Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, December 05, 2018, 6:30-8:30 PM
Santa Clara Family Health Plan, Redwood
6201 San Ignacio Ave, San Jose, CA 95119

AGENDA

1.	**Introduction**	Dr. Paul	6:30	5 min.
2.	**Meeting Minutes** Review minutes of the October 10, 2018 Quality Improvement Committee meeting. **Possible Action:** Approve 10/10/2018 minutes	Dr. Paul	6:35	5 min.
3.	**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 period to 30 minutes.	Dr. Paul	6:40	5 min.
4.	**Action Items**		6:45	45 min.
	a. Annual MedImpact Oversight Audit Share results of audit and present CAP for approval **Possible Action:** Approve MedImpact Audit CAP	Dr. Huynh		
	b. Quality and Accuracy Assessment of Pharmacy Benefit Information on the Member Portal Analysis of the quality and accuracy of pharmacy benefit information on the member portal **Possible Action:** Approve Quality and Accuracy Assessment of Pharmacy Benefit Information on the Member Portal	Dr. Huynh		
	c. Quailty and Accuracy Assessment of Pharmacy Benefit and Personalized Information available over the Telephone Analysis of telephone functionality for the Quality and Accuracy of providing personalized health plan information **Possible Action:** Approve Quality and Accuracy Assessment of Pharmacy Benefit and Personalized Information	Ms. Nguyen		

d. Performance Evaluation of the Clinical Practice Guidelines — Ms. Chang
Share results of performance evaluation of Clinical Practice Guidelines
Possible Action: Approve Performance Evaluation of Clinical Practice Guidelines

e. Member Experience Analysis — Mr. Breakbill
Analysis of members' experience with health plan services
Possible Action: Approve Member Experience Analysis

f. Experience with Complex Case Management — Ms. Carlson
Review process of gathering data and analysis to identify potential improvements to CCM program services
Possible Action: Approve Experience with Complex Case Management

g. Continuity and Coordination of Medical Care — Ms. Carlson
Review the analysis of continuity and coordination of medical care and opportunities for improvement
Possible Action: Approve Continuity and Coordination of Medical Care

h. Policies for Review — Ms. Enke
   i. Policy QI.28 Health Homes Program
   Review policy addressing administration of the Health Homes Program
Possible Action: Approve policy QI.28 as presented

i. Network Adequacy Assessment — Ms. Switzer
Assessment of Network Adequacy MY2018
Possible Action: Approve Network Adequacy Assessment

5. **Discussion Items** — 7:30 — 30 min.
   a. Appeals and Grievances — Mr. Breakbill
   b. Health Outcomes Survey (HOS) — Ms. Enke
   c. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey — Ms. Enke
   d. Q1 & Q2 IHA Audit — Ms. Chang
   e. Access and Availability — Ms. Switzer

6. **Committee Reports**
   a. Credentialing Committee — Dr. Robertson — 8:00 — 5 min.
   Review October 03, 2018 report of the Credentialing committee
   Possible Action: Approve Credentialing Committee report as presented.
   b. Pharmacy and Therapeutics Committee — Dr. Lin — 8:05 — 5 min.
   Review September 20, 2018 minutes of the committee meeting
   Possible Action: Approve Pharmacy and Therapeutics Committee minutes as presented.
   c. Utilization Management Committee — Dr. Lin — 8:10 — 5 min.
   Review minutes of the October 17, 2018 UM committee meeting
   Possible Action: Approve Utilization Management Committee minutes as presented.
   d. Compliance Report — Ms. Larmer — 8:15 — 5 min.

e.	Quality Dashboard	Ms. Chang	8:20	5 min.
7.	Adjournment	Dr. Paul	8:25	

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.
- 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 Caroline Alexander 48 hours prior to the meeting at 408-874-1835.
- To obtain a copy of any supporting document that is available, contact Caroline Alexander at 408-874-1835. 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

Meeting Minutes

SCCHA Quality Improvement Committee

Wednesday, October 10, 2018

Voting Committee Members	Specialty	Present Y or N
Nayyara Dawood, MD	Pediatrics	Y
Jennifer Foreman, MD	Pediatrics	Y
Jimmy Lin, MD	Internist	Y
Ria Paul, MD, Chair	Geriatric Medicine	Y
Jeff Robertson, MD, CMO	Managed Care Medicine	N
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y
Jeffrey Arnold, MD	Emergency Medicine	N
Christine Tomcala, CEO	N/A	N

