AGENDA

Santa Clara County Health Authority
Provider Advisory Council

Wednesday, August 8, 2018, 12:15 PM – 1:45 PM

Santa Clara Family Health Plan, Sycamore Conference Room
6201 San Ignacio Ave, San Jose, CA 95119

	AGENDA ITEM	RESPONSIBLE PARTY	TIME ALLOTMENT
	Roll Call / Establish Quorum	Dr. Padua, Chair	
1.	Meeting Minutes (Attachment 4) Review minutes from February 8, 2018 & May 9, 2018 ® Possible Action: Approve Minutes	Dr. Padua, Chair	5 minutes
2.	Public Comment Members of the public may speak to any item not on the agenda; 2 minutes per speaker. The Committee reserves the right to limit the duration of public comment period to 30 minutes	Dr. Padua, Chair	10 minutes
3.	Chief Executive Officer (Attachment 4) Discussion on SCFHP membership and current topics	Ms. Tomcala, CEO	10 minutes
4.	Review PAC Charter (Attachment 4)	Mr. Tatum	10 minutes
5.	Quality and Pharmacy (Attachment 4) ® Discussion on Drug Report	Johanna Liu, Pharm D.	10 minutes
6.	Membership of PAC a. Current (Attachment 4) b. Follow-Up c. Discussion	Dr. Robertson, CMO	10 minutes
7.	Six C's of Care 1. Community-engagement and participation of all major stakeholders-i.e. all networks 2. Collaboration-share in best practices and resources to enhance efficiency 3. Coordination-continually improve timely access to specialty care 4. Communication-keep all clinicians up to date on regulations and compliance 5. Caring-promote high patient satisfaction and clinician satisfaction 6. Compassion-provide a medical home for all members	Dr. Padua, Chair	10 minutes

	AGENDA ITEM	RESPONSIBLE PARTY	TIME ALLOTMENT
8.	SCFHP Authorization Process for Medical/Behavioral Health/LTSS 1. Regulatory Requirements 2. Policies and Procedures (Attachment 4) 3. Turn Around Time Reports	Jana Castillo	10 minutes
9.	SCFHP Authorization Process for Pharmacy 1. Regulatory Requirements (Attachment 4) 2. Policies and Procedures (Attachment 4) 3. Turn Around Time Reports	Dang Huynh, Pharm D.	10 minutes
10.	Discussion / Recommendations	All	5 minutes
11.	Adjournment		

Next Meeting November 14, 2018

Notice to the Public—Meeting Procedures

- Persons wishing to address the 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.

- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Robin Esparza 48 hours prior to the meeting at 408-874-1780.

To obtain a copy of any supporting document that is available, contact Robin Esparza at 408-874-1780. 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

Richard Garcia, MD
CMO, Excel MSO, San Jose, CA
richard.garcia@excelmso.com
(408) 418-1874

EDUCATION AND TRAINING

2007 USC Marshall School of Business, Master of Medical Management
1999 Children's Hospital Los Angeles, Pediatric Emergency Medicine Fellowship
1994 Los Angeles County+USC Medical Center, Pediatric Residency
1991 University of Illinois College of Medicine, Doctor of Medicine
1987 University of California at Berkeley, Bachelor of Arts

MANAGEMENT EXPERIENCE

2018 – present Chief Medical Officer, Excel MSO, San Jose, CA
2016 – 2017 Medical Director, Pioneer Medical Group, Cypreess, CA
2015 – 2016 Medical Director, Aetna Federal Employees Account
2014 – 1015 Medical Director, Chinese Community Health Plan, San Francisco, CA
2012 – 2014 Medical Director, United Healthcare, CCR Commercial Division

CLINICAL EXPERIENCE

2004 – 2012 General Pediatrician

SCHOLARLY PUBLICATIONS (selected)

1. **Garcia, Richard**. "Racial Socialization: Retrofitted and Refurbished." *Journal of the National Medical Association*. (Accepted.)
2. **Garcia, Richard**. "Diversity in Pediatrics: The Myth of Sisyphus." *Journal of the National Medical Association*. February 2, 2018.
3. **Garcia, Richard**. *On Race and Medicine: Insider Perspectives.* Rowman & Littlefield Publishers. April 2015.
4. **Garcia, Richard**, "The Misuse of Race in Medical Diagnosis." *The Chronicle of Higher Education*. May 9, 2003

INVITED LECTURES (selected)

March 2, 2018 – TEDx Talk, "Alternative Perspectives: Race and Medicine," Newport, CA
April 7, 2016 – UOP, "Race, Structure, Ideology, and Medicine," Stockton, CA
August 2, 2015 – NMA Convention, "On Race and Medicine," Detroit, MI
March 19, 2015 – UC Berkeley School of Public Health, "Integrated Community Healthcare"
August 6, 2014 – NMA Convention, "Why Quality Matters," Honolulu, HI
September 24-25, 2013 – U. of Texas, "Best Practices for Clinical Care and Medical Education in the 21st Century," Austin, TX
January 31, 2012 – University of Toledo School of Medicine, "Distractions and Distinctions in Race and Medicine," Toledo, OH
October 20, 2011 – American Studies Association Convention, "Interdisciplinarity in Health Disparities Research," Baltimore, MD
August 19, 2008 – University of Illinois College of Medicine, "Health Care Disparities: Toward Education and Research," Chicago, IL
May 1, 2008 – Arizona State University, "Health Disparities in the Borderlands," Phoenix, AZ

CERTIFICATIONS AND MEMBERSHIPS

- Diplomat, American Board of Pediatrics, 1995, 2002, 2009 (601695)
- State Medical Licenses: CA (G 75626), AZ (47839)

Santa Clara Family Health Plan
The Spirit of Care

www.scfhp.com

Regular Meeting of the Santa Clara County Health Authority Provider Advisory Council (PAC)

Thursday, February 1, 2018
12:15 PM – 1:45 PM
210 E. Hacienda Avenue
Campbell, CA 95008

Minutes

Members Present:
Chung Vu, M.D.
Dolly Goel, M.D.
Jimmy Lin, M.D.
Peter Nguyen, D.O.
Sherri Sager

Members Not Present:
Thad Padua, M.D. Chair
Bridget Harrison, M.D.
Kingston Lum
David Mineta

Staff Present:
Christine Tomcala, Chief Executive Officer
Lily Boris, MD, Medical Director, Acting Chair
Chris Turner, Chief Operating Officer
Johanna Liu, Director of QI and Pharmacy
Sherry Holm, Behavioral Health Program Manager
Abby Baldovinos, Provider Network Associate
Art Shaffer, Provider Network Associate
Claudia Graciano, Provider Network Associate
Rosa Perez, Provider Network Representative
Robyn Esparza, Administrative Assistant
Dang Huynh, Pharmacy Manager

1. ROLL CALL
   Lily Boris, MD, Medical Director, Acting Chairperson, called the meeting to order at 12:28 pm.
   Roll call was taken and a quorum was established.

2. MINUTES REVIEW AND APPROVAL
   Meeting minutes were reviewed. Dr. Boris asked the Committee if there were any additional questions or comments regarding the May 4, 2017 meeting minutes.
   - ü It was moved, seconded that the May 4, 2017 minutes be approved.

3. PUBLIC COMMENT
   - ü There were no public comments.

4. CHIEF EXECUTIVE OFFICER UPDATE

Ms. Tomcala presented the January 2018 Membership Summary, noting the current enrollment is 263,855, with the majority of membership in Medi-Cal.

- Healthy Kids: 3,209 (1%)
- Cal MediConnect: 7,389 (3%)
- Medi-Cal: 253,257 (96%)

With regard to Medi-Cal Membership by Age Group and Network, Ms. Tomcala presented the following:

- Pediatrics: 41%
- Adults: 59%

The decrease in membership since last January was noted. This is most likely due to undocumented families; increase in minimum wage, disqualifying eligibility due to increase in members' income; as well as families leaving the county due to the lack of affordable housing.

Ms. Tomcala discussed the following current events:

a) SCFHP'S NEW BUILDING

Ms. Tomcala advised the Committee that SCFHP has purchased a new building in South San Jose. The new location is less expensive than commercial properties in our current area or downtown. The location works for most staff, as it is opposite direction of traffic. We are currently in midst of planning the build out. Expected completion is June 2018.

b) CHANGE IN PAC STANDING MEETING DATE

Ms. Tomcala advised the Committee that we need to change the standing meeting date for this committee due to the unavailability of Dr. Jeff Robertson, Chief Medical Officer, on the first Thursday of the month. Other dates were discussed and the Committee recommended looking into the second Wednesday of the month.

ü Communication will be sent when date finalized.

c) SYSTEM UPGRADE

Ms. Tomcala advised the Committee that since the last meeting, SCFHP completed it's conversion of our Medi-Cal line of business to the QNXT system. As of July 1, 2017, there is a single claims processing platform for all lines of business.

5. OPIOD SAFETY PROGRAMS

Mr. Dang Nguyen, Pharmacy Manager, gave presentation on SCFHP's Opiod Safety Program. (Copy attached herein.)

6. CAHPS SURVEY

Ms. Johanna Liu, Director of QI & Rx, presented survey results from the Consumer Assessment of Healthcare Providers & Systems (CAHPS) 2017 findings (Copy Attached Herein).

7. PROVIDER LINK – SCFHP NEW PROVIDER PORTAL DEMO

Ms. Claudia Graciano and Ms. Abby Baldovinos, Provider Network Associates, demonstrated the SCFHP's new provider portal.

8. QUALITY AND PHARMACY

Ms. Johanna Liu, Director of QI and Pharmacy, presented drug utilization reports on the Top 10 Drugs by Total Cost and by Prior Authorization for the date range of 01/01/17 – 03/31/17 (Copy Attached Herein).

9. **2018 CALENDAR - CHANGE IN PAC STANDING MEETING DATE**

Dr. Boris advised the Committee a new calendar for the year will be sent once a new standing date for the committee meeting is set as previously discussed today due to Dr. Robertson's unavailability on the 1st Thursday of the month.

- ü 2nd Wednesday of the month is tentative. Discuss off line and send confirmation with new dates,

10. **2018 CONFIDENTIALITY STATEMENT**

Dr. Boris asked present committee members to sign their annual Confidentiality Statement.

- ü Statements to be filed accordingly.

11. **ADJOURNMENT**

It was moved, seconded, and approved to adjourn the meeting at 1:40pm. A new calendar will be sent when for the remaining meetings of 2018.

