the SCFHP's UM Program is included in the provider manual. In addition the Provider Manual describes how providers may obtain a copy of the clinical guidelines used to make medical determinations.
2. The Provider Manual and the web site also provide information about services/procedures requiring pre-authorization. Changes and updates are communicated to providers via faxed communications, newsletters, bulletins and the website.
3. Provider Bulletin is a monthly newsletter distributed to all contracted provider sites on topics relevant to the provider community and can include UM policies, procedures, and activities.
4. Evidence of Coverage (EOC) documents are distributed to members based on their product line. Members have the right to submit a complaint or grievance about any plan action, and the EOC document directs members to call the Customer Service phone number to initiate complaints or grievances involving UM issues and actions. Member complaints or grievances are documented in the data system and forwarded to the UM unit for follow-up response. The SCFHP Grievance and Appeal unit coordinates with the UM unit on appropriate responses to member complaints or grievances.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the UM Program information is available on the SCFHP website.

J. Behavioral Health Management

SCFHP provides access to all standard Medicaid based fee-for-service benefits, including applicable Behavioral Health services. Behavioral Health utilization management practices are in compliance with parity requirements of Medicaid managed care rules and the Affordable Care Act.

SCFHP members receive comprehensive behavioral health and substance abuse services according to their specific benefit package. SCFHP Medi-Cal members obtain mental health and substance use disorder services primarily through the Santa Clara County Behavioral Health Department (CBHD). The Severely Mentally Ill (SMI) population will be referred through the County Call Center to County Behavioral Health Services, Federally Qualified Healthcare Clinics or Community-Based Organizations. The CBHD will be responsible for payment of services to those who are determined by the CBHD to be SMI. The non-SMI diagnoses will be considered Mild to Moderate and after triage by the County Call Center, will be referred to Network providers by the SCFHP BH department.

Cal Medi-Connect (CMC) members will be treated the same as Medi-Cal members and referred through the County Call Center. The difference in terms of payment for CMC members is that the professional services for psychiatry, psychology and Licensed Clinical Social Work services are to be billed to SCFHP under the member's Medicare benefit. The Mild to Moderately diagnosed members will be screened by

the County Call Center and referred by SCFHP BH department. SCFHP is responsible for payment. Members may contact their County Call Center, or receive physician referral within the member's medical home. SCFHP maintains procedures for primary care providers to coordinate care and services for members in need of behavioral health services including, but not limited to, all medical necessary services across the behavioral health provider network.

Santa Clara Family Health Plan does not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.

1. **Behavioral Health Integration**

   The SCFHP uses a variety of mechanisms that ensure behavioral health services and management processes are actively integrated into the UM Program and include

   a) A behavioral healthcare practitioner is involved in quarterly HCQC meetings to support, advise and coordinate behavioral healthcare aspects into UM Program policies, procedures and processes.
   b) A behavioral healthcare practitioner participates as a member of the UM interdisciplinary care team. The UM interdisciplinary care team consists of a Medical Director, Registered Nurse, Pharmacist and Behavioral Healthcare practitioner. The team meets routinely to perform member case reviews. The interdisciplinary care team evaluates topics such as access, availability, health management systems, practice guidelines, clinical and service quality improvement activities, member satisfaction, continuity and coordination of care, and member's rights and responsibilities.
   c) SCFHP routinely receives clinical reports from Santa Clara County Behavioral Health Services Department, which are reviewed by the Manager of Behavioral Health Department or other designee.
   d) SCFHP participates in quarterly operational meetings with the CBHD to review and coordinate administrative, clinical and operational activities.

2. **Santa Clara County Behavioral Health Care Services**

   a) Specialty behavioral health services for Medi-Cal members, excluded from the SCFHP contract with DHCS, are coordinated under a Memorandum of Understanding executed with SCFHP. This is a carve-out arrangement for behavioral health management with the State of California directly overseeing and reimbursing the behavioral health services provided to Medi-Cal members.

3. **The referral procedure for SCFHP members includes**

   a) SCFHP Primary Care Providers (PCPs) render outpatient behavioral health services within their scope of practice.
   b) PCPs refer the members to Santa Clara County Behavioral Health Services Department for evaluation and coordination of medically necessary specialty behavioral health services by the Access Team, including inpatient psychiatric care.
   c) PCPs refer members to qualified Medi-Cal providers for the provision of services not covered by CBHD.

d) Members may contact the County Call Center to be screened and referred to SCFHP BH department for referrals to Network providers of Mild to Moderate services under Medi-Cal, or Cal MediConnect coverage

K. Pharmacy Management

SCFHP delegates pharmacy utilization management activities in the Cal MediConnect line of business to a pharmacy benefit management (PBM). The PBM possesses a UM program that manages pharmacy services under the delegated arrangement. Overall UM Program oversight is performed by the Chief Medical Officer or designee with supporting policies and procedures reviewed and approved by the Quality Improvement Committee. The Chief Medical Officer and the Director of Pharmacy are responsible for operational and clinical management of the pharmacy UM program. The scope of the UM Program encompasses all delegated processes performed by the PBM. These processes include: intake and triage requests, authorization guideline development, implementation of formulary tools and medication utilization review determinations. The Pharmacy and Therapeutics Committee provides oversight for evidence-based, clinically appropriate UM guideline criteria. Guidelines are developed in conjunction with review of peer-reviewed literature with consideration for such factors as safety, efficacy and cost effectiveness, and also with the input evaluation of external clinical specialists appropriate to the subject matter. In accordance with state, federal, and NCQA requirements, the pharmacy unit monitors timeliness and maintains policies and procedures on timeliness of UM decisions and notifications for pharmacy. An annual review process and ad hoc assessments support the development of guidelines that are current with the latest advancements in pharmaceutical therapy. The UM Program is evaluated annually and submitted to the Utilization Management Oversight Committee UMC for approval. This evaluation includes, but is not limited to: medication UM activities, UM structure and resources, measures to assess the quality of clinical decisions, overall effectiveness of the UM Program and opportunities for UM Program improvement.

L. Long Term Services and Supports

SCFHP has established and implemented guidelines for Long Term Services and Supports authorizations for services in this area. The LTSS Team including a Long Term Care UM RN and LTSS Case Managers coordinates with the UM department, LTSS providers, and community partners to identify care needs and facilitate access to appropriate services to achieve positive health outcomes.

M. Confidentiality

SCFHP has written policies and procedures to protect a member's personal health information (PHI). The Health Services Department collects only the information necessary to conduct case management services or certify the admission, procedure or treatment, length of stay, frequency and duration of health care services. We are required by law to protect the privacy of the member's health information. Before any PHI is disclosed, we must have a member's written authorization on file. Within the realm of utilization review and case management, access to a member's health information is restricted to those employees that need to know that information to provide these functions. A full description of SCFHP's Notice of Privacy Practices may be found on our website at: www.scfhp.com.

N. Interdepartmental collaboration

SCFHP departments collaborate to prevent conflicting information and to align member self-management tools, member education and information provided to the member.

Santa Clara Family Health Plan™

BHT Program Description - 2021

Santa Clara Family Health Plan (SCFHP) Behavioral Health Treatment (BHT) Program

Welcome to Santa Clara Family Health Plan! As a new contracted behavioral health treatment provider (BHT), Santa Clara Family Health Plan (SCFHP) would like to inform providers regarding SCFHP processes. These processes will include new members needing an initial authorization, a reauthorization to continue services when medically needed, and the expectations for the treatment plan. SCFHP will also be requesting from the provider, a description of the staff training plan and program description. A Behavioral Health Treatment Program Manager is available to assist providers and families with BHT related needs. The program manager is available by phone (408) 874-1923 or email at behavioralhealthhelpdesk@scfhp.com.

Process of authorization:

- SCFHP receives a referral from a Licensed Psychologist, or Licensed Medical Doctor for services. Referral must include supporting clinical documentation establishing medical necessity.
- If there is a Comprehensive Diagnostic Evaluation (CDE), it will be requested from the referring provider.
- SCFHP reviews the prior authorization request (PAR) and approves if the request meets medical necessity.
- Once approved, Behavioral Health Care Coordinator reaches out to the family if there is no provider identified on referral to find out availability of member, if any other language apart from English is needed, and obtains any other relevant information that the family can provide (ex. member in day care, member used to receive services under Early Start).
- The Behavioral Health Treatment Program Manager will outreach to BHT provider to find out if there is availability for the member to complete the assessment and if recommended based on medically necessity, be able to provide treatment.
- If BHT provider is able to provide services, an authorization letter for assessment is sent to the member, the referring provider, and BHT provider.
- The authorization for assessment completion is for 2 months. The timeframe can be extended if needed for some reason.
- Once the assessment is completed, the BHT provider submits the assessment report to SCFHP for review with the recommended hours for treatment if applicable.
- If BHT therapy is recommended, an approved authorization letter for behavioral health treatment with the recommended hours is sent to the member, referring provider and the BHT provider.
- Treatment is approved for 180 days.
- Progress reports for re-authorization need to be submitted every 180 days. In order to allow time to review and process, it is preferred that the report be submitted a minimum of 2 weeks before authorization expires.

All Plan Letter 19-014: RESPONSIBILITIES FOR BEHAVIORAL HEALTH TREATMENT COVERAGE FOR MEMBERS UNDER THE AGE OF 21
The approved behavioral treatment plan must also meet the following criteria:

- Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, or home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
- Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
- Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
- Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
- Include the member's current level of need (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, modified (include explanation).
- Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
- Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual provider who is responsible for delivering services.
- Include care coordination that involves the parents or caregiver(s), school, state disability programs, and other programs and institutions, as applicable.
- Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
- Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and in the community.
- Include an exit plan/criteria. However, only a determination that services are no longer medically necessary under the EPSDT standard can be used to reduce or eliminate services.

SCFHP Treatment Codes & Guidelines

- H0031 Initial Assessment & 6-month Reassessment
- H0032 Service Plan Development and/or Supervision *2 hours of Direct Supervision for every 10 hours of treatment; Service Plan Development 1 hour for every 2 hours of Direct Supervision; If exceeds these guidelines, please provide an explanation.*
- H2019 Direct Service*-If the recommendation exceeds 25 hours per week, please provide an explanation for review.*

- S5111 Direct Service Parent Training *SCFHP has added this treatment code to call out the importance of parent training as part of BHT.*
- H2014 Social Skills Group *Guideline is ratio of 1 provider to no more than 3 members in the group*

Every ABA treatment plan is based on individual needs; these are basic guidelines. If the needs are different, please submit an explanation for review.

All Plan Letter 19-014: RESPONSIBILITIES FOR BEHAVIORAL HEALTH TREATMENT COVERAGE FOR MEMBERS UNDER THE AGE OF 21

Medi-Cal does not cover the following as BHT services under the EPSDT benefit:

- Services rendered when continued clinical benefit is not expected, unless the services are determined to be medically necessary.
- Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
- Treatment where the sole purpose is vocationally- or recreationally-based.
- Custodial care. For purposes of BHT services, custodial care:
    a. Is provided primarily to maintain the member's or anyone else's safety; and,
    b. Could be provided by persons without professional skills or training.
- Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
- Services rendered by a parent, legal guardian, or legally responsible person.
- Services that are not evidence-based behavioral intervention practices.

BHT services for Autism Spectrum Disorder (ASD), or where there is suspicion of ASD that is not yet diagnosed, must be:

- Medically necessary, as defined for the EPSDT population;
- Provided and supervised in accordance with MCP-approve behavioral treatment plan that is developed by a BHT service provider who meets the requirements in California's Medicaid State Plan; and,
- Provided by a qualified autism provider who meets the requirements contained in California's Medicaid State Plan or licensed provider acting within the scope of their licensure.

BHT services for members without an ASD diagnosis must be:

- Medically necessary, as defined for the EPSDT population;
- Provided in accordance with an MCP-approved behavioral treatment plan; and,
- Provided by a licensed provider acting within the scope of their licensure.