Non-Voting Staff Members	Title	Present Y or N
Johanna Liu, PharmD	Director of Quality and Pharmacy	Y
Lily Boris, MD	Medical Director	Y
Robin Larmer	Chief Compliance and Regulatory Affairs Officer	Y
Shawna Cagle	Manager, Case Management	Y
Jamie Enke	Manager, Process Improvement	Y
Darryl Breakbill	Manager, Grievance and Appeals	Y
Caroline Alexander	Administrative Assistant	N
Eric Tatum	Director of Provider Network Management	Y
Carmen Switzer	Provider Network Access Manager	Y (via telephone)
Mai Chang	Manager of Quality Improvement	Y
Chris Turner	Chief Operating Officer	Y
Tiffany Franke	Social Work Case Manager Lead	Y
Renee Rodriguez	Supervisor, Grievance and Appeals	Y

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Introductions	Ria Paul, MD Chairman called the meeting to order at 6:35 p.m. Quorum was established at this time.			
Review and Approval of August 8, 2018 minutes	The minutes of the August 8, 2018 Quality Improvement Committee meeting were reviewed. It was moved, seconded to approve minutes as written.	Minutes of the August 8, 2018 meeting were approved as presented.		
Public Comment	No public comment.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
CEO Update	Ms. Turner presented the CEO Update on behalf of Ms. Tomcala, CEO. Healthy Kids membership is 3,217, Medi-Cal enrollment at 244, 493, Cal MediConnect 7, 601. Continue to see decline in enrollment in Medi-Cal line of business. Outreach team is working on improving Cal MediConnect enrollment working with providers doing outreach on Cal MediConnect. Plan relocated to new location. CMS audit activities have been keeping the plan busy.			
Action Items A. Email response evaluation	Ms. Enke presented the Email response evaluation on behalf of Ms. Nguyen. Annually monitor timeliness and quality of emails sent to members. Only one email received from CMC line of business. May be due to older population using phone more than internet/email. Reviewed four different measures: • Email turnaround time • Response comprehensiveness • Spelling errors • Member services contact information provided 100% goal met. Meeting NCQA requirements and will continue to do this analysis annually. Dr. Paul inquired as to if members know where to send emails to. Ms. Enke indicated on portal there is a generic email address. Ms. Breakbill indicated there is an area on website that members can submit questions regarding grievances.	Approved as presented.		

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B. Accessibility of Services Analysis	Ms. Switzer presented the Accessibility of Services Analysis. The purpose of the Santa Clara Family Health Plan's (SCFHP) annual timely access report is to demonstrate how the Plan has monitored compliance and non-compliance of timely access regulations during Measurement Year (MY) 2018. SCFHP's Timely Access & Availability Work Group and Quality Improvement Committee monitor timely access and reporting activities to ensure members receive timely access to services and care. SCFHP has a Plan-to-Plan arrangement for delivery of care with Valley Health Plan (VHP) and Kaiser and they conduct their own surveys; thus, this report does not include VHP or Kaiser survey results. The following surveys and assessments are included in this report: • Provider Appointment Availability Survey and After-hours Survey • CAHPS • Provider Satisfaction Survey • Member Grievances **Conclusion - Timely Appointment Access:** Survey results showed that PCPs are able to meet non-urgent/routine appointment standards; however, as noted they continue to show non-compliance with urgent care appointments. The Plan believes that PCPs are challenged with urgent appointment standards due to the stringent requirement to schedule appointments within a 48-hour timeframe, coupled with providers not having an adequate understanding of regulatory requirements. The PCP after-hours access compliance resulted in 100% in 2018, up from 88% in 2017, which is a marked improvement. However, it is clear that PCP providers will require training/education on meeting timeliness compliance, as only 44% were compliant out of 401 surveyed.	Approved as presented.		