Dr. Lily Boris, PAC Committee Acting Chair

Date

Santa Clara Family Health Plan
The Spirit of Care

www.scfhp.com

Regular Meeting of the Santa Clara County Health Authority Provider Advisory Council (PAC)

Wednesday, May 9, 2018
12:15 PM – 1:45 PM
210 E. Hacienda Avenue
Campbell, CA 95008

Minutes

Members Present:
Bridget Harrison, M.D.
Chung Vu, M.D.
Thad Padua, M.D., Chair
Sherri Sager

Members Not Present:
Dolly Goel, M.D.
Jimmy Lin, M.D.
Kingston Lum
David Mineta
Peter Nguyen, M.D.

Staff Present:
Lily Boris, MD, Medical Director
Jeff Robertson, Chief Medical Officer
Chris Turner, Chief Operating Officer
Johanna Liu, Director of QI & Pharmacy
Sherry Holm, Behavioral Health Program Manager
Abby Baldovinos, Provider Network Associate
Art Shaffer, Provider Network Associate
Claudia Graciano, Provider Network Associate
Rosa Perez, Provider Network Representative
Robyn Esparza, Administrative Assistant

ROLL CALL
Thad Padula, MD, Chair, called the meeting to order at 12:28 pm.
Roll call was takenand a quorum was not established.

1. **MINUTES REVIEW AND APPROVAL**
Meeting minutes were reviewed. Dr. Padua asked the Committee if there were any additional questions or comments regarding the February 1, 2018 meeting minutes.
   - Review and approval of the minutes is deferred to the next meeting.

2. **PUBLIC COMMENT**
   - There were no public comments.

3. CHIEF EXECUTIVE OFFICER UPDATE

Dr. Robertson presented the April 2018 Membership Summary, noting the current enrollment is 262,569, with the majority of membership in Medi-Cal.

- Healthy Kids: 3,454 (1%)
- Cal MediConnect: 7,435 (3%)
- Medi-Cal: 251,680 (96%)

With regard to Medi-Cal Membership by Age Group and Network, the following was noted:

- Pediatrics: 41%
- Adults: 59%

Observations regarding the membership of SCFHP include:

- The age of membership is trending toward an older demographic compared, as our younger population ages.
- The decrease in membership was noted as being down approximately 5%. As was noted at the last meeting, the decline in membership since January 2018, continues to be most likely due to undocumented families, disqualifying eligibility due to increases in members' income; as well as families leaving the county due to the lack of affordable housing.

The following current events were noted:

a. SCFHP'S NEW BUILDING

Dr. Robertson reminded the council of the upcoming move of The Plan to South San Jose at the end of July.

4. PAC CHARTER

Dr. Robertson advised the council that he, Dr. Boris, Dr. Padua and Ms. Turner met and had a conversation regarding the PAC charterHe presented a revised PAC Charter for review, discussion and approval (Copy attached herein). Ms. Turner reviewed the charter for the council and noted a recommended change (which is noted in red font and highlighted in yellow for reference) as follows: include **"high quality/effective"** preceding "system of care in accordance with the six "C's of care." Council suggested removing the slash, replacing it with the "and" to read **"high quality and effective…"**

- Quorum not present. Will be reviewed for approval at the next meeting.

5. QUALITY AND PHARMACY

Ms. Johanna Liu, Director of Quality Improvement and Pharmacy, presented drug utilization reports on the Top 10 Drugs by Total Cost and Top 10 Drugs by Prior Authorization for the date range of 01/01/18 – 03/31/18 (Copy attached herein).

6. MEMBERSHIP OF PAC

a. Current Membership

The current PAC Roster membership was reviewed (Copy attached herein). Dr. Robertson reminded the council that the Chairperson and members are appointed by the CEO, and serve 2-year terms.

b. Proposed Membership

Dr. Robertson queried the council as to the best size and mix of the committeein order to receive input from all aspects of the provider network, and facilitate robust discussion. Dr. Harrison suggested not putting a minimum or maximum number of members, in order to allow flexibility.

Council members shared that the council currently has a good diversity and size, elaborating that it's small enough to be nimble, to have meaningful conversation, to get to know one another and build trust to faciliate critical conversations and ask questions of each other, which is helpful in terms of the sustainability. There was agreement that it could be beneficial to representation from the front line, as well as more high volume specialists (i.e, G.I., Cardio, and Obstetrics) and mid-level providers. Dr. Harrison shared O'Conner's educational program includes learning about systems of care, allowing residents blocks in schedules. Ms. Sager suggested Chief Residents could participate and will invite her chief resident as a guest to the next meeting.

- Have a formal conversation regarding this matter at the next meeting.

7. SIX C'S OF CARE

The Six C's of Care come from the PAC Charter and include:

1. Community - engagement and participation of all major stakeholders - i.e. all networks
2. Collaboration - share in best practices and resources to enhance efficiency
3. Coordination - continually improve timely access to specialty care
4. Communication - keep all clinicians up to date on regulations and compliance
5. Caring - promote high patient satisfaction and clinician satisfaction
6. Compassion - provide a medical home for all members

The council was solicited for their feelings/comments around the 6 C's of Care and the committee's role in delivering upon these themes.

Dr. Padua queried the council for input as it relates to nteractingn with The Plan's authorization process and timely access to care and suggested this may be an area of interest for the Council to focus upon, including looking at disparities in care The Council agreed that starting off with some education in these areas would be of interest.

8. DISCUSSION, RECCOMENDATIONS

The frequency and timing of the meeting was discussed. .

Dr. Harrison noted that there were more people in attendance at past meetings. She inquired as the why meetings were cancelled last year. Ms. Turner noted one meeting was cancelled last year due to internal operations and the second cancellation was due tolack of a quorum.

We will confirm that this meeting time is acceptable to the Council members.

Ms. Sager complimented the council, noting she has used PAC as an example for several other managed care plans who were creating advisory councils that included just physician issues which isn't adequate. They now use input from ancillary providers which we added over the years on this advisory council.

9. ADJOURNMENT

It was moved, seconded, and approved to adjourn the meeting at 2:00pm.

Dr. Thad Padua, Committee Chair

Date

Santa Clara
Family Health Plan

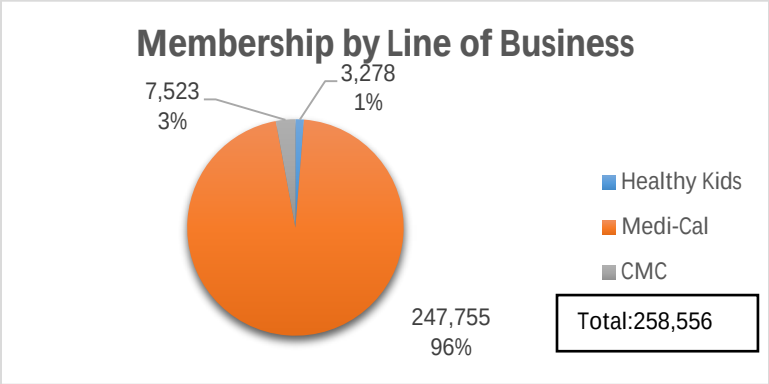
Medi-Cal Membership by Age Group and Network

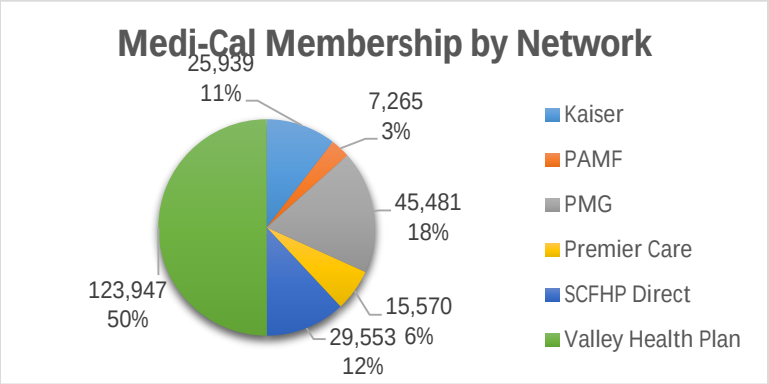
July 2018

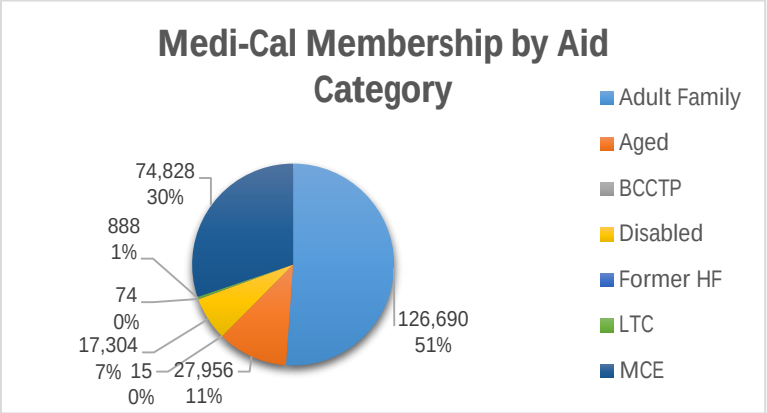
Age Group	SCFHP Direct	Valley Health Plan	Kaiser	PAMF	PMG	Premier Care	Total	Percentage
0 to 6	1,874	14,334	3,895	642	7,275	1,176	29,196	11.8%
6 to 17	4,974	30,675	8,697	1,734	17,177	4,170	67,427	27.2%
18 to 34	4,146	29,585	5,521	1,250	8,286	3,189	51,977	21.0%
35 to 44	1,795	10,345	2,024	494	3,077	1,391	19,126	7.7%
45 to 54	1,804	11,321	1,811	574	3,824	2,386	21,720	8.8%
55 to 64	2,121	14,347	1,857	677	4,092	2,755	25,849	10.4%
65 to 74	5,870	7,370	801	479	1,128	365	16,013	6.5%
75 to 84	4,672	4,498	852	914	541	119	11,596	4.7%
>= 85	2,297	1,472	481	501	81	19	4,851	2.0%
Total	**29,553**	**123,947**	**25,939**	**7,265**	**45,481**	**15,570**	**247,755**	100.0%
Percentage	11.9%	50.0%	10.5%	2.9%	18.4%	6.3%	100.0%	