Santa Clara Family Health Plan™

Annual Review of UM Policies

Santa Clara Family Health Plan™

Utilization Management Policy Review

#	Policy Name	Key Summary of Changes
HS.01	Prior Authorization	• Added additional description regarding UM Program. • Changed “minor consent services” to “consent services for a member who is a minor under 18 years of age.” • Removed statement regarding prior authorization is not required for post stabilization—refer to Policy HS.06. • Removed statement regarding initiation of prior authorization—already described in HS.01.01 Prior Authorization Procedure. • Removed statement regarding usage of standardized criteria—already described in Policy HS.02. • Removed statement regarding policy on denials and denial notification—already described in HS.04.01. Determination Notification Procedure. • Removed statement regarding evaluation of new technology—already described in Policy HS.05.
HS.02	Medical Necessity Criteria	• Added “of the local delivery system” to utilization management activities.
HS.03	Appropriate Use of Professionals	• Added “modification or” to “only a physician, designated behavioral health practitioner or pharmacist may make a necessity denial decision.”
HS.04	Denial of Services Notification	• No changes—Annual Review.
HS.05	Evaluation of New Technology	• No changes—Annual Review.
HS.06	Emergency Services	• Change “care necessary to stabilize the member’s medical condition” to “processes to handle post-stabilization request” • Removed statement regarding emergency department denial must be made by a physician reviewer—moved to HS.06.01 Emergency and Post Stabilization Services Procedure. • Removed statement regarding if treating provider disagree about the need for post stabilization care—moved to HS.06.01 Emergency and Post Stabilization Services Procedure.

		• Removed statement regarding plan reviews Emergency Services policy annually--- duplicate.
HS.07	LTC Utilization Review	• No changes—Annual Review.
HS.08	Second Opinion	• No changes—Annual Review.
HS.09	Inter-Rater Reliability	• No changes—Annual Review.
HS.10	Financial Incentives	• No changes—Annual Review.
HS.11	Informed Consent	• No changes—Annual Review.
HS.12	Preventive Health Guidelines	• No changes—Annual Review.
HS.13	Transportation Services	• No changes—Annual Review.
HS.14	System Controls	• No changes—Annual Review.

POLICY

Santa Clara Family Health Plan™

Policy Title:	**Prior Authorization**	**Policy No.:**	HS.01
Replaces Policy Title (if applicable):	Prior Auth for Non-Delegated SCFHP Mbrs., MLTSS Specialty Programs Prior Auth Process; Prior Authorization Process Continuity of Care Policy, Out of Network, Out of Area Referrals	**Replaces Policy No. (if applicable):**	UM002_07; UM002_09; UM002_08; UM031_04; UM033_04
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~Healthy Kids~~CMC	~~☒ CMC~~

I. Purpose

To define consistent processes and guidelines for conducting prior authorization ~~/~~and organization determinations.

II. Policy

A. Santa Clara Family Health Plan has developed, maintains, continuously improves and annually reviews a Utilization Management Program. The UM Program Description and written procedures addresses required functions to support the consistent application of criteria.

1. The Utilization Management Director and the Chief Medical Officer are responsible to develop, maintain, continuously improve and annually review a Utilization Management Program Description. The UM Program Description and written procedures include information about the following:

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i The process for prior-authorization and organization determinations

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ii Involvement of licensed healthcare professionals including a full time Medical Director

iii Involvement of the Medical Director or other designated licensed professional for any denials or modification decisions based on medical necessity

iv Involvement of the Medical Director or Pharmacist for any pharmaceutical denials / adverse determinations based on medical necessity

v Involvement of a Behavioral Health specialist for any behavioral health denials / adverse determination based on medical necessity

vi Use of established criteria for approving, modifying, deferring, or denying requested services as well as a separate policy regarding medical necessity criteria

vii Involvement of providers in adoption of specific criteria

viii Allowance for second opinions

ix The integration of UM activities into the Quality Improvement Committee (QIC)

POLICY

B. Communications to health care practitioners about the procedures and services that require prior authorization

~~A.~~

~~B.~~C. The plan shall provide or arrange for all medically necessary Medi-Cal and/or Medicare covered services, respectfully by the member's benefit, and to ensure that these services are provided in an amount no less than what is offered to members under fee-for-service.

~~1.~~ Prior Authorization is not required for Emergency Services (including Emergency Behavioral Health Services), ~~Urgent~~ urgent care, consent services for a member who is a minor under 18 years of age~~Minor Consent Services~~, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

D.

~~2.~~1. The Plan applies the prudent layperson or reasonable person's interpretation of what may be considered an emergent condition. A policy regarding coverage of emergency services is maintained, revised and reviewed annually and as needed.

~~C.A. Prior Authorization is not required for inpatient admissions for stabilization after emergency room treatment~~

~~Prior authorization is required for inpatient admissions and post stabilization admission in and out-of-network. Prior Authorization is not required for inpatient admissions for stabilization after emergency room treatment~~

~~D.~~

~~1. A member or member's representative can initiate prior authorization requests. In this case, the request is processed the same as a provider service request.~~

~~E. The Plan utilizes standardized criteria for medical necessity determinations and maintains a policy that is reviewed annually.~~

~~F.~~ The plan shall provide medically necessary enteral nutrition products, or formulas, and establish procedures for medical authorization requirements and list of enteral nutrition products.

E.

~~G.~~F. The Plan has established turn-around times for each line of business which is monitored for compliance

~~1.~~ Decisions are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services. In addition, all decisions are clearly documented.

1.

~~H.~~G. The plan allows for new members to continue services with out-of-network providers for a defined period of time in order to facilitate a smooth transition of care into the Plan's network as specified in Continuity of Care benefit.

~~I.~~H. The Plan maintains a procedure for Continuity of Care for both medical and behavioral health services.

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Commented [DH1]: No need to be in HS.01 since it's already in Policy HS.06 Emergency Services

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POLICY

~~J.~~I. Out of Area and Out of Network requests are processed in accordance to the Member's Evidence of coverage, the Plan's Continuity of Care procedure for medical and behavioral health and reviewed based on medical necessity.

~~K.~~J. Members and providers have access to the Utilization Management Department at least eight hours a day during normal business hours of at least 8:30 a.m. to 5:00 p.m. Pacific Time.

~~L.~~ The Nurse Line is available after hours for timely authorization of covered services that are Medically Necessary and to coordinate transfer of stabilized members in the emergency department, if necessary.

K.

~~1.~~ The Plan gathers all relevant information in order to make a prior authorization determination. This includes considerations outside of the clinical information such as support system, other resources and location.

1.

~~M.~~L. The Plan maintains a policy and procedure for allowing members access to a second opinion

~~N. The Plan maintains a policy on denials and denial notification~~

~~O.~~M. The Pan maintains a policy on requiring use of appropriate/qualified professionals for UM functions such as

1. Licensed vs. non-licensed functions
2. Specialist requirements (BH, other)

~~P. The Plan maintains policy and procedures to make certain that members have equal access to new technology or new uses of current treatment modalities through an established policy for the evaluation of new technology.~~

~~III.~~ Responsibilities

Health Services collaborates with internal and external stakeholders to ensure optimal utilization management of services for plan members. This includes working with of Quality, ~~Benefits,~~ Information Technology, Provider Network Operations, ~~and Member~~ Customer Services, ~~,~~ outside community resources, and providers.

~~IV.~~III. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, ~~Februrary~~February 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval

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POLICY

Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	**Original**	**Utilization Management**	**Approved 1/18/2017**	
1	**Reviewed**	**Utilization Management**	**Approved 1/17/2018**	
1	**Reviewed**	**Utilization Management**	**Approved 1/16/2019**	
2	**Revised**	**Utilization Management**	**Approved 10/16/2019**	
3	**Revised**	**Utilization Management**	**Pending Q1 2021 UMC**	

Santa Clara Family Health Plan™

POLICY

Policy Title:	Medical Necessity Criteria	**Policy No.:**	HS.02
Replaces Policy Title (if applicable):	Clinical Decision Criteria and Application Policy; Utilization Management Review Standards, Criteria and Guidelines; UM Interrater Reliability Testing	**Replaces Policy No. (if applicable):**	CSCFHP_UM121_01; UM039_02; UM038_
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define Santa Clara Family Health Plan's use of Medical Necessity Criteria for utilization management activities of the local delivery system, which includes the mandate that they are applied appropriately and consistently to determinations of medical necessity of coverage.

II. Policy

The Plan maintains a Utilization Management (UM) Program description and Prior Authorization Procedure which further describe the Plan's utilization of Medical Necessity Criteria. The following factors apply:

A. Criteria is based on sound clinical evidence to make utilization decisions
B. Criteria is specific to the services and procedures requested
C. Criteria is used to evaluate the necessity of medical and behavioral healthcare decisions
D. The Plan annually defines the hierarchy of application of criteria for each line of business
E. In addition to the UM hierarchy of guidelines, the Plan is licensed to use MCG™ guidelines ~~-~~to guide utilization management decisions
F. The criteria is reviewed and adopted at least annually by the Utilization Management Committee (UMC)
    1. The ~~UM Committee~~ UMC consists of external physicians, both primary care providers and specialists (including pediatric and behavioral health specialists), in developing, adopting, and reviewing criteria
G. The review for medical necessity ~~review~~ takes into account individual member needs and circumstances, relative to appropriate clinical criteria and the Plan's ~~SCFHP~~ policies
H. The P~~p~~lan defines the availability of criteria and states in writing how practitioners can obtain UM criteria and how the criteria is made available to the practitioners and members upon request
I. The plan evaluates the consistency with which health care professionals involved with any level of applying UM criteria in decision making and takes appropriate corrective actions to improve areas of non-compliance at least annually

J. Where applicable, UM criteria is developed for parity diagnoses, for the diagnosis and treatment of serious mental illnesses, autistic disorders, and other pervasive-developmental disorders and serious emotional disturbances of a child.

1. This includes criteria consistent with standards of practice for the following mental parity conditions: Schizophrenia, Schizoaffective disorder, Bipolar disorder, Major Depressive Disorders, Panic disorder, Obsessive-compulsive disorder, Pervasive developmental disorder or autism, Anorexia Nervosa, Bulimia Nervosa and Severe Emotional Disturbances of Children.

III. Responsibilities

Chief Medical Officer or designee shall review~~s~~ annually and submits criteria, policies and procedures to the Utilization Management Committee for approval.

IV. References

National Committee for Quality Assurance. 2020 Program Standards and Guidelines – UM 2: Clinical Criteria for UM Decisions

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 04/20/2016**	
v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/16/2019**	
v2	**Revised**	**Utilization Management**	**Approve 01/15/2020**	
v3	**Revised**	**Utilization Management**	**Approve 10/14/2020**	
v4	**Revised**	**Utilization Management**	**Pending Q1 2021 UMC**	

Santa Clara Family Health Plan™

POLICY

Policy Title:	**Appropriate Use of Professionals**	**Policy No.:**	HS.03
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To provide clear directives that Utilization Management (UM) activities are carried out by qualified personnel, not limited to but including utilization of licensed healthcare professionals for any determination requiring clinical judgment.

II. Policy

A. Santa Clara Family Health Plan's Health Services Department carries out various utilization management activities which require different levels of licensure or expertise.
B. The Plan specifies the type of personnel responsible for each level of decision making which includes:
   - Non-licensed staff may apply established and adopted UM Care Coordinator guidelines that do not require clinical judgment.
   - Only qualified licensed healthcare professionals assess clinical information used to support UM decisions.
   - Only a physician, designated behavioral health practitioner or pharmacist may make a medical necessity modification or denial decision.
C. Licensed professionals supervise all medical necessity decisions and provide day to day supervision of assigned UM staff.
D. Non-licensed and licensed staff receive training and daily supervision by UM Department management designee and medical directors.
E. The Plan maintains written job descriptions with qualifications for practitioners who review denials based on medical necessity which addresses education, training, experience and current appropriate clinical licensure.
F. The Plan maintains a fulltime Medical Director and Chief Medical Officer. Each maintain an un-restricted physician license in the state of California.
G. The Plan requires that each UM denial file includes the reviewer's initial, unique electronic signature, identifier or a signed / initialed note by the UM staff person attributing the denial decision to the professional who reviewed and decided the case.
H. The plan maintains written procedures for using board certified consultants to assist in making medical necessity determinations which documents evidence of the use of the consultants when applicable.

III. Responsibilities

Health Services follows appropriate professionals supported by Human Resources for licensing verification and Provider Network Management monitoring of the professional licensing organizations.