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	For High Volume/High Impact Specialists, only 1 specialist type (Ophthalmology) out of 4 met the urgent appointment standard and 2 met the non-urgent/routine appointment standards, which concludes that provider training on access standards is necessary. The least amount of survey participants were from behavioral health providers; thus, it may be difficult to identify trends; however, the results did indicate that all respondents were not able to meet the non-life threatening emergency within 6-hours. Training for behavioral health providers is needed across all standards with a focus on the non-life threatening emergency within 6-hours standard. Dr. Paul inquired as to when the training will take place for providers that were non-compliant. Ms. Switzer indicated letters were sent to providers with corrective action plans. Will re-survey these providers throughout the first part of November. Provider relations team will conduct outreach efforts and provide training the last two weeks of November to the providers identified as non-compliant. If still non-compliant after training, will continue to educate and work with providers. **Conclusion – CAHPS (Member Satisfaction Survey):** SCFHP is pleased to acknowledge 4 out of 6 measures show a marked improvement from 2017. The overall rating on satisfaction with the Health Plan improved by 4.8 percentage points, which may be attributed to the Plans on-going efforts to improve operational procedures and member/provider communications. SCFHP's Provider Network Management, Quality Management, Provider Relations and Contracting departments will continue to develop and improve initiatives to address timely access issues with PCPs, specialists and behavioral health providers. SCFHP has developed a Pay for Performance (P4P) program to improve quality, efficiency, and overall healthcare outcomes. SCFHP has taken a more active			

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	role working with network providers in support of plan initiatives that are aimed toward meeting regulatory requirements and improving overall access and quality of care. **Conclusion - Provider Satisfaction:** SCFHP met both stated standards and thresholds for provider satisfaction for 2018. The threshold standard for overall satisfaction is a new measure; therefore, 2018 results will be used as a benchmark for 2019. While the Plan is pleased that both threshold goals were met, the prior authorization and referral process results indicated a 9% decrease on satisfaction from 2017; thus there is room for improvement. As a result of the new questions added to the survey in MY 2018, the Plan will further assess the results that show a high level of dissatisfaction and determine steps to address and improve in those areas. SCFHP will work with staff members from Utilization Management, Contracting, Provider Relations, Customer Service and Claims to find ways to improve service to our providers. In addition, SCFHP will look at ways to increase awareness of timely appointment access standards. Dr. Paul asked which question is new on the survey. Ms. Switzer indicated it was the question regarding patient access to covered services. **Conclusion - Member Access Grievances:** The raw data on member complaints demonstrate that SCFHP is able to resolve complaints made by members expeditiously. For example, if a member must be seen before a provider is able to schedule the member, the Plan will contact the provider office and request that the member is scheduled within the established access standards. SCFHP continues to re-direct members to network and/or out-of-network specialists to ensure timely access to care is met.			

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	Opportunities: Identified some barriers and documented some opportunities and interventions. Focus on provider training and explore contracting opportunities to fill in any gaps.			
C. Continuity and Coordination Between Medical and Behavioral Healthcare	Ms. Franke presented the Continuity and Coordination Between Medical and Behavioral Healthcare. Santa Clara Family Health Plan collects data on the following factors: • Exchange of Information-Medical Record Review of Behavioral Health and Primary Care Practitioners. Goal of 80% of total number of samples meet the timeliness standards. Goal was not met in this area. Sample size of 58 records, 15 met timeliness. Dr. Paul inquired about how this analysis is done. Ms. Franke indicated this was done by chart reviews. • Diagnosis, treatment, and referral of behavioral disorders commonly seen in primary care (AMM HEDIS measure). Goal to maintain a rate in the HEDIS 75th percentile for both the Effective Acute Phase Treatment and Effective Continuation Phase Treatment measures. While achieving goal for the continuation phase, plan was 5.88 percentage points behind the 75th percentile for the acute phase. Results are based on HEDIS data and claims data. • Appropriate Use of Pyschotropic Medications-Primary Care Practitioners and Antidepressant Medication Prescriptions. Goal to have 75% of antidepressant medication prescriptions be provided by Primary Care Practitioners and 25% of antidepressant medication	Approved as presented		

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	prescriptions be provided by Psychiatrists. Analysis shows Primary Care Practitioners are prescribing 54.4% of the total antidepressants and Psychiatrists are prescribing 45.6%. For calendar year 2018, goal will be Primary Care Physicians prescribing at 59.4% and psychiatrists at 40.6%. Dr. Lin asked what kind of incentives Primary Care Physicians have to see psychiatric patients. Dr. Paul suggested that training would be helpful in this area to Primary Care Physicians. Dr. Paul asked what is the plan's strategy in this area, incentives or training? Dr. Franke indicated training will be one of the items the plan will move forward with. Dr. Paul suggested if primary care physicians had access to a psychiatrist to consult with for guidance, this would be helpful. Dr. Liu suggested looking at number of unique members for data rather than total number of prescriptions. Dr. Alkoraishi suggested using F codes ICD-10. Has levels as far as severity. Dr. Lin asked how this compares to other plans. Ms. Franke indicated there are no measures for comparison with other plans. • Management of Treatment access and follow-up for members with coexisting medical and behavioral disorders-management of treatment of members with Schizophrenia and Diabetes Mellitus Type II. Goal of 75% of CMC members identified with diagnoses of Schizophrenia and Diabetes Mellitus Type II to have attended at least one annual Primary Care Visit for ongoing physical health monitoring. Identified 135 members for this data set. Did not meet CY 2017 goal by 15.8 percentage points. Focus will be on educating members on importance of seeing primary care physician once a year. One of the barriers is			