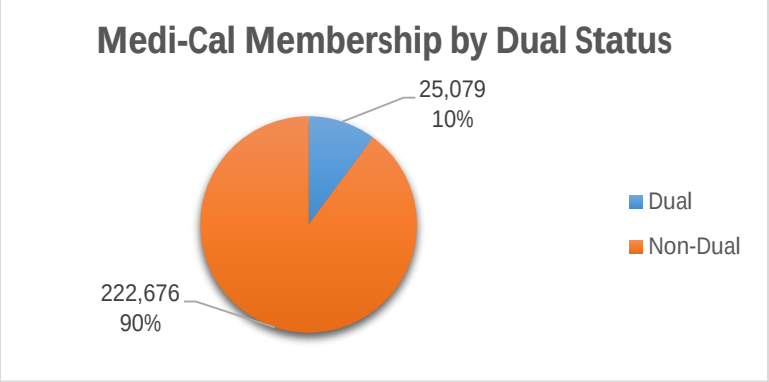
Santa Clara Family Health Plan

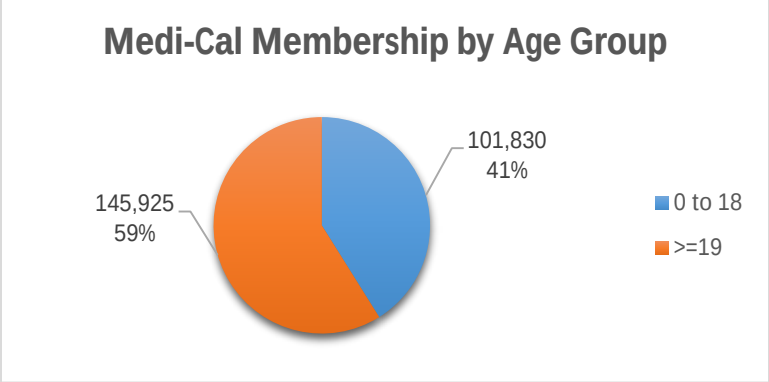
JULY 2018 ENROLLMENT SUMMARY

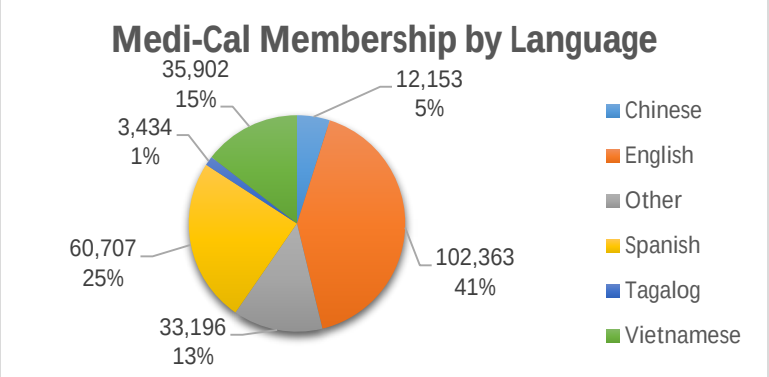












Santa Clara County Health Authority

Provider Advisory Council

Charter

Purpose

Pursuant to the Bylaws, the Governing Board shall establish a Provider Advisory Council whose members can provide expertise to the Santa Clara Family Health Plan (SCFHP) relative to their respective specialties. The Provider Advisory Council shall act as an advisory committee to assist SCFHP in creating and maintaining a high quality/effective system of care in accordance with the six C's of care -- Community, Collaboration, Coordination, Communication, Caring, and Compassion.

The Council's mission is to discuss regional or national issues regarding the relationships and interactions between providers, their patients and SCFHP. These issues include improving health care and clinical quality, improving communications, relations, and cooperation between providers and SCFHP, and clinical or regulatory matters that affect interactions between providers and SCFHP.

Members

The Provider Advisory Council shall have a sufficient number of members to provide necessary expertise and work effectively as a group. The Provider Advisory Council shall include contracted providers from a range of specialties as well as other representatives from the community including but not limited to representatives from contracted hospitals, Medical Directors from contracted IPAs, non-physician representatives who possess knowledge regarding the initiatives and issues facing the patient and provider community, and representation from the behavioral health community.

All Provider Advisory Council (PAC) members, including the Chairperson, shall be appointed by SCFHP's Chief Executive Officer (CEO). The CEO may also appoint physicians enrolled in an accredited Residency program as non-voting members.

All PAC members, including the Chair, serve two-year terms which may be renewed at the discretion of the CEO, provided that the member is in compliance with the requirements set forth in this charter.

Provider Advisory Council members shall annually sign a Confidentiality Agreement. Failure to sign the agreement or abide by the terms of the agreement shall result in removal from the Committee.

Meetings

Regular meetings of the Provider Advisory Council shall be scheduled quarterly. Additional special meetings, or meeting cancellations, may occur as circumstances dictate. Special meetings may be held at any time and place as may be designated by the Chair, the Chief Executive Officer, or a majority of the members of the Committee.

Committee members must attend at least two meetings per year. Attendance may be in person or via teleconferencing. Teleconferencing shall be conducted pursuant to California Government Code section 54953(d). The presence of a majority of the Committee members shall constitute a quorum for the transaction of business.

The Committee may invite other individuals, such as members of management, auditors, or other technical experts to attend meetings and provide pertinent information relating to an agenda item, as necessary.

Meetings of the Provider Advisory Council shall be open and public pursuant to the Ralph M. Brown Act (Gov. Code § 54950 et seq.)

The Director of Provider Network Management is responsible for notifying members of the dates and times of meetings and preparing a record of the Council's meetings.

Responsibilities

The following responsibilities shall serve as a guide, with the understanding that the Committee may carry out additional functions as may be appropriate in light of changing business, regulatory, legal, or other conditions. The Committee shall also carry out any other responsibilities delegated to it by the Board from time to time.

- Address clinical and administrative topics that affect interactions between physicians/providers and SCFHP.
- Discuss regional, state, and national issues related to enhancing patient care.
- Provide input on health care services of SCFHP.
- Provide input on the coordination of services between networks of SCFHP.
- Improve communications, relations, and cooperation between physicians/providers and SCFHP.
- Provide expertise to SCFHP relative to a Committee member's area of practice.

Santa Clara Family Health Plan
Top 10 Drugs by Total Cost
Fill date: 4/1/2018 – 6/30/2018

SAC01 – Medi-Cal

	Label Name	Total Cost	Patient Paid	Plan Paid	% of Total Plan Paid	Generic % of Plan Paid	Total Claims	% of Total Claims	Generic % of Total Claims	Plan Paid / Day	Plan Paid / Claim
1	HUMIRA 40 MG/0.8 ML PEN	$1,458,694	$0.00	$1,458,694	4.8%	0.0%	292	0.1%	0.0%	$177.76	$4,995.53
2	MAVYRET 100-40 MG TABLET	$1,007,562	$0.00	$1,007,562	3.3%	0.0%	159	0.0%	0.0%	$452.63	$6,336.87
3	FREESTYLE LITE TEST STRIP	$966,111	$0.00	$966,119	3.2%	0.0%	8,483	1.6%	0.0%	$3.32	$113.89
4	BASAGLAR 100 UNIT/ML KWIKPEN	$878,945	$0.00	$878,952	2.9%	0.0%	3,365	0.6%	0.0%	$8.16	$261.20
5	HUMALOG 100 UNITS/ML VIAL	$572,144	$0.00	$572,154	1.9%	0.0%	1,288	0.2%	0.0%	$16.75	$444.22
6	VENTOLIN HFA 90 MCG INHALER	$495,107	$0.00	$495,108	1.6%	0.0%	8,548	1.6%	0.0%	$2.60	$57.92
7	STELARA 90 MG/ML SYRINGE	$494,306	$0.00	$494,306	1.6%	0.0%	25	0.0%	0.0%	$337.18	$19,772.24
8	RENAGEL 800 MG TABLET	$420,817	$0.00	$420,817	1.4%	0.0%	205	0.0%	0.0%	$67.76	$2,052.77
9	ENBREL 50 MG/ML SURECLICK SYR	$410,631	$0.00	$410,631	1.3%	0.0%	87	0.0%	0.0%	$168.57	$4,719.89
10	HUMIRA 40 MG/0.8 ML SYRINGE	$339,487	$0.00	$339,487	1.1%	0.0%	72	0.0%	0.0%	$168.40	$4,715.10
Totals for Top 10		**$7,043,805**	**$0.00**	**$7,043,831**	**23.1%**	**0.0%**	**22,524**	**4.3%**	**0.0%**	**$10.90**	**$312.73**
Totals for SAC		**$30,456,007**	**$0.00**	**$30,456,053**	**100.0%**	**28.8%**	**528,299**	**100.0%**	**90.1%**	**$1.77**	**$57.65**

SAC02 – Healthy Kids

	Label Name	Total Cost	Patient Paid	Plan Paid	% of Total Plan Paid	Generic % of Plan Paid	Total Claims	% of Total Claims	Generic % of Total Claims	Plan Paid / Day	Plan Paid / Claim
1	VALGANCICLOVIR HCL 50 MG/ML	$10,246	$0.00	$10,246	8.8%	100.0%	3	0.2%	100.0%	$113.85	$3,415.48
2	HUMALOG 100 UNITS/ML VIAL	$9,875	$0.00	$9,875	8.5%	0.0%	13	0.8%	0.0%	$28.62	$759.64
3	ABSORICA 40 MG CAPSULE	$7,300	$0.00	$7,300	6.3%	0.0%	2	0.1%	0.0%	$121.67	$3,650.20
4	AUVI-Q 0.3 MG AUTO-INJECTOR	$4,940	$0.00	$4,940	4.2%	0.0%	1	0.1%	0.0%	$164.68	$4,940.30
5	VENTOLIN HFA 90 MCG INHALER	$4,933	$0.00	$4,933	4.2%	0.0%	85	5.5%	0.0%	$2.86	$58.03
6	PROGRAF 5 MG CAPSULE	$4,424	$0.00	$4,424	3.8%	0.0%	4	0.3%	0.0%	$37.18	$1,106.10
7	EPINEPHRINE 0.3 MG AUTO-INJECT	$3,819	$0.00	$3,819	3.3%	100.0%	11	0.7%	100.0%	$18.19	$347.19
8	MYCOPHENOLATE 200 MG/ML SUSP	$3,693	$0.00	$3,693	3.2%	100.0%	3	0.2%	100.0%	$28.41	$1,230.99
9	CLINDAMYCIN PH 1% GEL	$2,854	$0.00	$2,854	2.4%	100.0%	23	1.5%	100.0%	$4.80	$124.10
10	NITROFURANTOIN 25 MG/5 ML SUSP	$2,825	$0.00	$2,825	2.4%	100.0%	3	0.2%	100.0%	$33.63	$941.55
Totals for Top 10		**$54,910**	**$0.00**	**$54,910**	**47.1%**	**42.7%**	**148**	**9.7%**	**29.1%**	**$16.22**	**$371.02**
Totals for SAC		**$116,530**	**$0.00**	**$116,530**	**100.0%**	**56.7%**	**1,533**	**100.0%**	**86.5%**	**$3.39**	**$76.01**