IV. References

National Committee for Quality Assurance. 2020 Standards and Guidelines - UM 4: Appropriate Professionals

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 01/08/2017**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/16/2019**	
v2	**Revised**	**Utilization Management**	**Approve 01/15/2020**	
V3	**Revised**	**Utilization Management**	**Pending Q1 2021 UMC**	

Santa Clara Family Health Plan™

POLICY

Policy Title:	**Denial of Services Notification**	**Policy No.:**	HS.04
Replaces Policy Title (if applicable):	Member Notification about Adverse Medical Service Decisions	**Replaces Policy No. (if applicable):**	UM-01-96
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒CMC	

I. Purpose

To define Santa Clara Family Health Plan's expectations for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations.

II. Policy

A. The plan maintains strict processes on notification of denial decisions to members and providers. Notification includes verbal and written processes. A procedure is maintained that outlines timeliness guidelines.

B. A "peer to peer" review mechanism is in place to allow providers to discuss a denial with a physician reviewer prior to submitting an appeal. This is documented when such discussions occur.

C. Letters will be provided in the language noted on the member's plan file within the threshold language requirement.

D. Letters to members for denial, delay, or modification of all or part of the requested service include:

1. A clear and concise explanation of the reason(s) for the Plan's decision to deny or modify the requested service.
2. A reference to the specific benefit provision, criteria or guidelines used for the Plan's decision
3. A specific clinical reason(s) or rationale for the Plan's decision without the use of detailed medical verbiage and/or technical language that is easily understandable for a reasonable layperson
4. The specific information needed and the specific criterion used if the denial is due to not enough clinical information to support full clinical review
5. Notice that a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based is available upon request.
6. Notice that notifications are available in other languages upon request and that translation services in alternative formats can be requested for members with limited language proficiency

7. The name of the determining health care professional as well as the telephone number to allow the physician or provider to easily contact the determining health care professional on the written notification to the requesting provider
8. Instruction on how to file an appeal including:
    i. A description of appeal rights, including the right to submit written comments; documents or other information relevant to the appeal
    ii. An explanation of the appeal process; including members' rights to representation and appeal time frames
    iii. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials
    iv. A description on how to appeal to the Independent Medical Review body appropriate to their line of business (i.e. State DMHC for Medi-Cal, Maximus for Medicare)

III. Responsibilities

Health Services coordinates with both internal and external stakeholders in development, execution, maintenance and revisions to denial notifications. This includes but is not limited to collaboration with Quality, Benefits, IT, UM Committee, QIC, providers and community resources.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, February 22). Washington, DC, U.S.A.

Department of Health Care Services. ALL PLAN LETTER 17-011 STANDARDS FOR DETERMINING THRESHOLD LANGUAGES AND REQUIREMENTS FOR SECTION 1557 OF THE AFFORDABLE CARE ACT. Retrieved 12/18/2018*https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-011.pdf*

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/16/2019**	
v2	**Revised**	**Utilization Management**	**Approve 01/15/2020**	

v2	Reviewed	Utilization Management	Pending Q1 2021 UMC	

Santa Clara Family Health Plan™

POLICY

Policy Title:	**Evaluation of New Technology**	**Policy No.:**	HS.05
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define Santa Clara Family Health Plan's process used where members have equitable access to new technology or new developments in technology that is determined to be safe and effective as aligned with benefits.

II. Policy

A. The Plan establishes and maintains a formal mechanism for selective evaluation and adoption of new or innovative technologies.
   1. New developments in technology and new applications of existing technology is necessary for inclusion considerations in its benefits plan as allowed, to keep pace with changes in the industry and allow for improved outcomes of medical care.

B. The Plan maintains written processes for evaluating new technology and new applications of existing technologies for inclusion in its benefits, where allowed by payors. Processes will address assessment of new technologies for medical procedures, behavioral health procedures, pharmaceuticals, and devices.

C. The Plan investigates all requests for new technology or a new application of existing technology by using Up to Date as a primary guideline to determine if the technology is considered investigational in nature.
   1. Up to Date is an evidence-based clinical decision support resource for healthcare practitioners. If further information is needed, the plan utilizes additional sources, include Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This includes medical and behavioral health procedures and devices.

D. If the new technology, pharmaceutical, or new application of an established technology/pharmaceutical is not addressed in the above documents, the Medical Director's critical evaluation will proceed to conferring with an appropriate specialist consultant for additional information.

III. Responsibilities

Health Services coordinates efforts with internal stakeholders to ensure new technology is assessed for regulatory appropriateness and efficacy. Benefit changes are coordinated with IT and compliance.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/16/2019**	
v2	**Revised**	**Utilization Management**	**Approve 01/15/2020**	
v3	**Reviewed**	**Utilization Management**	**Pending Q1 2021 UMC**	

Santa Clara Family Health Plan™

Policy Title:	Emergency Services	Policy No.:	HS.06
Replaces Policy Title (if applicable):	None	Replaces Policy No. (if applicable):	None
Issuing Department:	Health Services	Policy Review Frequency:	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define coverage of Emergency Medical Conditions and Urgent Care services.

II. Policy

A. Emergency Services are available and accessible within the service area 24 hours-a-day, seven (7) days-a-week

B. The Plan maintains contracts with behavioral health practitioners and facilities to provide services to members that require urgent or emergent Behavioral Healthcare for crisis intervention and stabilization

C. SCFHP includes ambulance services for the area served to transport the member to the nearest 24-hour emergency facility with physician coverage

D. The Plan does not require prior authorization for access to emergency services

~~D.~~E. The Plan shall have processes to handle post-stabilization care requests ~~and care necessary to stabilize the member's medical condition~~

~~E.~~F. The Plan does not require prior authorization for Urgent services for contracted and non contracted providers.

~~F.~~G. The Plan applies prudent layperson or reasonable person's interpretation of what may be considered an emergent condition and to define emergency department access. Each case will be assessed on the presenting symptoms or conditions that steered the member to the Emergency Department.

~~G. In the occasion where an Emergency Department visit was to be denied, that denial must be made by a physician reviewer (except in administrative circumstances such as the claimant was not a member at the time of service).~~

H. It is the policy of SCFHP to allow 24-hour access for members and providers to obtain timely authorization for medically necessary care where the member has received emergency services and the care has been stabilized but the treating physician feels that member may not be discharged safely

I. The Plan will not deny reimbursement of a provider for a medical screening examination in the Emergency Department

~~J. If the Plan and the treating provider disagree about the need for post-stabilization care, then the Plan provider will personally take over the care of the patient within a reasonable amount of time for post-stabilization care or the Plan will have another hospital agree to accept the transfer of the member~~

~~K.~~J. The Plan makes the Emergency Department utilization management processes available to all facilities, including non-contracting hospitals by posting on the Plan website for public view and providing the phone number to call on the membership card.

~~L. The Plan reviews the Emergency Services poligy on an annual basis at a minimum~~

Commented [DH1]: Moved to HS.06.01

Commented [DH2]: This should be a procedure not a policy; already in procedure HS.06.01

Commented [DH3]: Policy header already states annual review

i. M. All ED practices are considered at least annually

III. Responsibilities

Health Services collaborates internally with Provider Network Management, compliance and ~~IT~~ Information Technology to ensure that emergency services are covered.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/16/2019**	
v2	**Revised**	**Utilization Management**	**Approve 01/15/2020**	
v3	**Revised**	**Utilization Management**	**Pending Q1 2021 UMC**	

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Santa Clara Family Health Plan™

POLICY

Policy Title:	**Long Term Care Utilization Review**	**Policy No.:**	HS.07
Replaces Policy Title (if applicable):	**Authorization and Review Process – Long Term Care (LTC)**	**Replaces Policy No. (if applicable):**	HS.14
Issuing Department:	Health Services	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define and outline the requirements for reviewing and processing Long Term Care (LTC) authorizations for a member's admission to, continued stay in, or discharge from a Skilled Nursing Facility (SNF)

II. Policy

A. The Plan shall authorize utilization of Medi-Cal long term care (LTC) services for its members when medically necessary and determine level of care and length of stay based on the member's current assessment consistent with Medi-Cal criteria.

B. Requests for admission to, continued stay in, or discharge from any LTC facility shall be processed in accordance with the California Department of Health Services (DHCS) standard clinical criteria for LTC level of service. LTC level of care Prior Authorization Request (PAR) processing procedure will be in compliance with applicable regulatory requirements.

C. Decisions to deny or authorize a duration or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition and disease or Managed Long Term Services and Supports (MLTSS) needs.

D. SCFHP notifies LTC providers of required supporting documentation for Utilization review. When PAR submissions do not include required documentation, SCFHP will follow up with the nursing facility with 3 outreach attempts to request the documents and if they are not received, the PAR will be reviewed and possibly denied by a medical professional for insufficient information.

E. On-site level of care review by a Licensed Nurse for an LTC PAR may be performed at the discretion of SCFHP. This review shall include an assessment of the Member and review of the current medical orders, and care plan, therapist treatment plan, the facility's multidisciplinary team notes, or other clinical data to assist SCFHP staff in making an appropriate determination on the authorization request. On-site review may be done when indicated for patterns of high service utilization, frequent acute hospitalization, and/or large number of member complaints or concerns.

F. Authorizations of LTC PAR for continued stay shall be submitted by the nursing facility to SCFHP prior to the expiration of the current LTC authorization. The requests shall include a completed LTC PAR signed by a physician, the most recent Quarterly Assessment MDS, and sufficient documentation to justify the level of care and continued stay. Authorizations for LTC may be approved for up to one year.

G. The Plan may arrange and coordinate with the nursing facility for modification of care or discharge of a member from a nursing facility if it determines that one or more of the following circumstances are present:
   - The SNF is no longer capable of meeting the member's health care needs;
   - The member's health has improved sufficiently so that he or she no longer needs SNF services;
   - The member poses a risk to the health or safety of individuals in the nursing facility; or
   - The SNF does not meet SCFHP network standards because of documented quality of care concerns.

H. The Plan shall include, as a separate benefit, any leave of absence, or Bed Hold, that a nursing facility provides in accordance with the Department of Health Care Services (DHCS) requirements of up to 7 calendar days per discharge. The member's attending physician must write a physician order for a discharge or transfer at the time the member requires a discharge or transfer from an LTC facility to a General Acute Care Hospital and include an order for Bed Hold with the reason.

I. The Plan shall be responsible for the timely provision of a member's medical needs, supports and services through the LTC post-discharge and transition to community. The discharge planning may include but is not limited to:
   - Documentation of pre-admission, or baseline status including: living arrangements, functional status, durable medical equipment (DME) and other services received; understanding of medical condition or functional status by the member or representative, physical and mental health status, financial resources and social supports.
   - Initial set-up of services needed after discharge including medical care, medication, DME, identification and integration of long term services and supports, type of placement preferred and agreed to, hospital recommendations and pre-discharge counseling recommended.
   - Initial coordination of care, as appropriate with the member's caregiver, other agencies and knowledgeable personnel, as well as providing care coordination contact information for the facility.
   - Provision of information for making follow up appointments

References

SCFHP Utilization Management Program Description

1. Duals Plan Letter (DPL) 14-002 Requirements for Nursing Facility Services
2. Duals Plan Letter (DPL) 14-004 Continuity of Care
3. Duals Plan (DPL) 16-003; Discharge Planning for Cal MediConnect
4. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
5. Title 22, California Code of Regulations (CCR) §§ 51120, 51121, 51124, 5125, 51118, and 51212
6. Welfare &Institutions Code §§ 14087.55, 14087.6, 14087.9 and 14103.06

III. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name/Title	Name/Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approved 4/18/2018**	
v2	**Reviewed**	**Utilization Management**	**Approved 1/16/2019**	
v3	**Revised**	**Utilization Management**	**Approved 1/15/2020**	
v4	**Reviewed**	**Utilization Management**	**Pending Q1 2021 UMC**	

Santa Clara Family Health Plan™

POLICY

Policy Title:	Second Opinion	**Policy No.:**	HS.08
Replaces Policy Title (if applicable):	Second Opinion Policy and Procedure	**Replaces Policy No. (if applicable):**	UM-30-96; UM036_01
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the process of obtaining second opinions and member access to a second opinion by appropriate healthcare professionals.

II. Policy

A. A request for a second opinion may be initiated by a member or a treating healthcare provider of a member
B. The member Evidence of Coverage provides all members with notice of the policy regarding the manner in which a member may receive a second medical opinion.
C. The Plan provides or authorizes a second opinion by an appropriately qualified health care professional, if requested by a member or participating health professional.
D. The Plan shall authorizes the second opinion requests not to exceed the any appliciable regulatory requirements.
E. The member may choose from any provider from any independent practice association or medical group within the network of the same or equivalent specialty to provide the second opinion
F. If the member requests a second opinion from an out-of-network specialist which is approved by the Plan, the Plan shall incur the cost for the second opinion due by the member.
G. The Plan shall notify the member and provider of any denial for a second opinion in writing within the appropriate timeframe. Information on how to file a grievance or appeal is included.