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	homelessness in terms of reaching out for appointments. Dr. Alkoraishi mentioned Alexian Brothers has a homeless medical clinic that includes behavioral health services. Suggested possibly can use as a resource to get medical and behavioral health care for homeless CMC members. • Secondary Preventative Behavioral Healthcare Program Implementation. Goal of 80-100% of CMC members with a depression indicator found within the HRA to be provided with a PHQ-9 assessment. 3,127 Cal MediConnect members identified, only 127 completed the PHQ-9 assessment. 42% of Cal MediConnect members identified showed signs of depressive symptoms. Goal was not met. Only 5.47% had a PHQ-9 assessment. Create automated trigger in Essette on when to do 6 month follow up. • Special Needs of Members with severe and persistent mental illness-HEDIS measure of Cardiovascular Monitoring for people with Cardiovascular Disease and Schizophrenia. Goal to fall within the 75th percentile of members following treatment care with their providers. Goal was met as 100% of members completed follow up care as indicated by their PCP. Despite meeting goal, this measure will not be an ongoing factor the Health Plan will continue to monitor due to its low impact on the CMC member population.			

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D. Annual Assessment of Experience with UM Process	Ms. Enke presented the Annual Assessment of Experience with UM Process. Presented the barriers and opportunities as result of provider satisfaction survey. Barrier #1: Providers and office staff are not familiar with SCFHP UM processes (turnaround times, appeal process, authorization grid). Opportunity: Make information regarding SCFHP UM processes more available and accessible to providers and office staff. Intervention: Add information regarding key UM processes to SCFHP's provider portal. Engage providers through additional education efforts. When providing verbal notification for authorization determinations, include the required time frame in the verbal message. Evaluate location of information on scfhp.com to make it more easily located by providers. Barrier#2: Office staff are completing the surveys over actual providers, who may be more familiar with SCFHP's UM processes. Opportunity: Develop alternative survey methods to reach more Providers vs. Office Staff. Intervention: Use a larger provider sample size in future provider satisfaction surveys. In addition to phone survey, publish future survey links to the provider portal and provider e-newsletters. Interventions will be initiated in 2018. Also presented barriers and opportunities as result of member satisfaction survey. Barrier #1: Members do not understand SCFHP's transportation benefits. Opportunity: Educate members on how to obtain transportation assistance for appointments. Intervention: Member transportation needs are assessed within the required Health Risk Assessment. Identified needs will be addressed by Case Management staff during the member's individual care planning process.	Approved as presented		

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	Barrier #2: PCP and Specialist access issues. Opportunity: SCFHP will evaluate and monitor all access and availability complaints. Intervention: Members will be educated through periodic newsletters to call SCFHP to inform of any provider access issues. Barrier#3: Members may not understand when an urgent appointment is needed. Opportunity: Educate members on the difference between urgent and routine appointments and when both are needed. Intervention: Train case management staff to educate members on SCFHP's Nurse Advice Line (NAL) when members report lack of access to appointments. Barrier #4: SCFHP's approval and denial letter language is not sufficiently member friendly. Opportunity: Improve denial and approval language. Intervention: Update denial language template grid to be more member-friendly. Conduct staff trainings on the importance of and guidelines for using member friendly language in all member correspondence.			

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E. Assessment of Physician Directory Adequacy	Ms. Enke presented the Assessment of Physician Directory Adequacy. Five measures were monitored for aspects of physician directory accuracy: • Accuracy of office locations • Accuracy of phone numbers • Accuracy of hospital affiliations • Accuracy of accepting new patients • Awareness of physician office staff of physician's participation in the organization network Goal is 100% for all measures. Accuracy percentages were as follows: Accuracy of office locations 97% Accuracy of Phone Numbers 93% Accuracy of hospital affiliations 97% Accuracy of accepting new patients 98% Awareness of physician office staff of physician's participation in the organization network 79% (possibly a bit low due to confusion by office staff of question) Barriers and opportunities were identified. Barrier #1: Delays in receiving changes from providers through their delegates Opportunity: Provide additional avenues for submitting provider changes Intervention: Ensure that timeliness of provider changes is discussed at quarterly joint operation committees. Continue to build out electronic attestation solutions available via the provider portal. Barrier #2: Rapidly changing provider data due to frequent staff changes. Opportunity: Inform providers of importance of submitting timely information	Approved as presented		