SAC06 – Cal MediConnect

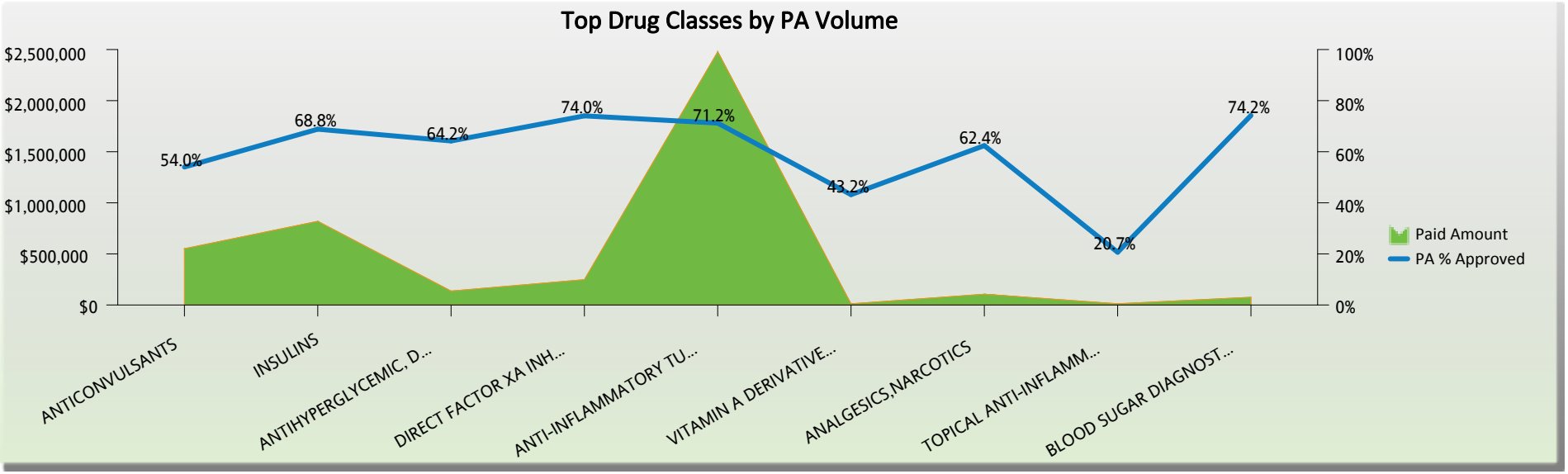
	Label Name	Total Cost	Patient Paid	Plan Paid	% of Total Plan Paid	Generic % of Plan Paid	Total Claims	% of Total Claims	Generic % of Total Claims	Plan Paid / Day	Plan Paid / Claim
1	FREESTYLE LITE TEST STRIP	$228,638	$0.00	$228,638	2.8%	0.0%	1,653	2.2%	0.0%	$2.98	$138.32
2	JANUVIA 100 MG TABLET	$187,903	$749	$187,153	2.3%	0.0%	245	0.3%	0.0%	$13.35	$763.89
3	INVEGA SUSTENNA 234 MG/1.5 ML	$156,669	$30	$156,639	1.9%	0.0%	61	0.1%	0.0%	$92.19	$2,567.85
4	XELJANZ 5 MG TABLET	$149,125	$11	$149,115	1.8%	0.0%	39	0.1%	0.0%	$127.45	$3,823.45
5	LANTUS SOLOSTAR 100 UNIT/ML	$148,710	$1,182	$147,528	1.8%	0.0%	362	0.5%	0.0%	$8.50	$407.54
6	LANTUS 100 UNIT/ML VIAL	$143,276	$834	$142,442	1.8%	0.0%	301	0.4%	0.0%	$11.96	$473.23
7	DESCOVY 200-25 MG TABLET	$137,792	$50	$137,742	1.7%	0.0%	86	0.1%	0.0%	$54.23	$1,601.65
8	XTANDI 40 MG CAPSULE	$132,051	$0.00	$132,051	1.6%	0.0%	13	0.0%	0.0%	$338.59	$10,157.78
9	ENBREL 50 MG/ML SYRINGE	$127,719	$7	$127,712	1.6%	0.0%	27	0.0%	0.0%	$168.93	$4,730.07
10	NOVOLOG 100 UNITS/ML FLEXPEN	$116,434	$514	$115,920	1.4%	0.0%	150	0.2%	0.0%	$16.78	$772.80
Totals for Top 10		$1,528,317	$3,378	$1,524,940	18.9%	0.0%	2,937	3.9%	0.0%	$11.42	$519.22
Totals for SAC		$8,148,914	$76,078	$8,072,825	100.0%	15.8%	75,007	100.0%	83.1%	$2.30	$107.63

Therapeutic PAs

SAC01 - Medi-Cal

Report Period: 04/01/2018 to 06/30/2018
Comparison Period: 04/01/2017 to 06/30/2017

Top Drug Classes by PA Volume



Top Drugs by PA Volume

Rank	Prior Rank	Drug Name	PA Count	% Approved	Rx Count	Plan Paid	Paid per Rx
1	3	XARELTO	148	79.7%	485	$214,858.15	$443.01
2	1	LYRICA	125	50.4%	299	$167,780.20	$561.14
3	4	TRETINOIN	111	45.9%	69	$20,357.15	$295.03
4	9	JANUVIA	110	71.8%	193	$83,405.98	$432.16
5	5	DICLOFENAC SODIUM	101	52.5%	103	$6,146.99	$59.68
6	10	HUMIRA PEN	77	74.0%	288	$1,433,327.78	$4,976.83
7	1	HUMALOG KWIKPEN U-100	76	76.3%	476	$300,404.48	$631.10
8	526	ALOGLIPTIN	71	57.7%	127	$29,056.64	$228.79
9	7	RESTASIS	68	54.4%	136	$69,156.55	$508.50
10	15	GABAPENTIN	61	31.1%	93	$2,216.58	$23.83
Totals for Top 10			**948**	**60.8%**	**2,269**	**$2,326,710.50**	**$1,025.43**
Totals for All			**4,679**	**56.2%**	**10,382**	**$14,301,048.24**	**$1,377.48**

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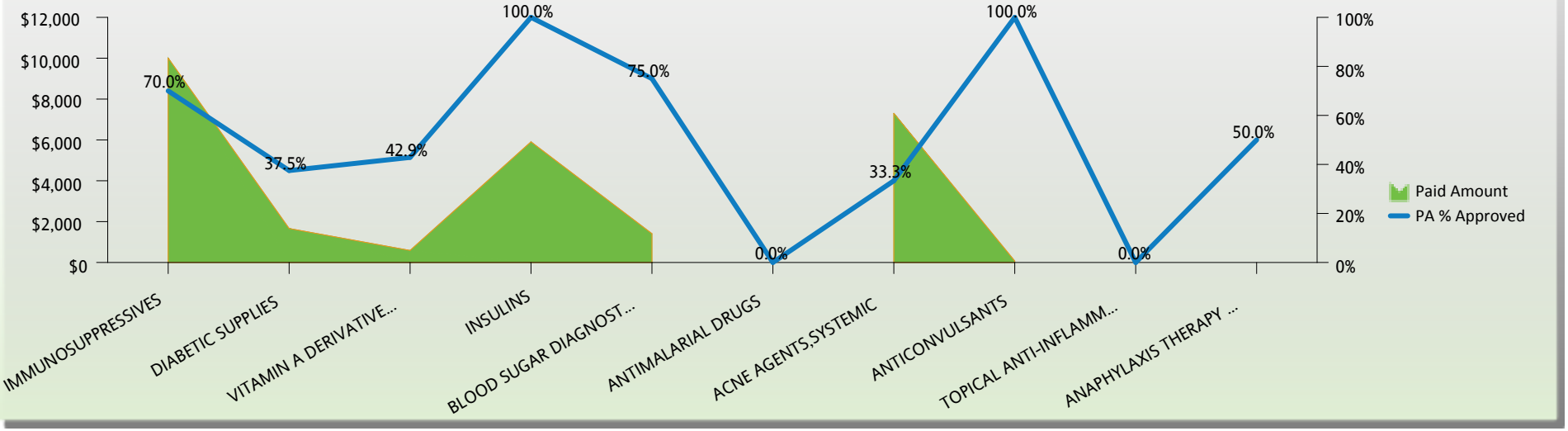
Therapeutic PAs

SAC02 - Healthy Kids

Report Period: 04/01/2018 to 06/30/2018
Comparison Period: 04/01/2017 to 06/30/2017

Top Drug Classes by PA Volume



Top Drugs by PA Volume

Rank	Prior Rank	Drug Name	PA Count	% Approved	Rx Count	Plan Paid	Paid per Rx
1	1	TRETINOIN	6	50.0%	4	$588.38	$147.10
2	22	DEXCOM G5	4	50.0%	1	$477.46	$477.46
3	22	MYCOPHENOLIC ACID	4	100.0%	3	$846.81	$282.27
4	22	PROGRAF	4	75.0%	6	$5,018.92	$836.49
5	7	HUMALOG	3	100.0%	7	$5,601.71	$800.24
6	7	TACROLIMUS	3	33.3%	1	$661.43	$661.43
7	22	CONTOUR NEXT TEST STRIP	3	66.7%	6	$1,410.50	$235.08
8	22	DEXCOM G6	3	0.0%	0	$0.00	$0.00
9	22	ATOVAQUONE-PROGUANIL HCL	2	0.0%	0	$0.00	$0.00
10	22	CLARAVIS	2	50.0%	0	$0.00	$0.00
Totals for Top 10			**34**	**55.9%**	**28**	**$14,605.21**	**$521.61**
Totals for All			**61**	**55.7%**	**55**	**$40,906.24**	**$743.75**