III. Responsibilities

Health Services follows the Second Opinion policy and procedure as directed and reviewed on an annual basis.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Utilization Management	Approve 01/18/2017	
v1	Reviewed	Utilization Management	Approve 01/17/2018	
v1	Reviewed	Utilization Management	Approve 01/16/2019	
v2	Revised	Utilization Management	Approve 01/15/2020	
v3	Reviewed	Utilization Management	Pending Q1 2021 UMC	

Santa Clara Family Health Plan™ **POLICY**

Policy Title:	**Inter-Rater Reliability**	**Policy No.:**	HS.09
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To outline Santa Clara Family Health Plan (SCFHP)'s process for Inter-Rater Reliability (IRR) testing to ensure accurate and consistent application of medical necessity criteria and guidelines.

II. Policy

SCFHP evaluates the consistency with which clinical and non-clinical staff involved with any level of applying Utilization Management (UM) criteria in decision making at least annually. When a staff member is found to not be proficient, corrective measures will be pursued.

A. IRR testing will include Medical and Behavioral Health

1. At least 10 hypothetical cases are presented to include a combination of:
   a. Approved and denied Prior Authorization requests
   b. Requiring non-clinician and/or clinician review
   c. Outpatient and Inpatient services
2. Reviewers will include all temp, interim, and permanent UM staff and any Health Services staff that are involved in prior authorization decision making: care coordinators, personal care coordinators and licensed nurses, social workers, pharmacists and medical directors.

B. Review

1. Identical cases are distributed to each reviewer
2. The reviewer completes the review individually on paper as if it was a real-time review
3. All cases will be reviewed by UM Management for a consensus decision-making within 1 week following due date.
4. Each item is worth one point.
5. 80% is considered a passing score.
   a. Below Proficient (<80%)
      i. A corrective action plan will be implemented by UM Management. The plan includes the following:
         a) Training in the area identified to be deficient
         b) Re-testing after training complete to ensure compliance

c) Oversight of employee determinations, including coaching and observation, as appropriate
d) Repeat of process as needed
e) Possible escalation to individualized Performance Improvement Plan which will be part of employee's personnel file.

III. Records

All results and internal Corrective Action Plans (CAPS) remain confidential and are maintained within Health Services and are reported to the UMC.

IV. Responsibilities

Health Services coordinates with both internal and external stakeholders in development and administration of IRR testing at least bi-annually in an effort to ensure consistency amongst staff for UM criteria.

V. Reference

National Committee for Quality Assurance. 2020 HP Standards and Guidelines - UM 2: Clinical Criteria for UM Decision, Element C.

VI. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve/01/18/2017**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/16/2019**	
v2	**Revised**	**Utilization Management**	**Approve 01/15/2020**	
v3	**Revised**	**Utilization Management**	**Approve 10/14/2020**	
v3	**Reviewed**	**Utilization Management**	**Pending Q1 2021 UMC**	

Santa Clara Family Health Plan™

POLICY

Policy Title:	**Financial Incentives (Prohibition of)**	**Policy No.:**	HS.10
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To provide clear directives prohibiting financial incentives for Utilization Management (UM) decisions.

II. Policy

A. Santa Clara Family Health Plan (SCFHP) does not reward decision makers or other individuals for UM decisions. Providers, practitioners and members are notified of this policy through the Member Handbook and Provider Manual, which are also available on the website.

B. The Plan, at no time, provides financial or other incentives for UM decisions. UM approvals and denial decisions are based strictly on the appropriateness of care or service and existence of coverage.

C. The Plan never specifically rewards practitioners or other individuals to deny, limit, or discontinue medically necessary covered services.

D. The Plan does not encourage decisions that result in underutilization of care or services.

E. SCFHP Staff and Providers are notified annually of the Plan policy of prohibition for financial or other incentives for UM decisions.

III. Responsibilities

All internal, contracted staff and vendors involved with UM activities are notified of the policy prohibiting financial incentives for UM decisions. IT and Benefits ensure the appropriate criteria/benefits are in place for appropriate decision making.

IV. References

3 Way Contract. *Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services*.

V. Approval/Revision History

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v1	Original	Utilization Management	Approve 01/18/2017	
v1	Reviewed	Utilization Management	Approve 01/17/2018	
v1	Reviewed	Utilization Management	Approve 01/16/2019	
v2	Revised	Utilization Management	Approve 01/15/2020	
v2	Reviewed	Utilization Management	Pending Q1 2021 UMC	

Santa Clara Family Health Plan™

POLICY

Policy Title:	Informed Consent	**Policy No.:**	HS.11
Replaces Policy Title (if applicable):	Informed Consent Policy	**Replaces Policy No. (if applicable):**	PPQI-04C
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To standardize Santa Clara Family Health Plan's (SCFHP) provider requirements for obtaining, documenting and storing informed member consent.

II. Policy

SCFHP recognizes that it is necessary for members to be aware of risks and benefits of treatment and options available. It is Plan policy that members be well informed and that consent for certain high risk procedures/services as well as reproductive health services be obtained and properly recorded and stored in the member medical record.

III. Responsibilities

Health Services developed and maintains the policy on Informed Consent. The Utilization Management Committee adopts and reviews the policy. Provider Relations and Marketing provide information to members and providers via the web site. Quality Improvement reviews medical records for necessary documentation.

IV. References

DHCS Renewed Contract; Exhibit A, Attachment 4, Medical Records, 6)
Knox Keene**§ 1363.02.** Reproductive health services information; statement

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Utilization Management	Approve 01/18/2017	
v1	Reviewed	Utilization Management	Approve 01/17/2018	
v1	Reviewed	Utilization Management	Approve 01/16/2019	
v1	Reviewed	Utilization Management	Approve 01/15/2020	
v1	Reviewed	Utilization Management	Pending Q1 2021 UMC	

Santa Clara Family Health Plan™

Policy Title:	**Preventive Health Guidelines**	**Policy No.:**	HS.12
Replaces Policy Title (if applicable):	Pediatric Preventive Health Services Adult Preventive Health Services	**Replaces Policy No. (if applicable):**	QM003_02 QM004_02
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To standardize Santa Clara Family Health Plan's (SCFHP) Preventive Health Guideline adoption, promotion and management.

II. Policy

SCFHP guidelines are intended to help clinicians, practitioners and members make informed decisions about appropriate preventive health care. This includes guidelines for perinatal care, children up to 24 months, 2-19 years, adults 20-64 years, or 65 or more years old.

The Utilization Management Committee (UMC) reviews and adopts preventive health guidelines that define standards of practice as they pertain to promoting preventive health services. Whenever possible, guidelines are derived from nationally recognized sources. They are based on scientific evidence, professional standards or in the absence of the availability of professional standards, an expert opinion. The preventive health guidelines are reviewed and updated when updates are released by the issuing entity. The Plan expects its practitioners to utilize the adopted guidelines in their practices, and recognizes the inability of the guidelines to address all individual member circumstances.

III. Responsibilities

Preventive health guidelines are reviewed periodically. Guidelines are available to providers and members on the Plan's website.

IV. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Utilization Management	Approve 01/18/2017	
v1	Reviewed	Utilization Management	Approve 01/17/2018	
v1	Reviewed	Utilization Management	Approve 01/16/2019	
v2	Revised	Utilization Management	Approve 01/15/2020	
v2	Reviewed	Utilization Management	Pending Q1 2021 UMC	

Santa Clara Family Health Plan™

POLICY

Policy Title:	**Transportation Services**	**Policy No.:**	HS.13
Replaces Policy Title (if applicable):	Non-Emergency Medical and Non-Medical Transportation Services	**Replaces Policy No. (if applicable):**	HS.14
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal ☒ CMC		

I. Purpose

To define Santa Clara Family Health Plan's (SCFHP) coverage for emergency, non-emergency medical (NEMT) and non-medical transportation services (NMT).

II. Policy

Emergency medical transportation does not require prior authorization.

Non-Emergency Medical Transportation (NEMT) Services

A. NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist or mental health or substance use disorder provider. NEMT services are subject to prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility. SCFHP will make our best effort to refer for and coordinate NEMT for carved out services.
B. Medical professional's decisions regarding NEMT will be unhindered by fiscal and administrative management. SCFHP will authorize, at a minimum, the lowest cost type of NEMT transportation that is adequate for the member's medical needs. There are no limits to receiving NEMT as long as the member's medical services are medically necessary and the NEMT has a prior authorization.
C. SCFHP will provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. The plan will provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The plan will ensure door-to-door assistance for all members receiving NEMT services.
D. SCFHP will provide transportation for a parent or a guardian when the member is a minor. With written consent of a parent or guardian, SCFHP will arrange NEMT for a minor who is unaccompanied by a parent or guardian. SCHFP will provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service.

POLICY

E. SCFHP will provide the following four available modalities of NEMT when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care:
    a. Ambulance services
    b. Litter van services
    c. Wheelchair van services
    d. Air
F. SCFHP will use a DHCS approved physician certification statement (PCS) form to determine the appropriate level of service. Once the member's treating physician prescribes the form of transportation, SCFHP will not modify the authorization. PCS form must be completed before NEMT can be prescribed and provided.
G. SCFHP will capture and submit data from the PCS form to DHCS.

Non-Medical Transportation (NMT) Services

A. SCFHP will provide NMT for members to obtain medically necessary services like primary care and specialty appointments, mental health, substance use disorder, dental and other services covered by SCFHP. In addition, SCFHP will also provide NMT for any other benefits delivered through the Medi-Cal FFS delivery system.
B. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans.
C. SCFHP will provide round trip-transportation for a member to obtain covered and carved out Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance.
D. The NMT approved must be the least costly method of transportation that meets the member's needs.
E. As a Member Services Guide, SCFHP will include information in the Evidence of Coverage on the procedures for obtaining NMT services, a description of NMT services and the conditions under which NMT is available.
F. NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation.
G. SCFHP will provide transportation for a parent or a guardian when the member is a minor. With written consent of a parent or guardian, SCFHP will arrange NMT for a minor who is unaccompanied by a parent or guardian. SCHFP will provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service.
H. SCFHP will provide mileage reimbursement consistent with the IRS rate for medical purposes when conveyance is in a private vehicle arranged by the member. The member must attest in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. In order to receive gas mileage reimbursement for use of a private vehicle, the driver must have a valid driver's license, valid vehicle registration, and valid vehicle insurance.
I. NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.

POLICY

J. SCFHP will meet DHCS contractually required timely access standards for NEMT and NMT.

III. Responsibilities

Health Services will review prior authorization for NEMT. Customer Services will coordinate NMT and NEMT. Provider Network Management will educate the provider network on NEMT and NMT benefits and requirements.

IV. References

APL 17-010 Non-Emergency Medical and Non-Medical Transportation Services

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name Medical Director	Name Chief Medical Officer
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Utilization Management	Approve 01/16/2019	
v2	Revised	Utilization Management	Approve 01/15/2020	
v2	Reviewed	Utilization Management	Pending Q1 2021 UMC	

POLICY

Santa Clara Family Health Plan™

Policy Title:	**System Controls**	**Policy No.:**	HS.14
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe Santa Clara Family Health Plan's (SCFHP) system controls specific to Utilization Management (UM) denial and appeal notification and receipt dates.

II. Policy

A. Turn-around-times (TAT) for requests are based on the date and time of receipt
    1. Due date and time of reviews, depending on the type of request, is calculated from the date and time the request was received by the UM department

B. Written notification of decisions will be sent to the member and provider within the appropriate turn around timeframe of the type of request based on the receipt date and time of the faxed request

C. The UM department only uses the date and time stamp found on the bottom of the faxed document when it is received by UM as the receipt date and time. The receipt date and time is not to be modified.
    1. At the time of data-entry, the UM staff will enter the receipt date and time of the request into the UM platform, QNXT, to automatically calculate the due date and time based on type of request and line of business

D. Quality Assurance reports are run monthly and as needed to cross check accuracy of data entry from the receipt date to the recorded information in the UM platform.