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	Intervention: Ensure that timeliness of provider changes is part of provider orientation onboarding. Continue to build out electronic attestation solutions available via the provider portal.			
F. Member Experience Analysis	Deferred to next Quality Improvement Committee meeting in December.			
G. Assessing Member Understanding of Marketing Information Analysis	Ms. Enke presented the Assessing Member Understanding of Marketing Information Analysis. Call report was generated from an internal call reporting system for calls received between January 1, 2018 and April 5, 2018. The records in the call report were filtered by specific call codes reported under the [Type_Issue1] field to help focus the analysis. Next the analysis focused on the members that called within 90 days of their enrollment date with the CMC plan. Individual call records were grouped and assessed by issue type and their descriptions. Benefit Inquiry was the highest occurrence in individual call records at 55.47%. The calls were then ranked by prevalence. The top four most frequent descriptions were: • Pharmacy 12.17% • Case Management 6.47% • Specialist 5.55% • Dental 4.31% In summary, calls related to pharmacy, case management, and specialists were diverse and specific to each member. In many cases, the appropriate course of action for the member to take is to call the plan to resolve a specific issue. Volume of call records specific to issue type “Inquiry Benefit” and description “INQ Benefit Dental Services” identified opportunity to improve communication to new members about their dental benefits.	Approved as presented		

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	New members were unaware that their dental benefits are provided through Denti-Cal. They were unsure how to find a provider. Content was subsequently developed for Summer 2018 Cal MediConnect member newsletter to communicate this information.			
Discussion Items				
A. Access and Availability	Ms. Switzer presented the Access and Availability report. Conducted a re-survey for those providers that were found to be non-compliant for measurement year 2017. The resurvey results are reviewed by the Provider Network Access Manager, who will list the providers who show continued non-compliance on a provider outreach matrix. The provider outreach matrix is submitted to the provider relations team who will make contact with the providers and offer training/education on timely access standards. As instructed, the provider relations team documents all outreach efforts and completed training sessions within the matrix. Resurvey results are also reviewed in the Joint Operation Committee meetings with our delegated provider groups, and they are advised that a corrective action plan must be submitted to the Plan, and that access training will be required. The findings showed some improvement in PCPs meeting the urgent appointment within 48 hours at 61% and a marked improvement in meeting the appointment within 10 days at 84%, with an average improvement of 73%. Findings on specialists providing access to urgent appointments within 96-hours and appointments within 15-days only showed an average improvement of 40%. The Provider Network Access Manager has submitted the provider outreach matrix to the Provider Relations team to ensure that notification of continued non-compliance, timely access training and education is completed and documented. A resurvey report (specific to the group) was presented at the Joint			

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	Operating Committee meetings for both Physicians Medical Group of San Jose and Premier Care of Northern California on September 13, 2018. To ensure SCFHP policies and procedures are met, both groups were advised to submit a CAP to SCHP by September 28, 2108. The CAP will be reviewed and the group (s) will be notified if SCFHP accepts the proposed CAP, or if additional information is required. Both groups were also advised that SCFHP's provider relations team will make contact to schedule access training. SCFHP maintains provider corrective action plans and access training sign-in sheets to document actions taken to improve patient access in accordance with regulatory requirements.			
B. Appeals and Grievances	Mr. Breakbill presented the Appeals and Grievances report. Reviewed regulatory reporting. Submitted the following regulatory reports in Q2: • CMC Complaints & Resolution • CBAS Report • DHCS BHT Report • DHCS Grievance Report • Mental Health Report • DMHC Grievance Report Bundle • Monthly NMT/NEMT reports Submitted the following JOC reports: • Premier Care of Northern California (PCNC) • Physicians Medical Group (PMG) • Valley Health Plan (VHP) Increase in Medi-Cal line of business cases attributed to issue with DME vendor. Increase in Medi-Cal appeals from Valley Health Plan from February to March. No real increase in Pharmacy appeals. Attributed to language change in initial			