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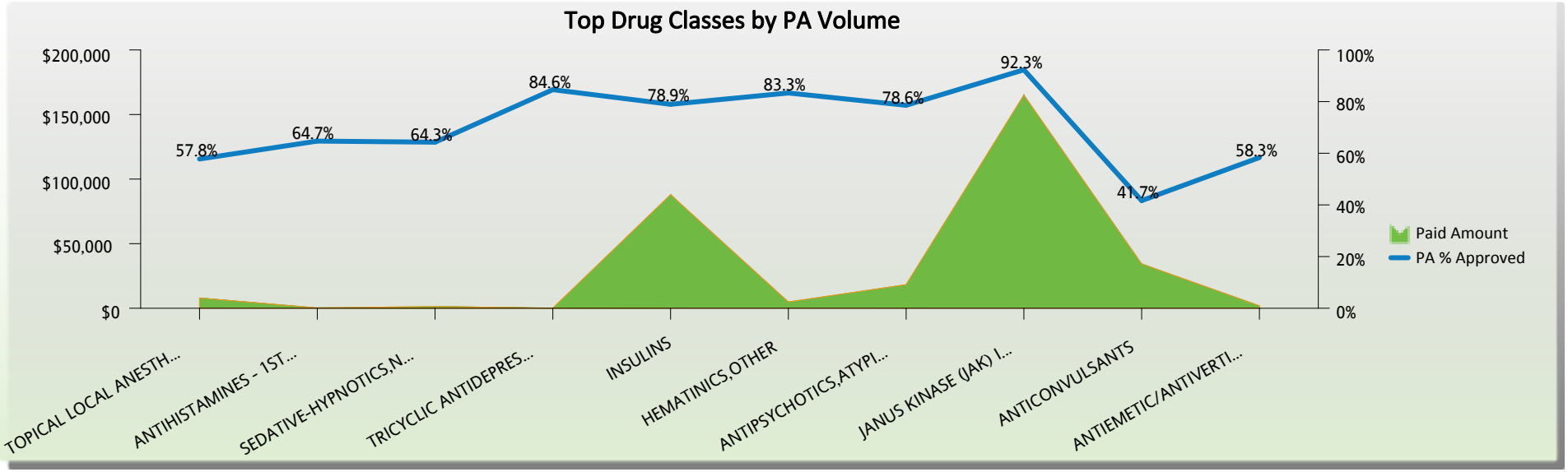
Therapeutic PAs

SAC06 - Cal MediConnect

Report Period: 04/01/2018 to 06/30/2018
Comparison Period: 04/01/2017 to 06/30/2017

Top Drug Classes by PA Volume



Top Drugs by PA Volume

Rank	Prior Rank	Drug Name	PA Count	% Approved	Rx Count	Plan Paid	Paid per Rx
1	3	LIDOCAINE	43	55.8%	70	$7,625.69	$108.94
2	209	HYDROXYZINE HCL	26	61.5%	13	$111.14	$8.55
3	1	ZOLPIDEM TARTRATE	24	62.5%	61	$310.61	$5.09
4	2	PROCRIT	16	93.8%	2	$4,846.58	$2,423.29
5	209	AMITRIPTYLINE HCL	16	75.0%	1	$88.76	$88.76
6	209	NORTRIPTYLINE HCL	10	100.0%	5	$13.84	$2.77
7	8	CYCLOBENZAPRINE HCL	9	55.6%	4	$31.66	$7.92
8	20	TEMAZEPAM	9	55.6%	11	$368.49	$33.50
9	209	MEGESTROL ACETATE	9	0.0%	0	$0.00	$0.00
10	7	XIFAXAN	8	87.5%	34	$63,161.02	$1,857.68
Totals for Top 10			**170**	**64.1%**	**201**	**$76,557.79**	**$380.88**
Totals for All			**540**	**66.5%**	**1,448**	**$2,009,792.72**	**$1,387.98**

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PROVIDER ADVISORY COUNCIL MEETING
ROSTER
2017–2018

NAME	STIPEND	COMPANY	OFFICE INFORMATION	2017				2018			
				Feb	May	Aug	Nov	Feb	May	Aug	Nov
N. Thad Padua, M.D. NT 50 Pediatric & Adolescent Med	*Yes*	IHC – Pediatric Center	2039 Forest Ave., #105 San Jose, CA 95128 408-947-2697 (Ofc) 408-283-7720 (Fax) ntpadua@ihcscv.org	P	P	NO MEETING HELD	NO MEETING HELD		P		
Sherri Sager NT 10	*Yes*	LPCH - DSH	725 Welch Road, Mail Code 5524, Palo Alto, CA 94304 650-497-8277 (Ofc) 650-498-4305 (Fax) SSager@LPCH.org		P			P	P		
Peter L. Nguyen, D.O. NT 50 – Family Practice Hospital Affiliation: OCH	*Yes*	Kelly Park Medical Clinic	749 Story Road, Suite #20 San Jose, CA 95122 408-794-2088 (Ofc) 408-292-2179 (Fax) lpnguyendo@yahoo.com	P	P			P			
Bridget Harrison, M.D. NT 20 changed in 2016 to NT 10		IHC	bridget.m.harrison@gmail.com	P	P				P		
Chung Vu, MD President – NT60		Premiere Care - IPA	2593 S. King Road, #15, San Jose, CA 95122 408-274-9226 chungvumd@yahoo.com	P	P			P	P		
Dolly Goel, MD CMO – NT 20		VHP	2480 N First Street, San Jose, CA 95131 dolly.goel@VHP.sccgov.org melissag.miner@VHP.sccgov.org	P				P			
Jimmy Lin, MD NT 60 Internal Medicine - PCP	*Yes*	Premiere Care Internal Medicine - PCP	2411 Forest Ave, San Jose, CA 95128 (408) 983-1012 docjjl@hotmail.com	P	P			P			
David Mineta Mental Health Representative	*Yes*	Momentum for Mental Health	5103 Elrose Ave, San Jose, CA 95124 650.270.7511 davidmineta@gamail.com kaquino@momentummh.org	P							
Kingston Lum		IHSS	(408) 792-1666 Kingston.Lum@ssa.sccgov.org	P							
Richard Garcia, MD	*Yes*	CMO Excel MSO	richard.garcia@excelmso.com	N/A	N/A	N/A	N/A	N/A	N/A		

Procedure

Santa Clara
Family Health Plan

Policy Title:	**Prior-authorization and Organization Decisions**	**Procedure No.:**	HS01.01
Replaces Policy Title (if applicable):	Prior Auth for Non-Delegated SCFHP and VHP ReRMC Contra ct TERM FINAL Prior Auth Process REDLINE 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

I. Purpose

To ensure that process and guidelines are consistently followed when conducting pre-authorization determinations. Pre-authorization may also be referred to as prior authorization or prospective authorization

II. Procedure

A. Submissions

Prior authorization requests may be submitted to SCFHP in a variety of ways

1. Electronic
2. Secure e-mail
3. Fax
4. US Mail

B. Provider Education

Practitioners and providers are educated on the prior authorization requirements through

1. On-boarding education
2. Annual education
3. Provider manual
4. Plan web-site
5. Calling Provider Services or Utilization Management Departments

C. Timeliness

1. Decisions to approve, modify, or deny prior authorization requests for the provision of health care services and behavioral health services to members shall be processed in a timely manner to meet the needs of the member's condition within the following time frames from receipt of request:
    a. Medi-Cal/ HK:
        i. 24 hours for urgent concurrent review.
        ii. 3 calendar days for expedited and urgent request

iii. 5 business days for routine standard request
iv. 30 calendar days for retroactive request

b. CMC:
i. 24 hours for urgent concurrent review
ii. 72 hours for expedited and urgent request
iii. 14 calendar days for routine standard request
iv. 30 calendar days for retroactive request

c. Twenty-four (24) hours for pharmacy requests

2. Decisions to approve, modify, or deny prior authorization requests for the provision of health care services and behavioral health services to members shall be communicated to the requesting practitioner or provider within two (2) business days of the decision

D. Extensions
Should the decision require extended time, the Plan may send the member a letter of extension allowing an addition 14 calendar days to make the final decision
a. Lack of information is not a sufficient reason to use an extension letter

E. Notification
Notification to the member shall include the following:
1. Expedited and urgent decisions are communicated to the member within the 72 hour timeframe and must be received either by phone or mail within 72 hour time frame.
2. A clear and concise and member specific reason for any modification or denial decision
3. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based
4. Appropriate and understandable language
5. Language assistance and interpretation options
6. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal
7. An explanation of the appeal process, including members' rights to representation and appeal time frames
8. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials
9. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care
a. Right for an Independent Medical Review
b. For all Medi-Cal members, an IMR form and a pre-addressed envelope will be included in the member notification
10. Expedited and urgent referral request decisions are communicated telephonically within 72 hours of the receipt of the request followed by written communication

F. Notification to the requesting practitioner or provider shall include the following:
1. Routine standard decisions are sent to the requesting provider via fax
2. Expedited and urgent decisions are communicated to the requestor via phone followed by a written notification
3. A clear and concise and member specific reason for any modification or denial decision
4. Appeal rights
5. Name of the physician or other designated licensed professional with direct phone number with the opportunity to discuss the decision with the Plan's medical director for Medical denials.
6. Utilization Management Department phone number with the opportunity to discuss the decision with department lead.

G. Medical necessity criteria applied to the modification or denial decision or applicable EOC, or other

published materials applied to the denial. Reopening and Revising Determinations and Decisions

1. Reopening and revising determinations and decisions is not an appeal right, it is an administrative procedure, applicable only after the appeal rights are exhausted.
2. All organizations and reconsideration decisions are considered final and binding.
3. Any of the above decisions may only be reopened or revised:
   a. By the entity that made the determination or decision.
   b. May be initiated by any of the appealing entities.
   c. To correct an error
   d. In response to fraud
   e. In response to info not available or known to exist at the time of the decision
4. CMC will process a reopened determination or decision when:
   a. Reopening request is in writing.
   b. Reason clearly stated (dissatisfaction is insufficient)
   c. Request made within 12 months of reconsideration determination.
   d. It is for good cause and is after 12 months, but before 4 years
   e. Fraud affected any part of the recourse process.

H. Member initiated organization determination

1. Organization determination may be made by a member through phone call and the same method on how providers send request.
2. UM will determine if this request is appropriate for expedited review or not.
3. UM will notify the member if expedited request is granted or not.
4. UM will create an authorization if prior authorization is required for the requested service.
5. UM will follow same turnaround time and use same criteria as a provider initiated organization determination.
6. If necessary, UM will gather data from member's PCP or other specialist related to the requested service.
7. Notification of the decision will follow the same process as provider initiated organization determination.
8. Member will maintain same appeal rights.
9. Member will not be redirected back to PCP or other provider to have them submit request to SCFHP.

I. Denial to Expedite an Organization Determination Request

1. An expedited request for authorization may not be requested for services in which the only issue involves a claim for payment which the member has already received.
2. The member or physician can submit an oral or written request for expedited organization determination for the health plan to make a decision within 72 hours of receipt of such request.
3. The health plan automatically provides an expedited organization determination if a physician indicates, either orally or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.
4. SCFHP staff will call the ordering physician to confirm that standard determination time frames would jeopardize the life or health of member. If this is not supported verbally or in writing by the physician, SCFHP's UM Review Nurse can downgrade the request to standard determination time frames, documenting this information within the member case file.