III. Responsibilities

Health Services collaborates with IT to ensure the information received on the faxed document is accurately reflected in the UM platform

IV. References

National Committee for Quality Assurance. 2020 HP Standards and Guidelines: UM 12: UM System Controls

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Utilization Management	Approve 01/15/2020	
v2	Reviewed	Utilization Management	Pending Q1 2021 UMC	

Santa Clara Family Health Plan™

Membership

Membership

Source: iCat (01/01/2021)

Mbr Ct Sum		Cap Month												
LOB	Network Name	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
CMC		**8,401**	**8,486**	**8,601**	**8,725**	**8,837**	**8,987**	**9,029**	**9,266**	**9,428**	**9,570**	**9,679**	**9,820**	**9,807**
	Santa Clara Family Health Plan	8,401	8,486	8,601	8,725	8,837	8,987	9,029	9,266	9,428	9,570	9,679	9,820	9,807
MC		**231,435**	**231,548**	**233,229**	**235,049**	**240,656**	**244,888**	**248,007**	**251,004**	**253,252**	**256,490**	**259,202**	**261,287**	**263,093**
	INDEPENDENT PHYSICIANS	15,021	14,744	14,709	14,781	15,216	15,610	15,844	16,113	16,358	16,627	16,829	16,938	16,987
	KAISER PERMANENTE	24,743	24,764	25,097	25,300	25,985	26,541	27,212	27,844	28,232	28,868	29,337	29,706	30,131
	MEDICARE PRIMARY	15,422	15,455	15,460	15,463	15,649	15,653	15,696	15,684	15,698	15,742	15,830	16,002	15,941
	PALO ALTO MEDICAL FOUNDATION	6,536	6,473	6,481	6,448	6,583	6,633	6,696	6,759	6,823	6,935	6,985	7,010	7,065
	PHYSICIANS MEDICAL GROUP	40,820	40,860	41,050	41,212	42,040	42,632	43,036	43,436	43,695	44,223	44,560	44,861	45,178
	PREMIER CARE	14,485	14,407	14,467	14,487	14,802	15,011	15,144	15,274	15,344	15,473	15,593	15,646	15,695
	VHP NETWORK	114,408	114,845	115,965	117,358	120,381	122,808	124,379	125,894	127,102	128,622	130,068	131,124	132,096
Grand Total		**239,836**	**240,034**	**241,830**	**243,774**	**249,493**	**253,875**	**257,036**	**260,270**	**262,680**	**266,060**	**268,881**	**271,107**	**272,900**

Santa Clara Family Health Plan™

Over/Under Utilization

UMC Goals and Objectives

- Compare SCFHP utilization levels against relevant industry benchmarks and monitor utilization trends among SCFHP membership over time
- Analyze key drivers and potential barriers, prioritize opportunities for improvement, and develop interventions that promote high-quality and cost-effective use of medical services

Membership

Source: iCAT (1/12/2021)

Year-Month	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12
Medi-Cal	248,007	251,004	253,252	256,490	259,202	261,287
Cal MediConnect	9,029	9,266	9,428	9,570	9,679	9,820
Total	**257,036**	**260,270**	**262,680**	**266,060**	**268,881**	**271,107**

Inpatient Utilization: Medi-Cal –SPD DOS 1/1/2020 – 12/31/2020

Source: MCL Enrollment & QNXT Claims and Encounter Data (Run Date:1/11/2021)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2020-Q1	1,059	16.04	5,865	5.54
2020-Q2	819	12.28	4,318	5.27
2020-Q3	762	11.42	3,774	4.95
2020-Q4	533	7.98	2,653	4.98
Total	3,173	11.92	16,610	5.23

Note: Data are less complete for more recent quarters due submission lag.

Inpatient Utilization: Medi-Cal – Non-SPD DOS 1/1/2020 – 12/31/2020

Source: MCL Enrollment & QNXT Claims and Encounter Data (Run Date:1/11/2021)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2020-Q1	2,506	4.44	11,031	4.40
2020-Q2	2,076	3.56	7,788	3.75
2020-Q3	2,383	3.90	9,592	4.03
2020-Q4	1,503	2.38	6,222	4.14
Total	8,468	3.54	34,633	4.09

Note: Data are less complete for more recent quarters due submission lag.

Inpatient Utilization: Cal MediConnect (CMC)
DOS 1/1/2020 – 12/31/2020

Source: CMC Enrollment & QNXT Claims Data (Run Date:1/11/2021)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2020-Q1	518	21.08	3,337	6.44
2020-Q2	358	13.88	2,156	6.02
2020-Q3	454	16.65	2,542	5.60
2020-Q4	296	10.38	1,481	5.00
Total	1,626	15.32	9,516	5.85

Note: Data are less complete for more recent quarters due submission lag.

Medi-Cal Inpatient Utilization
DOS 1/1/2020 – 12/31/2020

	Medi-Cal Population		
Measure	**Non-SPD**	**SPD**	**Total**
Discharges / 1,000 Member Months	3.54	11.92	4.38
ALOS	4.09	5.23	4.40

Note: Data are less complete for more recent quarters due submission lag. Therefore comparison is limited.

Inpatient Readmissions: Medi-Cal

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 1/1/2020 – 12/31/2020 measurement period (Run Date: 12/21/2020)

LOB	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1,2,3]
MC - All	5,070	898	17.71%

[1] A lower rate indicates better performance.
[2] Only for members aged 18-64 in Medi-Cal.
[3] HEDIS PCR 2019 used. This includes outliers in comparison to PCR 2020.

Note: Data are less complete for more recent quarters due submission lag. Therefore comparison is limited.

Cal MediConnect (CMC) Readmission Rates Compared to NCQA Medicare Benchmarks

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 1/1/2020 – 12/31/2020 measurement period (Run Date: 12/21/2020)

Rate Description	PCR
Count of Index Hospital Stays	1313
Count of 30-Day Readmissions	210
Actual Readmission Rate	15.99%
NCQA Medicare 50th Percentile	16.39%
SCFHP Percentile Ranking	>50th

[1] A lower rate indicates better performance.
[2] The PCR rate applies only to SCFHP's CMC line of business and includes members 18 years of age and older.

Note: Data are less complete for more recent quarters due submission lag. Therefore comparison is limited.

ADHD Medi-Cal Behavioral Health Metrics

Source: HEDIS data for 1/1/2020 – 12/31/2020 measurement period (Run Date: 12/21/2020)

Measure	Rate	NCQA Medicaid 50th Percentile	SCFHP Percentile Rank
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	42.64%	43.41%	<50th
Continuation & Maintenance Phase	35.42%	55.5%	<50th
Antidepressant Medication Management			
Acute Phase Treatment	64.20%	52.35%	>75th
Continuation Phase Treatment	49.47%	36.51%	>75th
Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia	69.23%	77.63%	<50th

Note: Data are less complete for more recent quarters due submission lag. Therefore comparison is limited.

Santa Clara Family Health Plan™

Dashboard Metrics/Turn-Around Time – Q4 2020

Santa Clara Family Health Plan

Cal MediConnect Compliance Dashboard	Oct	Nov	Dec
CONCURRENT ORGANIZATION DETERMINATIONS			
# of Concurrent Requests Received	7	8	6
# of Concurrent Review of Authorization Requests (part C) completed within five (5) working days of request	7	8	6
% of Concurrent Review of Authorization Requests (part C) completed within five (5) working days of request	**100.0%**	**100.0%**	**100.0%**
# of Concurrent Notifications Sent	7	8	6
# of Concurrent Initial Determination Notification (part C) sent to Provider/Member within five (5) working days of request	7	8	6
% of Concurrent Initial Determination Notification (part C) sent to Provider/Member within five (5) working days of request	**100.0%**	**100.0%**	**100.0%**
PRE-SERVICE ORGANIZATION DETERMINATIONS			
Standard Part C			
# of Standard Pre-Service Prior Authorization Requests Received	600	578	683
# of Standard Pre-Service Prior Authorization Requests (part C) completed within five (5) working days	600	578	678
% of Standard Pre-Service Prior Authorization Requests (part C) completed within five (5) working days	**100.0%**	**100.0%**	**99.3%**
# of Standard Pre-Service Prior Authorization Notifications Sent	600	578	632
# of Standard Pre-Service Prior Authorization Notification (part C) sent to Provider/Member within five (5) working days of request	599	577	631
% of Standard Pre-Service Prior Authorization Notification (part C) sent to Provider/Member within five (5) working days of request	**99.8%**	**99.8%**	**99.8%**
Expedited Part C			
# of Expedited Pre-Service Prior Authorization Requests Received	282	294	263
# of Expedited Pre-Service Prior Authorization Requests (part C) completed within sevety-two (72) hours	280	294	217
% of Expedited Pre-Service Prior Authorization Requests (part C) completed within seventy-two (72) hours	**99.3%**	**100.0%**	**82.5%**

# of Expedited Prior Authorization Notifications Sent	282	294	263
# of Expedited Initial Determination Notification (part C) sent to Provider/Member verbally within 72 hours from receipt and in writing within 3 calendar days from verbal notification	276	285	230
% of Expedited Initial Determination Notification (part C) sent to Provider/Member verbally within 72 hours from receipt and in writing within 3 calendar days from verbal notification	**97.9%**	**96.9%**	**87.5%**
POST SERVICE ORGANIZATION DETERMINATIONS			
# of Retrospective Requests Received	7	62	97
# of Retrospective Requests (part C) completed within thirty (30) calendar days	7	62	97
% of Retrospective Requests (part C) completed within thirty (30) calendar days	**100.0%**	**100.0%**	**100.0%**
PART B DRUGS ORGANIZATION DETERMINATIONS			
# of Standard Prior Authorization Requests (part B drugs) Requests Received	13	10	16
# of Standard Prior Authorization Requests (part B drugs) completed within sevety-two (72) hours of request	13	9	16
% of Standard Prior Authorization Requests (part B drugs) completed within seventy-two (72) hours of request	**100.0%**	**90.0%**	**100.0%**
# of Standard Prior Authorization Requests (part B drugs) Notifications Sent	13	10	16
# of Standard Prior Authorization Notification (part B drugs) sent within seventy-two (72) hours of request	13	9	16
% of Standard Prior Authorization Notification (part B drugs) sent within seventy-two (72) hours of request	**100.0%**	**90.0%**	**100.0%**
# of Expedited Prior Authorization (part B drugs) Requests Received	13	14	**28**
# of Expedited Prior Authorization requests (part B drugs) completed within twenty-four (24) hours of request	12	14	**28**
% of Expedited Prior Authorization requests (part B drugs) completed within twenty-four (24) hours of request	**92.3%**	**100.0%**	**100.0%**
# of Expedited Prior Authorization (part B drugs) Notifications Sent	13	14	28
# of Expedited Initial Determination Notification (part B drugs) sent to Provider/Member verbally within twenty-four (24) hours from receipt and in writing within three (3) calendar days from verbal notification	12	14	28
% of Expedited Initial Determination Notification (part B drugs) sent to Provider/Member verbally within twenty-four (24) hours from receipt and in writing within three (3) calendar days from verbal notification	**92.3%**	**100.0%**	**100.0%**

Santa Clara Family Health Plan

MEDICAL AUTHORIZATIONS - HS COMBINED	Oct	Nov	Dec
Concurrent Review			
Total # of Concurrent Requests Resolved	10	1	2
# of Concurrent Review of Authorization Requests completed within five (5) working days of request	10	1	2
% of Concurrent Review of Authorization Requests completed within five (5) working days of request	100.0%	100.0%	100.0%
Routine Authorizations			
Total # of Routine Prior Authorization Requests Resolved	1,102	902	945
# of Routine Prior Authorization Requests completed within five (5) working days of request	1,099	900	944
% of Routine Prior Authorization Requests completed within five (5) working days of request	99.7%	99.8%	99.9%
Expedited Authorizations			
Total # of Expedited Prior Authorization Requests Resolved	191	163	161
# of Expedited Prior Authorization Requests completed within seventy-two (72) hours of request	186	163	159
% of Expedited Prior Authorization Requests completed within seventy-two (72) hours of request	97.4%	100.0%	98.8%
Retrospective Review			
Total # of Retrospective Requests Resolved	380	216	315
# of Retrospective Requests completed within thirty (30) calendar days of request	378	216	315
% of Retrospective Requests completed within thirty (30) calendar days of request	99.5%	100.0%	100.0%
Member Notification of UM Decision			
Total # of UM decisions	1,693	1,287	1,423
# Member Notification of UM decision in writing within two (2) working days of the decision.	1,652	1,259	1,335
% Member Notification of UM decision in writing within two (2) working days of the decision.	97.6%	97.8%	93.8%
Provider Notification of UM Decision			
# Provider Notification of UM decision by telephone, facsimile or electronic mail and then in writing within twenty-four (24) hours of making the decision	1,645	1,249	1416
% Provider Notification of UM decision by telephone, facsimile or electronic mail and then in writing within twenty-four (24) hours of making the decision	97.2%	97.0%	99.5%