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	review notice. Providers are submitting all documentation needed with requests. Q2 2018 Medical Appeals by Determinations: 65% Upheld, 31% Overturned, 4% Dismissed Q2 2018 Pharmacy Appeals by Determinations: 36% Upheld, 52% Overturned, 12% Partially Favorable In November, an increase in CMC Appeals attributed to claims appeals. Increase in CMC Grievances was attributed to CHME appliance delivery issues. Increased education to members by CHME regarding deliveries. Q2 2018 Reconsiderations by Determination: 52% Overturned; 31% Upheld; 15% Dismissed; 2% Auto-Forward IRE Q2 2018 Redeterminations by Determination: 56% Upheld; 37% Overturned; 5% Withdrawn; 2% Dismissed Volume of CHME Grievances Rate per 1,000 increased for Medi-Cal and also CMC.			
C. Experience with Case Management	Ms. Cagle presented Experience with Case Management. The case management department evaluates member's experience with Complex Case Management (CCM) Services by obtaining feedback from members and analyzing member complaints for the purpose of identifying opportunities for improvement. 100% of members enrolled in CCM are provided the opportunity to complete the survey within 30 days of their transition to a lower level of CM services. Specific feedback measured: Information about the overall program, the program staff, member's ability to adhere to the recommendations, percentage of members indicating that the program helped them achieve health goals and complaints. Members who were enrolled in CCMS for 60 days or more are provided telephonic outreach by coordination staff not directly involved in their care. Survey responses are collected on an			

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	ongoing basis and reported monthly. Responses are analyzed and interpreted as part of Evaluating PHM Strategy Effectiveness on an annual basis. Feedback data is documented in and reported from the CM software platform Essette. Questions are scored on a 0-5. Highest score possible is 44. Overall goal is to have members respond "agree" or "strongly agree" for questions 1-8 and "satisfied" or "very satisfied" for question 9 for a total score of 35 or better or 90% overall satisfaction. Members are also encouraged to provide comments and feedback. Members do have the right to refuse to participate in all or parts of the survey. Overall 100% of members stated they were overall satisfied or somewhat satisfied resulting in meeting the 90% goal for this measure. 100% of members believe that their assigned case manager treated them with respect and listened to what they had to say. 100% of members felt their assigned case manager returned phone calls in a timely manner. 71% of members believe that their case manager helped them find the services they needed. 29% stated they were unsure. 71-72% of members responded that they better understand their disease or condition, are better able to manage their health and their situation is better because of their case manager's help. 14% were not sure, and another 14% disagreed. SCFHP did not meet the 90% performance goal in four areas: • Help in finding services needed (71%) • Increased understanding of the members' condition (71%) • Improved ability to manage own health (72%) • Improved overall health situation (72%) However, in areas 2-4, only one person answered that they "disagreed." In area 1, two people answered "not sure" which equated to 28% outlier status. Although the majority of people surveyed expressed satisfaction, the performance rates indicate			

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	possible areas of improvement within the CCM program. Dr. Alkoraishi asked if this included those with heart problems, strokes. Also asked who is responding to the survey, members or authorized representatives of the members. Potential barriers identified: Of the 14 members enrolled for 60 days or more, 7 were reached and 7 were unable to be reached. Provide a paper survey to mail to members. Opened the floor to discussion about possible barriers identified. Ms. Franke indicated behavioral health members may have difficulty giving valid information if they are experiencing symptoms. Possibly have behavioral health department connect with case management to better capture survey results from behavioral health members. As population grows, possibly outsource survey to vendor.			
D. Continuity and Coordination of Medical Care	Ms. Enke presented the Continuity and Coordination of Medical Care report. Santa Clara Family Health Plan monitors activities directed at improving continuity and coordination of medical care and takes action, as necessary, to improve the outcomes of the monitored activities. Reviewed four data measures associated with member movement between practitioners and member movement between settings. Movement across settings: • Ambulatory Care Follow-Up Visit 30 Days Post Discharge • HEDIS: Plan All-Cause Readmissions (PCR) Movement Across Practitioners: • PCP Experience Survey • HEDIS: Comprehensive Diabetes Care-Eye Exam Rate (CDC) Quarterly, SCFHP monitors CMC members that have been discharged from an acute inpatient hospital stay and			