5. Provider and member will be notified of the downgrade at the time of the call and followed by "delay/DNME" letter.
6. Request will automatically be processed under standard determination time frame, 14 calendar days after the date of receipt of your request

J. Utilization Management Program Structure
   1. The Director of Health Services 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:

      a. The process for prior-authorization and organization determinations
      b. Involvement of licensed healthcare professionals including a full time Medical Director
      c. Involvement of the Medical Director or other designated licensed professional for any denials or modification decisions based on medical necessity
      d. Involvement of the Medical Director or Pharmacist for any pharmaceutical denials / adverse determinations based on medical necessity
      e. Involvement of a Behavioral Health specialist for any behavioral health denials / adverse determination based on medical necessity
      f. Use of established criteria for approving, modifying, deferring, or denying requested services as well as a separate policy regarding medical necessity criteria
      g. Involvement of providers in adoption of specific criteria
      h. Allowance for second opinions. The plan also maintains a policy regarding the allowance of second opinions.
      i. The integration of UM activities into the Quality Improvement Committee (QIC)
      j. Communications to health care practitioners about the procedures and services that require prior authorization

K. SCFHP does not require prior authorization for the following services
   1. Emergency Services
   2. Consent Services for a member who is a minor under 18 years of age,
   3. Family planning services
   4. Preventive services
   5. Basic prenatal care
   6. Sexually transmitted disease services
   7. HIV testing

L. Post-stabilization care
   1. Requests for post-stabilization care from an emergency services provider are made within 30 minutes of the request.
      a. Admissions from the emergency room are deemed approved without prior authorization

M. Member/Member Representative authorization/service requests
   a. Members or a member representative may initiate prior authorization requests.
   b. The member or representative may call Customer Service or Health Services to initiate the request.
   c. The request is processed the same as a provider care or service request.

d. Should a member representative submit the UM prior authorization request, the UM staff shall validate that there is a current and applicable AOR on file with the Plan
e. Out of Area requests – see Continuity of Care protocol for medical and behavioral health
f. The plan provides the prior authorization process to members/member representatives upon request
e. Handling of second opinions
f. Handling of post-stabilization of care

N. Medical Necessity Criteria
1. The Utilization Management Committee is responsible to review and adopt medical necessity criteria on an annual basis
2. The Plan utilizes standardized approved criteria for medical necessity determinations

O. Continuity of Care
1. The plan shall allow 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 contracted network. Continuity of care will apply to the following circumstances
    a. Acute episode of care
    b. Active treatment for chronic condition
    c. Pregnancy
    d. Terminal illness
    e. Newborn care ages birth to 36 months
    f. Surgeries
    g. Other courses of treatment

2. The Plan maintains a protocol regarding Continuity of Care for both medical and behavioral health services. (See HS.01.05 Continuity of Care)

P. Clinical Information
1. The UM Department gathers all relevant information in order to make a prior authorization determination and only that is reasonably necessary to make a determination. This includes considerations outside of the clinical information such as support system, other resources and location. Examples of information which may be obtained for consideration include but will not be limited to the following:

a. Office and hospital records
b. A history of the presenting issue
c. Physical exam results
d. Diagnostic testing results
e. Treatment plans and progress notes
f. Patient psychosocial history
g. Information on consultations with the treating practitioner
h. Evaluations from other health care practitioners and providers
i. Operative or procedural and pathological reports
j. Rehabilitation evaluations
k. A printed copy of criteria related to the request
l. Information regarding benefits for services or procedures
m. Information regarding the local delivery system

n. Patient characteristics and information
o. Information from family members

2. UM staff makes 3 documented attempt to acquire necessary documentation for review before considering denial for insufficient information.

Q. Reporting/Monitoring

A. The Utilization Management Committee oversee the monitoring the timeliness of the resolution of prior authorizations. On a quarterly basis, the UM Committee will assess and when necessary take action on the following:

1. Turnaround times for routine standard requests
2. Turnaround times for expedited urgent requests which are monitored on a real-time basis with interventions taken at the time of identification.
3. Verbal notification of members within 72 hours of receipt of the request
4. Content of the member notification
   a. Reason for the denial is specific to the request and the member's condition
   b. Reason for the denial is in layperson language
   c. Medical necessity criteria is noted
   d. Appeal process is offered
   e. Language assistance options included
   f. IMR Form and self-addressed envelope is included

R. Denials

Utilization Management recognizes 2 types of Denial: Medical and Administrative of which follow same denial notification process stated in Denial notification Procedure.

1. Medical denial-Authorization requests that were denied due to medical or clinical reasons as well as non covered benefits. These are reviewed by licensed staff and denied by the Medical Director or appropriate specialist.
2. Administrative denial-Authorization requests that were denied due to non clinical reasons. These may be for the following but not limited to:
   a. Member not eligible during date of service.
   b. Other health coverage primary.
      i. Member with Medicare A requesting for inpatient services.
      ii. Member with Medicare B requesting for NEMT Ambulance, DME, and outpatient services without proof of Medicare Denial.
      iii. Member with commercial insurance requesting any type medical services.
   c. LTC denials for incomplete LTC authorization request packet
   d. PAMF outpatient physical, occupational and speech therapy for Medi-Cal line of business.
   e.
3. Denials are reviewed on an annual basis or as needed and ordered by the CMO. These are applied to the following circumstances:
   a. Administrative Denials
   b. Pharmacist Denials

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, IT, Provider and

Member Services, outside community resources and providers.

IV. Policy References

HS.01 Prior Authorization

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Sandra Carlson	Signature Jeff Robertson, MD
Name Health Services Director	Name Chief Medical Officer
Title July 03, 2018	Title July 03, 2018
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**			
v1	**Revised**			

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Prior Authorization**	**Policy No.:**	PH03
Replaces Policy Title (if applicable):	Issuing Notices to providers and Members of a Pharmacy Medication PA Request Denial Prior Authorization Member Notification Regarding Drug PA Determinations	**Replaces Policy No. (if applicable):**	PM 102 PM 106 PM 125
Issuing Department:	Pharmacy	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To support a process for members to obtain authorization for medically necessary prior authorization (PA) and non-formulary (NF) drugs and to ensure this process is communicated in the EOC and disclosure forms.

II. Policy

A. SCFHP maintains written procedures and processes on how to conduct Utilization Management prior authorization
B. SCFHP defines how prior authorization procedures and processes address the adoption of review criteria, application of criteria, and review of consistency of applying the criteria
C. The Plan defines the prior authorization turn-around times including the handling of routine requests and expedited requests including the Plans conversion of a routine to expedited or expedited to routine requests
D. The Plan provides clear and concise requirements of prior authorization denial notifications to members and requesting providers and practitioners
E. The Plan defines the mechanisms on how prior authorization requests can be submitted and by whom
    1. The Plan allows both practitioners/providers as well as members to submit requests for prior authorization
F. The Plan defines how requests for second opinions are handled through the prior authorization process

III. Responsibilities

A. Chief Medical Officer, or designee, shall make appropriate PA determinations based of clinical criteria and evidence.
B. Director of Pharmacy, or designee, shall monitor and ensure compliance with this policy including review time frames and oversight of any delegation including the pharmacy benefit manager.

IV. References

1. Department of Managed Health Care Technical Assistance Guide, Rx Drug TAG Module, Requirement RX-001: Non-Formulary Prescription Drug Authorization

2. Department of Managed Health Care Title 28 California Code of Regulations Section 1300.67.241 Prescription Drug Prior Authorization Form Process Control No. 2012-3880
3. CA Health and Safety Code sections 1367.01(e), (h)(1) through (4)
4. CA Health and Safety Code sections 1367.24(a), (b) and (d)
5. Medicare Prescription Drug Manual, Chapter 6 Part D Drugs and Formulary Requirements, 10.6 Medically-Accepted Indication
6. Medicare Prescription Drug Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 30.1 Prior Authorization and Other Utilization Management Requirements
7. Medicare Prescription Drug Manual, Chapter 18 Part D Enrollee Grievances, Coverage Determinations, and Appeals, 30.2 Exceptions
8. SCFHP DHCS Contract
9. NCQA, Quality Management and Improvement, UM4: Appropriate Professionals
10. NCQA, Quality Management and Improvement, UM5: Timeliness of UM Decisions
11. NCQA, Quality Management and Improvement, UM6: Clinical Information
12. NCQA, Quality Management and Improvement, UM7: Denial Notices

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title March 15, 2018	Title March 15, 2018
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**	**Pharmacy & Therapeutics Committee**	**Approve 3/24/2016**	
1	**Reviewed**	**Pharmacy & Therapeutics Committee**	**Approved 3/16/2017**	
1	**Reviewed**	**Pharmacy & Therapeutics Committee**	**Approved 3/15/2018**	

Santa Clara
Family Health Plan

Procedure Title:	**Medi-Cal/Healthy Kids Prior Authorization**	**Procedure No.:**	PH.03.01
Replaces Procedure Title (if applicable):	Prior Authorization (PA) Process	**Replaces Procedure No. (if applicable):**	Desktop 01
Issuing Department:	Pharmacy	**Procedure Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☐ CMC

I. Purpose

To outline Santa Clara Family Health Plan's (SCFHP) prior authorization process for medically necessary drugs with formulary restriction(s) or non-formulary status.

II. Procedure

A. Prior Authorization (PA) Form:
   i. PA requests may only be accepted if submitted on the Prescription Drug Prior Authorization Request Form, No. 61-211.

B. PA Turn-Around Time (TAT) Requirement:
   i. Respond to all pharmaceutical drug PA requests within 24 hours; and in accordance with Welfare & Institutions Code Section 14185(a)(1) from when the request was received.
   ii. The plan will expedite authorization decisions clearly marked "URGENT" as expeditiously as the member's health condition requires and not later than 24 hours from when the request was received.
   iii. PA requests designated as urgent are subject to review by a SCFHP physician or clinical pharmacist to determine if the expedited PA request is medically necessary and should be processed in as expedited or routine based on the condition of the member and not unduly delay the treatment of medical conditions requiring time sensitive services.

C. After Hours Emergency Access:
   i. SCFHP's contracted Pharmacy Benefit Manager (PBM) is authorized to respond to emergency PA requests (during and outside of SCFHP's normal business hours, including weekends and holidays).
   ii. The PBM may authorize up to a 3-day supply of medication.

D. Retroactive PA Requests:
   i. Request must be received by SCFHP within 30 business days of the requested date of service.
   ii. After 30 business days of the requested date of service, the request may be considered for review under one of the following condition(s):
      1. Delayed in certification of the member's Medi-Cal eligibility by the Social Services Agency.
      2. Other coverage denied payment of a claim for services (e.g. Medicare or other health insurance programs).
      3. Member did not identify himself/herself to the prescriber as a SCFHP member by deliberate concealment or because of physical or mental incapacity.