Santa Clara Family Health Plan™

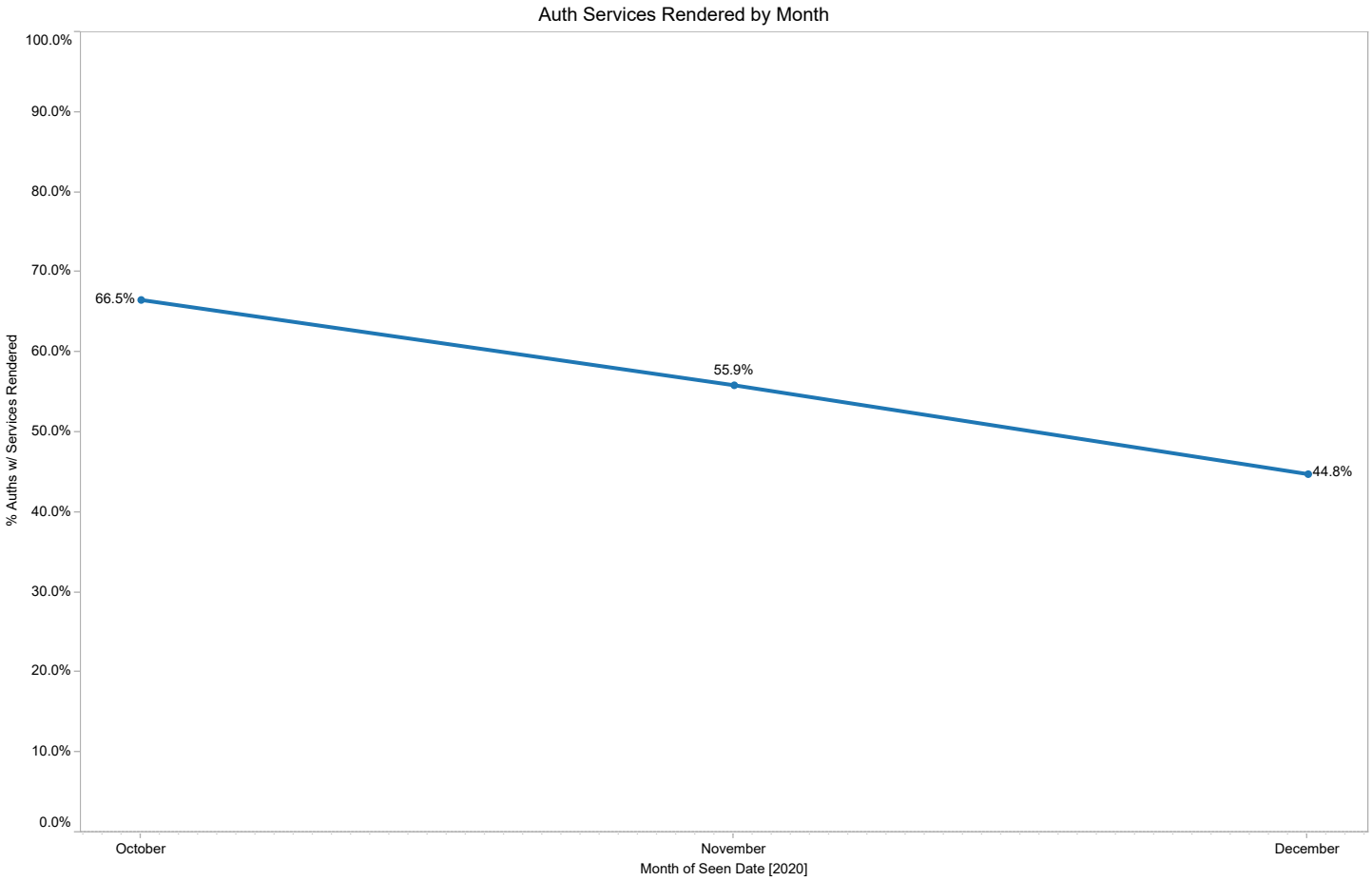
Cal MediConnect and Medi-Cal Quarterly Referral Tracking

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Cal MediConnect	CBAS	Retro Request	17	16	0	1	5.9%
		Routine - Extended Service	6	3	0	3	50.0%
	CONT OF CARE	Member Initiated Org Determi..	4	0	0	4	100.0%
		Member Initiated Org Determi..	2	1	0	1	50.0%
	CUSTODIAL	Retro Request	142	133	0	9	6.3%
		Routine - Initial Request	35	27	0	8	22.9%
	DME	Member Initiated Org Determi..	1	0	0	1	100.0%
		Member Initiated Org Determi..	2	0	0	2	100.0%
		Member Rep Initiated Org Det..	3	0	0	3	100.0%
		Non Contracted Provider - Ret..	1	0	0	1	100.0%
		Non Contracted Provider - Ro..	8	5	0	3	37.5%
		Retro Request	11	5	0	6	54.5%
		Routine - Extended Service	3	1	0	2	66.7%
		Routine - Initial Request	197	132	0	65	33.0%
		Urgent - Initial Request	33	23	0	10	30.3%
	HomeHealth	Member Initiated Org Determi..	3	1	0	2	66.7%
		Member Rep Initiated Org Det..	1	0	0	1	100.0%
		Modified original request – Se..	1	1	0	0	0.0%
		Non Contracted Provider - Ro..	2	0	0	2	100.0%
		Non Contracted Provider - Urg..	15	4	0	11	73.3%
		Operational PA	61	25	0	36	59.0%
		Retro Request	21	10	0	11	52.4%
		Routine - Extended Service	18	11	0	7	38.9%
		Routine - Initial Request	11	6	0	5	45.5%
		Urgent - Extended Service	157	56	0	101	64.3%
		Urgent - Initial Request	177	71	0	106	59.9%
	HOSPICE	Non Contracted Provider - Ret..	9	6	0	3	33.3%
	Inpatient	Non Contracted Provider - Ro..	2	2	0	0	0.0%
		Non Contracted Provider - Urg..	1	0	0	1	100.0%
		Routine - Extended Service	1	1	0	0	0.0%
		Routine - Initial Request	583	563	0	20	3.4%
		Urgent - Initial Request	19	16	0	3	15.8%
	InpatientAdmin	Operational PA	1	0	0	1	100.0%
		Routine - Initial Request	2	1	0	1	50.0%
	OP-BehavioralGr	Non Contracted Provider - Ro..	1	0	0	1	100.0%
	OP-Behavorial	Care Coordinator Initiated Org..	2	1	0	1	50.0%
		Non Contracted Provider - Ret..	2	2	0	0	0.0%
		Non Contracted Provider - Ro..	1	0	0	1	100.0%
	OPHospital	Member Initiated Org Determi..	9	1	0	8	88.9%
		Member Initiated Org Determi..	3	0	0	3	100.0%
		Member Rep Initiated Org Det..	1	0	0	1	100.0%
		Member Rep Initiated Org Det..	7	2	0	5	71.4%
		Non Contracted Provider - Ro..	19	5	0	14	73.7%
		Non Contracted Provider - Urg..	8	3	0	5	62.5%
		Retro Request	12	8	0	4	33.3%
		Routine - Extended Service	16	3	0	13	81.3%
		Routine - Initial Request	562	135	0	427	76.0%
		Urgent - Extended Service	3	2	0	1	33.3%
		Urgent - Initial Request	241	83	0	158	65.6%

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Cal MediConnect	OPHospitalGr	Member Initiated Org Determi..	4	2	0	2	50.0%
		Member Initiated Org Determi..	5	5	0	0	0.0%
		Member Rep Initiated Org Det..	1	0	0	1	100.0%
		Member Rep Initiated Org Det..	1	1	0	0	0.0%
		Retro Request	2	0	0	2	100.0%
		Routine - Extended Service	12	9	0	3	25.0%
		Routine - Initial Request	162	65	0	97	59.9%
		Urgent - Initial Request	50	31	0	19	38.0%
	SkilledNursing	Operational PA	3	3	0	0	0.0%
		Retro Request	6	4	0	2	33.3%
		Routine - Initial Request	11	8	0	3	27.3%
		Urgent - Initial Request	100	90	0	10	10.0%
	Transportation	Member Initiated Org Determi..	5	1	0	4	80.0%
		Member Initiated Org Determi..	2	0	0	2	100.0%
		Retro Request	9	0	0	9	100.0%
		Routine - Initial Request	37	2	0	35	94.6%
Grand Total			**2,847**	**1,586**	**0**	**1,261**	**44.3%**

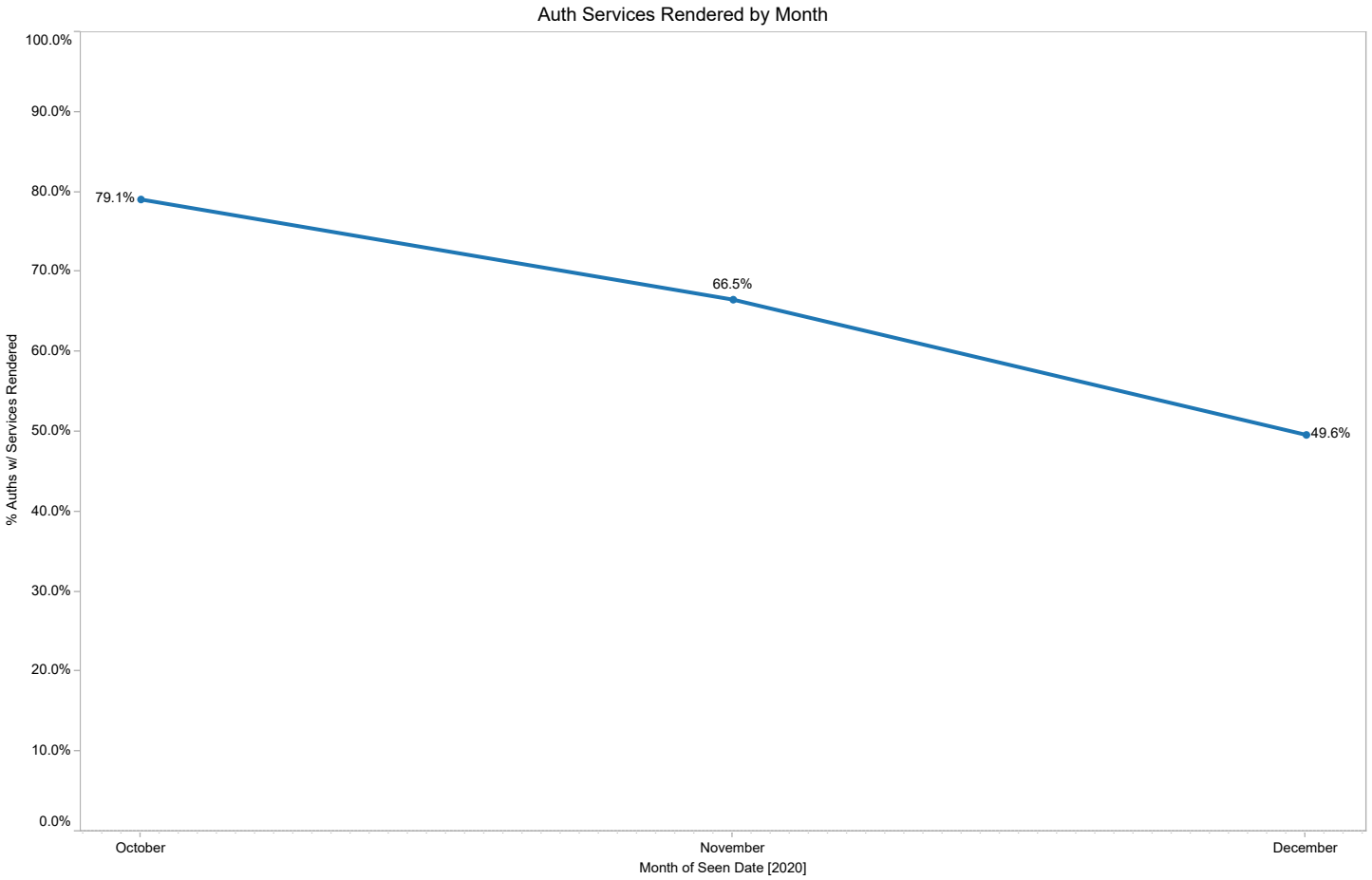

Auth Services Rendered by Month
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
% Auths w/ Services Rendered
66.5%
55.9%
44.8%
October
November
December
Month of Seen Date [2020]