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	subsequently had an ambulatory care follow-up visit within 30 days of discharge. Required measure for Medicaid-Medicare Plans (MMPs) participating in the duals demonstration-CA 1.11 SCFHP's UM Management team determined the performance goal to be 90%. Rigorous goal considering member non-compliance, however will ensure that we are constantly reassessing our interventions for continued improvement. For 2017 ended with a rate of 78% on measure of 30 day follow-up post discharge. The 2017 cumulative rate of 78% shows that SCFHP is 12 percentage points away from meeting the goal of 90%. This gap indicates opportunities for improvement in the existing process of encouraging members to schedule and keep appointments with their physicians after discharge from an acute inpatient hospital stay. Opened the floor for discussion with QIC providers regarding barriers to consider as to why our members cannot seek ambulatory follow up care within 30 days. One barrier identified is that physicians are not always notified of admissions. Dr. Lin indicated follow up is very important for medication reconciliation. Follow up within one week after discharge rather than waiting one month. Dr. Paul inquired as to when the health plan receives reports on admissions. Schedule appointment with primary care physician for follow up as part of discharge process. Possibly send home health out to see member. Do a trial with one hospital and have case managers do outbound calls to members discharged. HEDIS: Plan All-Cause Readmissions (PCR) SCFHP monitors all-cause acute readmission annually as part of HEDIS reporting and as part of the Quality Withhold data set. Included are members 18 years of age and older with an inpatient acute hospital stay within the measurement year, followed by an unplanned acute readmission for any diagnosis,			

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	within 30 days of discharge. Performance goal is CMS 2018 Benchmark of 11%. Went from 13.49% in 2017 to 14.79%, which is above CMS Benchmark. Goal was not met. SCFHP missed the performance goal of 11% by 2.5 percentage points in 2017, and 3.8 percentage points in 2018. The slight decrease in 2017 indicates and opportunity to improve existing processes in place to prevent unplanned acute readmissions. Opened the floor to discussion with our QIC providers. Asked if any barriers to consider as to why our members may experience unplanned acute readmissions within 30 days of discharge from the hospital. Identified internally that SCFHP Transition of Care (TOC) program focused on Regional Hospital only. Opportunities for improvement identified: increased collaboration between SCFHP UM and CM departments to identify transitions of care. Expand scope of TOC calls. PCP Experience Survey: SCFHP conducts an annual PCP survey to assess experience with continuity and coordination of care between primary care and specialty care. Survey Sample of 59 PCPs selected from a universe of 428 claims from Q2 2018 where a PCP-assigned member visited a Specialist. Conducted telephonically in September 2018. Three call attempts made over a span of two weeks. PCPs were given the option to complete telephonically, via fax or online (using surveymonkey.com). Two areas where goal of 90% was not met: • Frequency of receiving information about patients from Specialty Care 53% • Effectiveness of information received about care patients received from Specialty Care 84% 100% of PCPs surveyed were generally satisfied with their patients' continuity and coordination of care and the process for			

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	hand-off between specialty and primary care. 100% of PCPs reported that information from Specialty Care was generally useful, and 94% reported that the information was generally timely. Opened the floor for general discussion with QIC providers. Potential know barriers included lack of HER integration between providers and referring providers not always specific in identifying the reason for specialty referrals. CDC Eye Exam Rate: SCFHP monitors the CDC Eye Exam HEDIS rate to assess the movement of diabetic patients between practitioners. Measures the percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. Time frame is from 1/1/2017 to 12/31/2017 and reported for year 2018. The performance goal set by Quality Improvement is to meet or exceed the previous year rate. In Measurement Year 1 (MY) 2016, a performance goal of 47.41% was set and in MY2 2017, the target goal was to maintain or exceed the rate of 62.53% achieved from MY1 2016. Performance goal was met for both measurement years.			