E. Prior Authorization Process:
   i. Data Entry: SCFHP staff will transcribe PA requests

ii. Initial Review: A pharmacy technician will review the transcribed PAs in queue. The technician will first check for member eligibility information, then review the PA against SCFHP criteria. Based off this review, the technician can take one of the following actions:
    1. Approve if PA request meets SCFHP's clinical criteria approved by the Pharmacy and Therapeutics (P&T) Committee.
    2. Forward the PA for a clinical review if the submitted information does not meet SCFHP criteria.
    3. Close: Any of the following reason(s):
        i. PA was not submitted on the Prescription Drug Prior Authorization Request Form (Form No. 61-211)
        ii. Requested drug does not require authorization
        iii. Duplicate PA request (same drug, same prescriber while an existing determination is open)
        iv. Requesting prescriber wants to cancel the PA
        v. PA request from prescriber was incomplete
        vi. Not a pharmacy PA request (wrong department, eg UM, DME)
            1. Non-pharmacy requests will be forwarded to appropriate department within SCFHP
        vii. There is currently an open/pending grievance, appeal, or State Fair Hearing for the same drug from the same prescriber
        viii. Member not an eligible member of SCFHP on date of service
iii. Clinical Review: A qualified Physician or Pharmacist will review PA against SCFHP criteria and use clinical judgment based on generally accepted drug compendia and professional practice guidelines to approve or deny the PA.
iv. Secondary Clinical Review: If a decision cannot be made based on the information provided in the request due to questionable medical necessity or inappropriate use of a drug, the PA will be reviewed by a second qualified Physician or Pharmacist to approve or deny the PA.
v. Finalization: A pharmacy technician will finalize PAs and generate the appropriate notification letters.

F. Notification:
    i. All decisions shall be communicated to the requesting prescriber by telephone, facsimile, or electronic mail within 24 hours of the decision followed by written notification within 24 hours.
    ii. Decisions resulting in denial, delay, or modification of all or part of the requested health care services will be communicated to the member in writing within two business days.
    iii. Approved, Denied, and Closed PAs will generate letter communications to the prescriber and the pharmacy. Denied PAs will also generate letters to members.
        1. If the member's preferred language in MedAccess is one of the threshold languages as designated by DHCS, the member will receive the determination letter in that language.
        2. If the member's preferred language is not listed or not a threshold language, the member will receive the determination letter in English.
    iv. Approved PAs will include the following if applicable:
        1. Prior authorization expiration date
        2. Refill or quantity limitations
        3. Re-authorization criteria
    v. Denied PAs:
        1. Clear and concise explanation of the reasons for the plan's decision
            a. Without medical jargon and technical language
        2. Description of the criteria or guidelines used in decision
        3. Member specific language for reason of denial
        4. Any formulary alternative drugs offered by the plan
        5. Clinical rationale for the decisions regarding medical necessity

G. Prior Authorization Renewal:
    i. When an approved PA expires, a new prior authorization request is required.

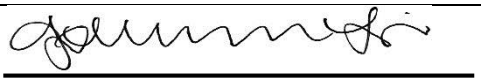
H. Duplicate:
   i. If a prescriber submits a duplicate PA at a later date (same drug, same prescriber, after previously being denied) within 60 days, it will be forwarded to Appeals & Grievances.
   ii. Duplicate requests made after 60 days will be reviewed as an initial request if no appeal or grievance case is open for the request.
      1. If the duplicate request is made within 120 days from an appeal upheld decision, it will be forwarded to Appeals & Grievances.

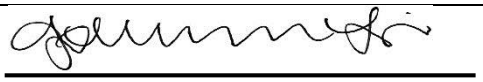
I. Quality Monitoring of Denial Letters:
   i. Pharmacy Director or licensed health care professional designee will review monthly samples of Denied PA request for appropriate denial language including inaccurate rationales.

III. Policy Reference

PH03 Prior Authorization

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
1	Original	 Signature Johanna Liu, PharmD Name Director of Quality and Pharmacy Title 01/04/2017 Date	 Signature Jeff Robertson, MD Name Chief Medical Officer Title 01/04/2017 Date
2	Revised	 Signature Johanna Liu, PharmD Name Director of Quality and Pharmacy Title 07/05/2017 Date	 Signature Jeff Robertson, MD Name Chief Medical Officer Title 09/13/2017 Date
3	Revised	 Signature Johanna Liu, PharmD Name Director of Quality and Pharmacy Title 11/07/2017 Date	 Signature Jeff Robertson, MD Name Chief Medical Officer Title 11/13/2017

			Date
4	Revised	 Signature Johanna Liu, PharmD Name Director of Quality and Pharmacy Title 01/11/2018 Date	 Signature Jeff Robertson, MD Name Chief Medical Officer Title 02/14/2018 Date

Santa Clara
Family Health Plan

Procedure Title:	**Cal MediConnect Coverage Determinations**	**Procedure No.:**	PH.03.02
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Pharmacy	**Procedure Review Frequency:**	Annually
Lines of Business (check all that apply):	☐ Medi-Cal	☐ Healthy Kids	☒ CMC

I. Purpose

To outline Santa Clara Family Health Plan's (SCFHP) process for benefit coverage determination or payment/reimbursement for medically necessary drug.

II. Procedure

a. SCFHP network pharmacies will provide beneficiaries with a written copy of the standardized pharmacy network notice to inform beneficiaries of their right to request and receive a coverage determination when their prescription(s) cannot be filled under the Part D benefit and the issue cannot be resolved at the point of sale.
b. The Pharmacy Benefit Manager (PBM), on behalf of SCFHP will accept coverage determination requests and physicians' or other prescribers' supporting statements (PSS) 24 hours a day, 7 days a week (including holidays).
c. Coverage determination requests for benefit and for payment will be accepted by the plan, or designee, by phone or in writing. No specific form will be required for submission of a coverage determination.
    i. A beneficiary, a beneficiary's prescriber, or a beneficiary's representative may request a standard or expedited coverage determination.
    ii. All expedited coverage determination requests for benefit will be treated as such and will follow the expedited processing timeframe.
    iii. Coverage determinations for payment will not be expedited.
        1. If a case includes both a payment denial and a pre-benefit denial, the beneficiary has a right to request an expedited coverage determination for the pre-benefit denial.
d. If SCFHP expects to issue a partially or fully adverse medical necessity decision based on the initial review of the request, the coverage determination will be reviewed by a current and unrestricted licensed physician or other appropriate health care professional within the scope of his or her profession, including knowledge of Medicare coverage criteria, before issuing a determination.
e. Processing timeframes:
    i. *Expedited* coverage determination for *benefit*:
        1. If request does not involve an exception, the PBM on behalf of SCFHP will provide notice of its decision within 24 hours after receiving the request.
        2. If the request is for an exception and waiting for a PSS, PBM will wait a minimum of 48 hours after receiving the request before issuing a determination.
        3. With notice to the member and requesting provider, the request may be placed on hold for up to 5 calendar days in order to allow the prescribing physician or other prescriber a reasonable amount of time to submit a PSS. Once PSS is received, a decision is rendered within 24 hours. If PSS is not received after 5 days, a decision will be made based on the existing request.
    ii. *Standard* coverage determination for *benefit*:
        1. If request does not involve an exception, the PBM on behalf of SCFHP will provide notice of its decision within 72 hours after receiving the request.

2. If the request is for an exception and waiting for a PSS, PBM will wait a minimum of 96 hours after receiving the request before issuing a determination.
3. With notice to the member and the requesting provider, the request may be placed on hold for up to 14 calendar days in order to allow the prescribing physician or other prescriber a reasonable amount of time to submit a PSS. Once PSS is received, a decision is rendered within 72 hours. If PSS is not received after 14 days, a decision will be made based on the existing request.

iii. Coverage determination for *reimbursement/payment*:
1. For all payment requests (including those that involve exceptions), the PBM on behalf of SCFHP will provide written notice of its decision and make payment when appropriate within 14 calendar days after receiving the request.
2. The 14 calendar day timeframe is not tolled pending receipt of PSS when a reimbursement request involves an exception.

f. Determination outside appropriate time frame:
i. The PBM will forward the request and case file containing any oral and/or written evidence obtained to Independent Review Entity (IRE) for review and notify SCFHP.
1. Exception: If the PBM makes a favorable decision soon after the adjudication timeframe expires (up to 24 hours) and notifies the beneficiary of the decision, the PBM should not forward the case file to the IRE and should provide notice as described in section (g.) below. The PBM will use this exception sparingly.

g. Written notification of decision:
i. Any written notice will be written in a manner that is understandable to the beneficiary.
ii. SCFHP or designee will provide written notice of any favorable or adverse decision it issues. SCFHP or designee may make its initial notification orally, so long as it also mails a written follow-up notice within 3 calendar days of the oral notification.
iii. If a beneficiary files the request, notice will be provided to the beneficiary.
iv. If a beneficiary has identified a representative, notice will be sent to the beneficiary's representative instead of the beneficiary.
v. If a beneficiary's prescribing physician or other prescriber files a request on behalf of the beneficiary, notice will be sent to both the prescriber and the beneficiary. However, written notice is not required to be provided to a beneficiary's prescribing physician or other prescriber after providing oral notice to the physician or other prescriber.
vi. Approval notice will include:
1. The duration of the approval
2. Limitations associated with the approval
3. Any coverage rules applicable to subsequent fills

vii. Denial notice will include:
1. The specific reason for the denial that takes into account the beneficiary's presenting medical condition, disabilities, and special language requirements, if any
2. A description of any applicable Medicare coverage rule or any other applicable Part D plan policy upon which the denial decision was based, including any specific formulary criteria that must be satisfied for approval. If the drug could be approved under the exception rules, the denial notice will explicitly state the need for a PSS and clearly identify the type of information that should be submitted when seeking a formulary or tiering exception.
3. Information regarding the right to appoint a representative to file an appeal on the beneficiary's behalf
4. For coverage denials, a description of both the standard and expedited redetermination processes and time frames, including conditions for obtaining an expedited reconsideration, and the rest of the appeals process
5. For payment denials, a description of the standard redetermination process and time frames, and the rest of the appeals process

III. Policy Reference

PH03 Prior Authorization

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
1	Original	 Signature Johanna Liu, PharmD Name Director of Quality and Pharmacy Title January 04, 2017 Date	 Signature Jeff Robertson, MD Name Chief Medical Officer Title January 04, 2017 Date

Santa Clara
Family Health Plan

Procedure Title:	**Part B J-Code Authorization**	**Procedure No.:**	PH.03.03
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Pharmacy	**Procedure Review Frequency:**	Annually
Lines of Business (check all that apply):	☐ Medi-Cal	☐ Healthy Kids	☒ CMC

I. Purpose

To outline the Pharmacy Department process of reviewing J-codes for Part B organization determinations.