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Medi-Cal	CBAS	Retro Request	81	80	0	1	1.2%
		Routine - Extended Service	39	33	0	6	15.4%
		Routine - Initial Request	3	1	0	2	66.7%
	CONT OF CARE GR	Routine - Initial Request	1	0	0	1	100.0%
	CUSTODIAL	Retro Request	703	653	0	50	7.1%
		Routine - Initial Request	251	178	0	73	29.1%
	Dental	Routine - Initial Request	20	18	0	2	10.0%
		Urgent - Initial Request	12	6	0	6	50.0%
	DME	Non Contracted Provider - Ret..	27	26	0	1	3.7%
		Non Contracted Provider - Ro..	7	5	0	2	28.6%
		Non Contracted Provider - Urg..	2	0	0	2	100.0%
		Operational PA	1	0	0	1	100.0%
		Retro Request	5	3	0	2	40.0%
		Routine - Extended Service	3	2	0	1	33.3%
		Routine - Initial Request	265	173	0	92	34.7%
		Urgent - Extended Service	1	0	0	1	100.0%
		Urgent - Initial Request	44	35	0	9	20.5%
	HomeHealth	Non Contracted Provider - Ret..	3	2	0	1	33.3%
		Operational PA	17	5	0	12	70.6%
		Retro Request	2	1	0	1	50.0%
		Routine - Extended Service	10	1	0	9	90.0%
		Routine - Initial Request	4	2	0	2	50.0%
		Urgent - Extended Service	21	5	0	16	76.2%
		Urgent - Initial Request	29	13	0	16	55.2%
	HOSPICE	Non Contracted Provider - Ret..	24	15	0	9	37.5%
		Non Contracted Provider - Ro..	9	5	0	4	44.4%
		Non Contracted Provider - Urg..	4	1	0	3	75.0%
		Retro Request	1	1	0	0	0.0%
		Urgent - Extended Service	1	0	0	1	100.0%
	Inpatient	Non Contracted Provider - Ro..	1	1	0	0	0.0%
		Non Contracted Provider - Urg..	1	1	0	0	0.0%
		Retro Request	6	6	0	0	0.0%
		Routine - Initial Request	588	541	0	47	8.0%
		Urgent - Initial Request	12	11	0	1	8.3%
	InpatientAdmin	Operational PA	1	1	0	0	0.0%
		Routine - Initial Request	3	2	0	1	33.3%
	OP-BehavioralGr	Non Contracted Provider - Ret..	3	2	0	1	33.3%
		Non Contracted Provider - Ro..	14	10	0	4	28.6%
		Retro Request	20	16	0	4	20.0%
		Routine - Extended Service	145	110	0	35	24.1%
		Routine - Initial Request	6	1	0	5	83.3%
		Urgent – RN review; Expedite..	1	1	0	0	0.0%
	OP-Behavorial	Non Contracted Provider - Ret..	2	1	0	1	50.0%
		Non Contracted Provider - Ro..	7	4	0	3	42.9%
		Retro Request	1	1	0	0	0.0%
		Routine - Extended Service	11	4	0	7	63.6%
		Routine - Initial Request	39	12	0	27	69.2%
	OPHospital	Non Contracted Provider - Ret..	9	3	0	6	66.7%
		Non Contracted Provider - Ro..	15	3	0	12	80.0%
		Non Contracted Provider - Urg..	14	5	0	9	64.3%

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Medi-Cal	OPHospital	Retro Request	15	8	0	7	46.7%
		Routine - Extended Service	63	21	0	42	66.7%
		Routine - Initial Request	423	152	0	271	64.1%
		Urgent - Extended Service	6	1	0	5	83.3%
		Urgent - Initial Request	160	69	0	91	56.9%
	OPHospitalGr	Non Contracted Provider - Ret..	2	1	0	1	50.0%
		Non Contracted Provider - Ro..	4	4	0	0	0.0%
		Retro Request	1	1	0	0	0.0%
		Routine - Extended Service	67	33	0	34	50.7%
		Routine - Initial Request	386	175	0	211	54.7%
		Urgent - Extended Service	6	2	0	4	66.7%
		Urgent - Initial Request	87	65	0	22	25.3%
	SkilledNursing	Retro Request	5	3	0	2	40.0%
		Routine - Initial Request	22	12	0	10	45.5%
		Urgent - Initial Request	68	60	0	8	11.8%
	Transportation	Non Contracted Provider - Ret..	1	0	0	1	100.0%
		Non Contracted Provider - Ro..	1	0	0	1	100.0%
		Operational PA	1	0	0	1	100.0%
		Retro Request	42	13	0	29	69.0%
		Routine - Initial Request	305	104	0	201	65.9%
Grand Total			**4,154**	**2,724**	**0**	**1,430**	**34.4%**


Auth Services Rendered by Month
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
% Auths w/ Services Rendered
79.1%
66.5%
49.6%
October
November
December
Month of Seen Date [2020]

Santa Clara Family Health Plan™

Cal MediConnect and Medi-Cal Annual Referral Tracking

Cal MediConnect and Medi-Cal Annual Referral Tracking for 2020

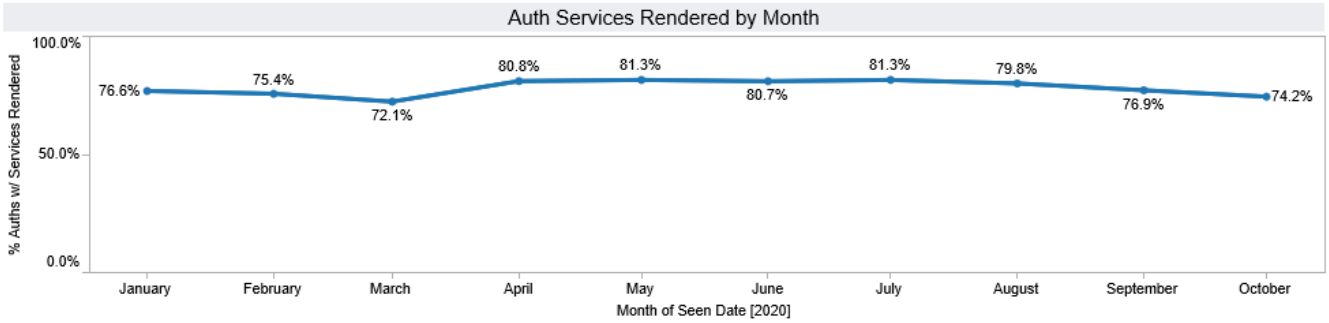
In accordance with the Santa Clara Family Health Plan (SCFHP) Referral Tracking System HS.01.02, SCFHP tracks all authorizations for the completion of the authorization to claims paid cycle to identify opportunities for improvement. Authorizations are to both contracted and non-contracted providers and include behavioral and non-behavioral health requests. SCFHP has a referral tracking system which tracks approved, modified, and deferred medical and behavioral health prior authorizations to completion on an ongoing basis.

DATA

- The authorization report was completed for the rolling 12 month look back of October 1, 2019 to October 1, 2020
- Because of system issues, the claims report could only be generated rolling back January 2020 to October 2020

FINDINGS

1. There were 22,819 unique authorizations for both lines of business (1,900 authorizations per month on average).
   - Cal MediConnect: 8,898
     - 27.5% without claims
   - Medi-Cal: 13,921
     - 19.3% without claims
2. It was identified that there is an average 3 months claim lag time.
   - 76.1% of authorized services were rendered and a claim paid within 90 days of authorization
   - 1.4% were rendered and a claim paid after 90 days of authorization.
   - 22.4% did not yet have a claim paid.



3. Types of requests, volume, and percentage of authorizations with no claims match:

Types of Service	Total Number of Authorizations	% of Authorizations With No Claims Match
Behavioral health	895	14.0%
CBAS	544	1.7%
Continuity of Care	21	61.9%
Dental Anesthesia	104	24.0%
DME	2,004	22.2%
Home Health	1,514	31.2%
Hospice	148	23.6%
Inpatient	3,935	2.2%
Long Term Care	3,466	4.1%
Outpatient Hospital	7,324	40.0%
Skilled	945	6.6%
Transportation	1,815	38.5%
Other	103	56.3%

FOLLOW UP

Authorizations for the current year were pulled and a random sampling of 55 unique approved authorizations that did not have claims attached were reviewed. Outreach was made to each member by phone to assess why the service was not received or delayed.

1. 55 unique authorizations (5 for oversample).
    - 27 Cal MediConnect
    - 28 Medi-Cal

2. Types of services:
    - Outpatient therapy – 14
    - Home health – 10
    - DME – 9
    - MRI – 4
    - Endoscopy – 3
    - Transportation – 3
    - Behavioral Health – 2
    - Outpatient surgery – 2
    - Wound care – 2
    - Outpatient medication – 2
    - CBAS – 1
    - Continuity of Care – 1
    - Sleep Study – 1
    - SPECT – 1

3. Results of the outreach to these 55 members:
    - Outreach successful for 18 members:
        - 6 members reported they received the service
        - 12 members did not get the service due to:
            a. Fear related to COVID 19 – 4
            b. Did not feel the service is necessary – 4
            c. Did not hear from provider – 3
            d. Did not recall the service requested – 1
    - Outreach unsuccessful for 37 members:
        - 23 members did not return calls
        - 11 members had disconnected phone numbers
        - 1 member declined to discuss authorization
        - 1 member was hospitalized
        - 1 member expired

SUMMARY

The data confirms that the highest authorization to claim mismatch are requests for Continuity of Care. The next highest authorization to claim mismatch are outpatient hospital which, is also the highest volume of approved requests. The highest cost services, inpatient and skilled care, had very low authorization to claim mismatch. The lowest authorization to claim mismatch was CBAS and long term care services.

Santa Clara Family Health Plan is committed to working on improving the service delivery systems to our members. The Utilization Management team will continue to track referrals and report findings to the UM Committee.

Santa Clara Family Health Plan™

Quality Monitoring of Plan Authorizations and Denial Letters

Quality Monitoring of Plan Authorizations and Denial Letters
HS.04.01 – 4th Quarter 2020

PURPOSE OF THE QUALITY ASSURANCE (QA)

Santa Clara Family Health Plan (SCFHP) completed the 4th quarter review for timely, consistent, accurate, and understandable notification to members and providers regarding adverse determinations.

PROCEDURE

In accordance with procedure HS.04.01, the Utilization Management (UM) Manager conducts a review of a minimum of 30 randomly selected denied authorizations to assess the integrity of member and provider notifications on a quarterly basis. These findings are presented to the Utilization Management Committee (UMC).

A. The assessment includes the following elements:
   1. Turn-around time for decision making
   2. Turn-around time for member notification
   3. Turn-around time for provider notification
   4. Type of denial – medical or administrative
   5. The reason for the denial is in clear and concise language
   6. The criteria or Evidence of Coverage (EOC) applied to make the denial decision and instructions on how to request a copy of this guideline
   7. The clinical reasons for the denial
   8. What conditions need to exist to have the request be approved
   9. Written notification to members include:
      a. Appeal and Grievance rights
      b. Nondiscrimination notice
      c. Language assistance services
      d. Letter is in the member's preferred language within the plan's language threshold
   10. Written notification to providers include the name and direct phone number of the appropriate licensed professional making the denial decision

FINDINGS

The dates of service of the random sample of 30 unique denied authorizations for Q4 2020 were pulled in January 2021.