II. Procedure

A. J-Code Review:
   a. All Medicare Part B Specialty Drugs on the Organizational Determination List requires clinical review by a licensed medical doctor or pharmacist.
   b. All J-codes requiring an organizational determination/prior authorization will be initially reviewed by the Utilization Management (UM) Department and assigned to the Pharmacy Department for drug review.
   c. A medical doctor or pharmacist will check the queue daily and ensure that their review follows the required turnaround time.
   d. Clinical pharmacist or designee will review any pertinent notes from the UM Department
   e. Reviewer will assess the request and chart notes to determine if the J-codes are medically necessary and meet Medicare criteria for coverage (if applicable).
   f. Reviewer will enter any pertinent clinical information and use language that is understandable to the beneficiary.

B. Approval and denial determinations:
   a. Approval will be assigned to a UM Care Coordinator with:
      i. Name of the medication being approved
      ii. Indication that the medication is being approved for
      iii. Length of approval
      iv. How the patient can continue to obtain approval in the future
   b. Denials will be deferred to a UM nurse with:
      i. Name of the medication being denied
      ii. Diagnosis/indication that the medication is being denied for

iii. Specific reason for the denial that takes into account the enrollee's presenting medical condition and disabilities
iv. A description of any applicable Medicare coverage rule(s), SCFHP clinical guidelines, or any other applicable policies upon which the denial decision was based
v. How the patient can appeal

C. Turn Around Times:
    a. Standard Determination
        i. The plan must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination.
        ii. The plan may extend the time frame up to 14 calendar days. This extension is allowed to occur if the enrollee requests the extension or if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee.
        iii. When the plan grants itself an extension to the deadline, it must notify the enrollee, in writing, or the reasons for the delay, and inform the enrollee of the right to file a grievance if he or she disagrees with the plan's decision to grant an extension. The plan must notify the enrollee, in writing, of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration of any extension that occurs.
    b. Expedited Determinations
        i. If the plan decides to expedite the request, it must render a decision as expeditiously as the enrollee's health condition might require, but no later than 72 hours after receiving the enrollee's request. Although the plan may notify the enrollee orally or in writing, the enrollee must be notified within the 72 hour time frame. Mailing the determination within 72 hours in and of itself is insufficient. The enrollee must receive the notice in the mail within 72 hours. When the determination is adverse, the plan must mail written confirmation of its determination within 3 calendar days after providing oral notification, if applicable.
        ii. The plan will extend the 72-hour time frame by up to 14 calendar days if the enrollee requests the extension. The plan also may extend the time frame by up to 14 calendar days if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee. When the plan extends the time frame, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the plan's decision to grant an extension. The plan must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration of the extension.
        iii. If the plan requires medical information from non-contracted providers to make a decision, the plan must request the necessary information from the

non-contracted provider within 24 hours of the initial request for an expedited organization determination.

iv. If the plan denies the request for an expedited organization determination, it must automatically transfer the request to the standard time frame and make a determination within 14 calendar days (the 14-day period starts when the request for an expedited determination is received by the plan), give the enrollee prompt oral notice of the denial including the enrollee's rights, and subsequently deliver to the enrollee, within 3 calendar days, a written letter of the enrollee's rights that:
    1. Explains that the organization will automatically transfer and process the request using the 14-day time frame for standard determinations;
    2. Informs the enrollee of the right to file an expedited grievance if he or she disagrees with the organization's decision not to expedite;
    3. Informs the enrollee of the right to resubmit a request for an expedited determination and that if the enrollee gets any physician's supporting documentation indicating that applying the standard time frame for making determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, the request will be expedited automatically; and
    4. Provides instructions about the expedited grievance process and its time frames.

III. Policy Reference

PH3 Prior Authorization

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
1	Original	 Signature Johanna Liu, PharmD Name Director of Quality and Pharmacy Title January 04, 2017 Date	 Signature Jeff Robertson, MD Name Chief Medical Officer Title January 04, 2017 Date

Santa Clara
Family Health Plan

Procedure Title:	**Part B Authorization**	**Procedure No.:**	PH.03.04
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Pharmacy	**Procedure Review Frequency:**	Annually
Lines of Business (check all that apply):	☐ Medi-Cal	☐ Healthy Kids	☒ CMC

I. Purpose

To outline the Pharmacy Department process of reviewing Part B organization determinations for nebulized medications and diabetic supplies (test strips and lancets) for Cal MediConnect (CMC) line of business.

II. Procedure

A. Part B organization determinations may be received from:
   a. SCFHP's contracted Pharmacy Benefit Manager (PBM).
      i. If the PBM receives a Part B organization determination, they will close the authorization and forward the request and any other pertinent information to SCFHP Pharmacy Department via email.
   b. SCFHP's member Services Department, initiated by a member or provider call.

B. Confirmation that the requested medication/diabetic product is payable under the Part B benefit:
   a. A SCFHP pharmacist or pharmacy technician will check the Medicare Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements to determine if the medication/diabetic product is covered under Part B.
   b. Verify that the requested medication/diabetic product is not listed on the CMC drug formulary.
   c. Check the weekly Pre-Processing Drug Lists (PPDL), specifically the CMS_B file (list of Part B only drugs), CMS_PA_BVD file (list of drugs that may be covered under Part B or Part D depending upon the circumstance or indication), and the CMS_NEBU file (list of nebulized drugs that are covered under Part B except when used in a long-term care setting (LTC))
      i. If the medication/diabetic product is listed in the CMS_B file, the pharmacy should be able to process the medication/diabetic product under Part B without requiring an organization determination. If the pharmacy is unable to process the claim under Part B, contact the PBM's Benefit Analyst for assistance.
      ii. If the medication/diabetic product is listed in the CMS_PA_BVD file, the PBM should have reviewed the request under clinical guidelines and determined

proper payment under Part B or Part D. Contact the PBM's Prior Authorization Department for assistance.

iii. If the medication/diabetic product is listed in the CMS_NEBU file and is not being used in an LTC setting, the pharmacy should be able to process the medication/diabetic product under Part B without requiring an organization determination. If the pharmacy is unable to process the claim under Part B, contact the PBM's Benefit Analyst for assistance.

d. If the medication/diabetic product is defined as a Part B drug per Chapter 6, is not on the CMC formulary, and is not in any of the PPDL files, then it will be uploaded for review by a SCFHP pharmacist or pharmacy technician.

C. Part B Review:
   a. Requests for test strips and lancets will reviewed by a pharmacy technician per the SCFHP guideline criteria.
   b. Requests for nebulized solutions will be clinically reviewed by a pharmacist for medical necessity.
   c. If more information is needed from the prescriber to make a decision, the decision may be pended based on its required turnaround time.

D. Turnaround time:
   a. Standard Determination
      i. The plan must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination.
      ii. The plan may extend the time frame up to 14 calendar days. This extension is allowed to occur if the enrollee requests the extension or if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee.
      iii. When the plan grants itself an extension to the deadline, it must notify the enrollee, in writing, or the reasons for the delay, and inform the enrollee of the right to file a grievance if he or she disagrees with the plan's decision to grant an extension. The plan must notify the enrollee, in writing, of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration of any extension that occurs.
   b. Expedited Determinations
      i. If the plan decides to expedite the request, it must render a decision as expeditiously as the enrollee's health condition might require, but no later than 72 hours after receiving the enrollee's request. Although the plan may notify the enrollee orally or in writing, the enrollee must be notified within the 72 hour time frame. Mailing the determination within 72 hours in and of itself is insufficient. The enrollee must receive the notice in the mail within 72 hours. When the determination is adverse, the plan must mail written confirmation of its determination within 3 calendar days after providing oral notification, if applicable.

ii. The plan will extend the 72-hour time frame by up to 14 calendar days if the enrollee requests the extension. The plan also may extend the time frame by up to 14 calendar days if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee. When the plan extends the time frame, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the plan's decision to grant an extension. The plan must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration of the extension.

iii. If the plan requires medical information from non-contract providers to make a decision, the plan must request the necessary information from the non-contract provider within 24 hours of the initial request for an expedited organization determination.

iv. If the plan denies the request for an expedited organization determination, it must automatically transfer the request to the standard time frame and make a determination within 14 calendar days (the 14-day period starts when the request for an expedited determination is received by the plan), give the enrollee prompt oral notice of the denial including the enrollee's rights, and subsequently deliver to the enrollee, within 3 calendar days, a written letter of the enrollee's rights that:

    1. Explains that the organization will automatically transfer and process the request using the 14-day time frame for standard determinations;
    2. Informs the enrollee of the right to file an expedited grievance if he or she disagrees with the organization's decision not to expedite;
    3. Informs the enrollee of the right to resubmit a request for an expedited determination and that if the enrollee gets any physician's supporting documentation indicating that applying the standard time frame for making determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, the request will be expedited automatically; and
    4. Provides instructions about the expedited grievance process and its time frames.

III. Policy Reference

PH03 Prior Authorization

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
1	Original	 Signature Johanna Liu, PharmD Name Director of Quality and Pharmacy Title January 04, 2017 Date	 Signature Jeff Robertson, MD Name Chief Medical Officer Title January 04, 2017 Date

Santa Clara Family Health Plan™

Pharmacy Prior Authorization Turn-Around-Times

Presented by Dang Huynh, PharmD – SCFHP Pharmacy Manager

REGULATORY REQUIREMENTS

Pharmacy decision to approve, modify, or deny requests in a timely fashion

Medi-Cal [1]

Standard: 24 hours

Urgent: 24 hours

Healthy Kids [2]

Standard: 5 Business Days

Urgent: 72 hours

Cal MediConnect [3]

Standard: 72 hours

Urgent: 24 hours

1. Medi-Cal: Department of Health Care Services (DHCS) Two-Plan Boilerplate Contract.

2. Department of Managed Health Care (DMHC) Office of Plan Monitoring Division of Plan Surveys. Technical Assistance Guide: RX Drug Tag Module. September 10, 2014 Issuance.

3. Centers for Medicaid and Medicare Services (CMS). Prescription Drug Benefit Manual. Chapter 18 – Part D Enrollee Grievances, Coverage Determinations, and Appeals. Last Updated – Rev. 9, 5/12/14.

REGULATORY REQUIREMENTS

Pharmacy decision to approve, modify, or deny requests in a timely fashion

Medi-Cal

Standard: 24 hours

Urgent: 24 hours

Healthy Kids

Standard: 5 Business Days

Urgent: 72 hours

Cal MediConnect

Standard: 72 hours

Urgent: 24 hours

SCFHP Pharmacy Department

All PA decisions are held to 24 hours turn-around-time including Healthy Kids requests

Delegated to PBM

Monthly oversight of Pharmacy Benefit Manager (PBM)