A. 100% or 30/30 were denials

1. Line of business:
    a. 50% or 15/30 were Medi-Cal
    b. 50% or 15/30 were Cal MediConnect
2. Types of denials:
    a. 33% or 10/30 were administrative
    b. 67% or 20/30 were medical
3. Licensed clinician making decision:
    a. 3% or 1/30 was denied by a pharmacist
    b. 97% or 29/30 were denied by a medical director
4. Turnaround time:
    a. 70% or 21/30 were standard requests
        - 100% or 21/21 were compliant with regulatory turnaround time (5 business days for Medi-Cal LOB and 14 calendar days for CMC LOB)
    b. 30% or 9/30 were expedited requests
        - 100% or 9/9 were with regulatory turnaround time of 72 calendar hours
5. Notification:
    a. 100% or 21/21 of standard requests were compliant with written notification to member and provider
    b. 100% or 9/9 of expedited requests were compliant with written notification to member and provider
        - 78% or 7/9 of expedited requests were compliant with oral notification to member and provider
    c. 100% or 30/30 of the member letters are in the member's preferred language.
    d. 100% or 30/30 of the letters were readable and included the rationale for denial
    e. 100% or 30/30 of the letters included the criteria or EOC of which the decision was based upon
    f. 100% or 30/30 of the letters included interpreter rights and instructions on how to contact CMO or Medical Director.

II. FOLLOW UP

The Manager of Utilization Management and Medical Director reviewed the findings of this audit with recommendations as follows:

A. Quality and productivity will continue to be monitored on a regular basis including these quarterly audits. Findings will be reported to the Medical Director with a plan of action of how to correct errors if necessary.

Santa Clara Family Health Plan™

Inter-Rater Reliability (IRR) Report – BH - 2021

InterRater Reliability Summary – Behavioral Health Department
2020

1. In accordance with Policy HS.09, Santa Clara Family Health Plan (SCFHP) scheduled IRR testing is completed biannually. Behavioral Health Department IRR Testing for December 2020 is complete. This testing is required twice a year. IRR testing is scheduled for SCFHP 1st and 2nd half of the calendar year. In accordance with NCQA/DHCS, DMHC guidelines, and SCFHP policy, 10 random BH authorizations are selected to test BH staff with the authority to Authorize services. Our BH staff consists of non-licensed Personal Care Coordinators (PCC).
2. It is the policy of SCFHP to monitor the consistency and accuracy of review criteria applied by all reviewers - physicians and non-physicians - who are responsible for conducting Behavioral Health service reviews and to act on improvement opportunities identified through this monitoring.
3. The Chief Medical Officer or Manager of Behavioral Health will review and approve the assessment report of decision making performance of staff responsible for conducting Behavioral Health approval reviews for BH staff. The report results and recommendations for improvement will be presented annually to the Utilization Management Committee.
4. The Plan classifies reviews into one of two performance categories: Proficient (80% - 100% of the records are in compliance with the criteria); Not proficient (below 80% in compliance) Scores below 80% require increased focus by Supervisors/Managers with actions described in Policy/Procedure HS.09/HS.09.01 or an individual corrective action plan.

The following are the findings for all BH UM staff tested December 2020:

Reviewer	Percent Score	UM (BH) Staff Position	Pass/Failed
1	100	Manager Behavioral Health	Pass
2	100	Project Manager BHT	Pass
3	100	Behavioral Health PCC	Pass
4	90	Behavioral Health PCC	Pass

In the testing, we found that 4/4 of our staff are proficient during this review. There was no need for any corrective action planning. The Project Manager for Behavioral Health Treatment has provided trainings to Behavioral Health staff to monitor and implement any necessary UM Chagnes.

Currently all Behavioral Health Department staff who are completing authorizations have received a passing grade.

Our common finding after the testing process was:

1. Staff who are currently authorized to review/approve BH services through SCFHP express comfort in knowing the process/where to go to for clarification.
2. Ongoing support throughout the department helps all performing UM functions to operate at an efficient level – all of those who completed BH IRR testing passed with 90-100% grading.

The corrective action's plan after identifying the common findings:

1. Mandatory remedial training with post testing for all non-proficient staff – Required.
    a. None necessary to Provide at this time
2. Mandatory bi-annual review of guidelines and criteria, as well as biannual testing, will continue to be scheduled for all staff who complete Behavioral Health Authorizations.

Santa Clara Family Health Plan™

Annual Physician Peer-to-Peer- 2020

Peer to Peer Annual Review Calendar Year
Year to Date January 1 to December 31, 2020

In accordance with Procedure HS.02.02, the provider dispute process also includes a Peer to Peer (P2P) review with the SCFHP physician who makes the determination (in cases of denials of service). It is the goal of SCFHP medical director team to ensure quality of service and return of calls when there is a requested P2P. This analysis evaluates the completion rate and final determinations for those calls.

All cases were reviewed for compliance. This was to ensure that the Peer to Peer process is working and that community physician requests for P2P are completed and do in fact occur.

The findings are as follows:
41 Peer to Peer Requests were scheduled.

1. 95% (39/41) calls were completed with the SCFHP Medical Director and the requesting Practitioner.
2. 97% (40/41 cases) had documentation of the call in our QNXT system.
3. In terms of upheld or overturning of auth after P2P:
    - 21/41 (51%) requests were overturned after the P2P
    - 19/41 (46%) requests were upheld after P2P
    - 1 request lacks sufficient info

SCFHP recommendation to UMC:

1. Since 6/2017, QNXT is the one system that now holds authorizations for all Lines of Business (Medi-Cal and Cal MediConnect). As such both SCFHP Medical Directors know the system and have agreed to enter their call documentation into QNXT.

2. The current findings are that 95% of P2P occurred and documentation occurred for 97% of P2P's as such, no corrective action is needed.

3. SCFHP will continue annual monitoring.

Santa Clara Family Health Plan™

Behavioral Health UM

BEHAVIORAL HEALTH TREATMENT

AUTHORIZATION STATUS*

- **258** APPROVED AND CURRENTLY IN TREATMENT (Q4, 2020)
- **0** APPROVED FOR TREATMENT, WAITING FOR PREFERRED TIME
- **1** APPROVED FOR TREATMENT BUT HAVE UNABLE TO REACH (Q4, 2020)
- **19** IN TREATMENT IN 2020 UNDER LOA FOR NON-CONTRACTED PROVIDER

*AS OF 01/13/2021

BEHAVIORAL HEALTH TREATMENT

NEW PROVIDERS

Providers	
Roman Empire ABA	Contract effective 11/2020
Badoni Behavioral Services LLC	Contract effective 12/2020

BEHAVIORAL HEALTH

UTILIZATION*

- **PSYCHIATRIC ADMISSIONS**
  - 9 PSYCHIATRIC ADMISSIONS (CMC) Total, Q4, 2020
  - 39 PSYCHIATRIC ADMISSIONS (CMC) Total 2020
  - 62 PSYCHIATRIC ADMISSIONS (CMC) Total 2019

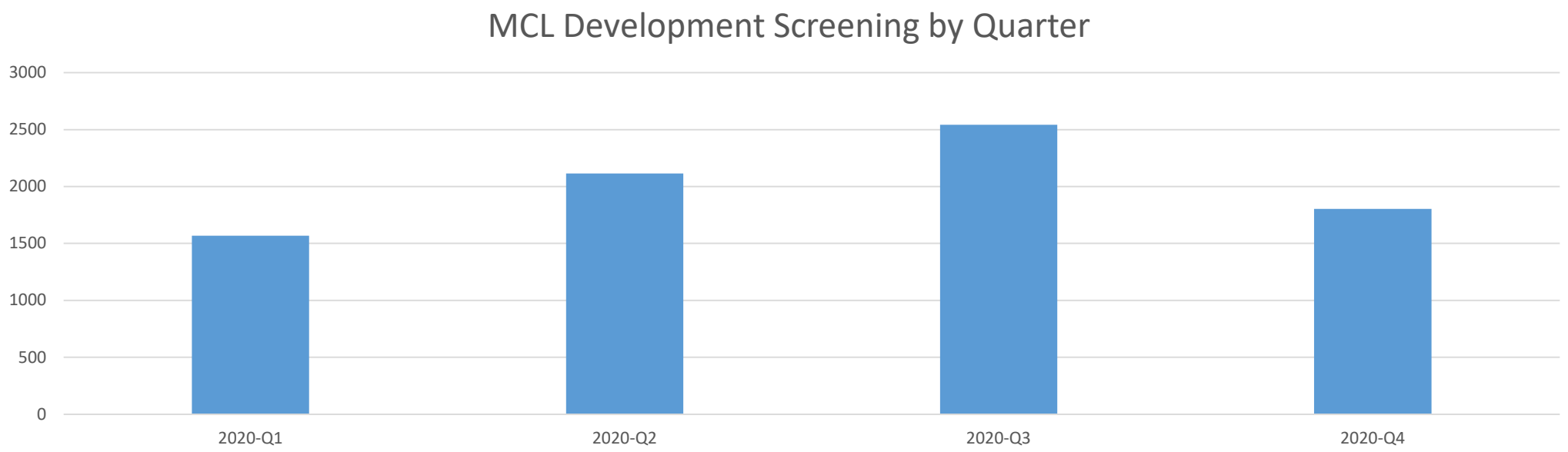
- **COUNTY BEHAVIORAL HEALTH CALL CENTER**
  - OCTOBER: 625 (ALL SCFHP, M2M AND SPECIALTY)
  - NOVEMBER: 558 (ALL SCFHP, M2M AND SPECIALTY)
  - DECEMBER: NOT REPORTED

- *AS OF 1/13/2021

DEVELOPMENTAL SCREENS

COMPLETED SCREENS BY QUARTER

as of 1/13/2021



DEVELOPMENTAL SCREENS

SCREENS BY QUARTER

as of 1/13/2021

2020-Q1	1567
202-Q2	2114
2020-Q3	2542
2020-Q4	1804
Grand Total-2020	8027

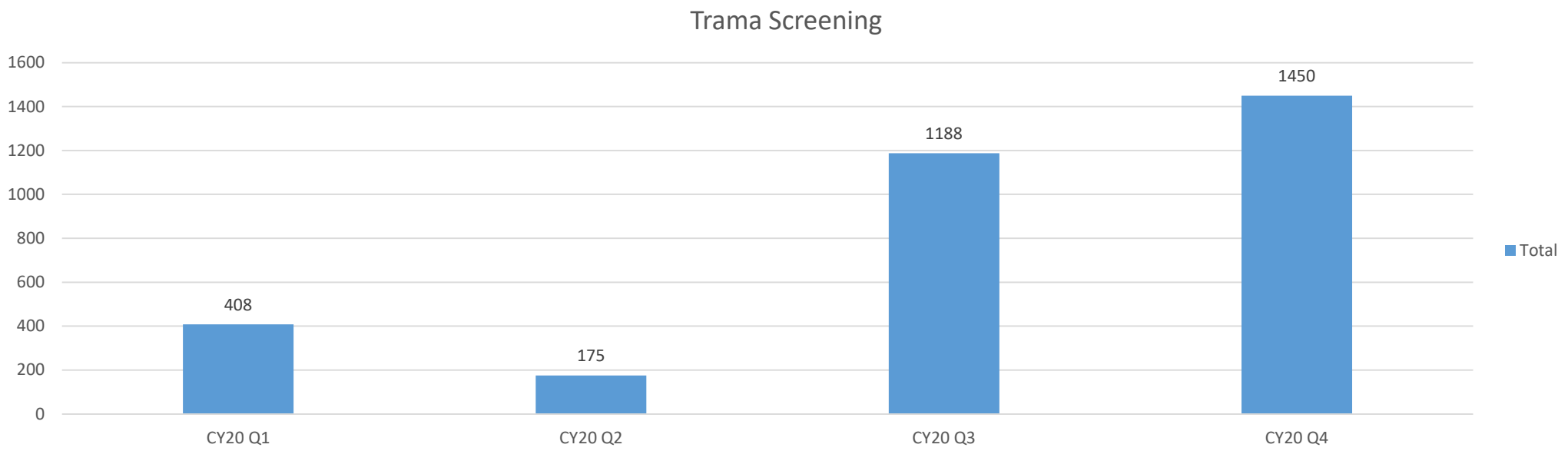
DEVELOPMENTAL SCREENS

NETWORK	TOTAL COMPLETED SCREENS 2020
Independent Physicians	234
VHP	3932
PAMF	167
PMG	2441
Premier Care	1251

TRAUMA SCREENS

QUARTER	TOTAL COMPLETED
Q1	408
Q2	175
Q3	1188
Q4	1450
TOTAL	3221

TRAUMA SCREENS



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Adjournment