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Committee Reports				
A. Credentialing Committee	Dr. Boris presented the August 15th Credentialing Committee meeting minutes. No providers were terminated, all passed credentialing. .	Minutes of the August 15th, 2018 Credentialing Committee meeting were approved as presented.		
B. Pharmaceutical and Therapeutics Committee	Dr. Lin presented the June 21st Pharmaceutical and Therapeutics Committee meeting minutes. New drugs were presented during generic pipeline presentation. Reviewed formulary changes. Prior authorization criteria presented for approval on Diabetic Supplies, Androgel, Humira, and Enbrel.	Minutes of the June 21st, 2018 Pharmaceutical and Therapeutics Committee meeting were approved as presented.		
C. Utilization Management Committee	Dr. Lin presented the July 18th, 2018 Utilization Management Committee minutes. Updated care coordinator guidelines for wheelchair replacement. Care Coordinator can approve if wheelchair is 3 years old or less. Presented procedure for documentation requirements when no clinical notes are attached to an authorization request. Reviewed Nurse Advice Line Stats. Highest volume for Triage Guidelines used for call types were: • Medi-Cal information only, abdominal pain, chest pain, allergic reactions • Healthy Kids-information only, bites and stings • Cal MediConnect-information only, abdominal pain	Minutes of the July 18th, 2018 Utilization Management Committee meeting were approved as presented.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
D. Compliance Report	Ms. Larmer presented the Compliance Report. Medicare Data Validation audit took place. Field audit took place. Working on corrective action plans. Preliminary report issued. Total of seven conditions requiring immediate corrective action plans. Working on systems and staffing. Moving towards integration of business units. Working on NCQA submissions.			
E. Quality Dashboard	Dr. Liu presented the Quality Dashboard. FSR is for Medi-Cal and IHA is Medi-Cal. IHA is stable and FSR continues to be 100%. Re-evaluating metrics in all departments.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Adjournment	Meeting adjourned by Dr. Ria Paul at 8:44 p.m.			
Next Meeting	Wednesday, December 5, 2018- 6:30 PM	Calendar and attend.	All	

Reviewed and approved by:

_____ Date _____

Ria Paul, MD
Quality Improvement Committee Chairperson

Santa Clara Family Health Plan™

QIC – MedImpact Oversight

Dang Huynh, PharmD

Annual MedImpact Oversight Audit

Results of Audit & CAP for Approval

Audit Period: 1/1/2017 – 12/31/2017

Area of Audit: **Complaint**

#	Area Of Audit
1001	Communication Services
1002	Procedure for Pharmaceutical Management
1003	Cultural Competency
1004	Formulary Versions
1005	Record Retention
1006	Eligibility Data Load
1007	P & T Committee Attendance
1008	Drug Monographs
1009	Cost and Utilization Data
1010	Pharmacy Audit
1011	Pharmacy Audit of Drug Storage
1012	Pharmacy Audit of Member Drug Signing Process
1013	Good Faith and Fair Dealing

#	Area Of Audit
1014	Rebate Payment Process
1015	Credentialing
1016	Pharmacy Medi-Cal Verification Process
1017	Fraud, Waste, and Abuse
1018	Hierarchy Rules
1019	Communication with Pharmacies
1020	Accidental Disclosures
1023	Membership File
1024	Delegated Entity Annual Audit Material Delivery
1028	Delegate Reporting
1029	Financial Solvency
1030	Credentialing and Recredentialing Standards
1031	Part D Formulary Benefit Administration (FA)

Area of Audit: **Non-Compliant**

#	Area Of Audit
1026	Fraud, Waste, and Abuse (FWA) Compliance Training
1027	Health Insurance Portability Accountability Act (HIPAA)
1032	Part D Coverage Determinations, Appeals and Grievances (CDAG)

#1026: FWA Compliance Training

Factor (As per 42 C.F.R §§ 422.503(b)(4((vi)(C), 423.504(b)(4)(vi)(C)):

Policies & procedures and supporting documentation annual FWA compliance training.

Findings:

Documentation provided by MedImpact did not demonstration confirmation.

Corrective Action Required:

MedImpact to provide correct documentation and verification to confirm training is being documented for HIPAA, FWA, and general compliance training in correct CMS formats.

#1027: HIPAA

Factor (As per 42 C.F.R §§ 422.503(b)(4((vi)(C), 423.504(b)(4)(vi)(C)):

Policies & procedures and supporting documentation annual HIPAA compliance training.

Findings:

Documentation provided by MedImpact did not confirm that new employees are trained within 90 days of hire and annually thereafter (within 12 months).

Corrective Action Required:

MedImpact to provide that HIPPA training is being documented upon hire and annually (within 12 months).

#1032: Part D CDAG

Medicare Prescription Drug Benefit Manual – Chapter 6 & Chapter 18

Appropriateness of Clinical Decision-Making & Compliance with CMS Requirements

Findings:

1. PA# 11821 – Denial language not member friendly.
2. PA# 11875, 11875, 11715, 11391, 11723 – Incorrect language preference.
3. PA# 11323, 11329, 11232, 11579 – Incorrect verbiage.
4. PA# 10914, 11199, 11661, 11537 – Incorrect denial/review.

Corrective Action Required:

MedImpact to provide Root Case Analysis and Impact Report with CAP for each prior authorization case. CAP will need to include on-going monitor and process improvement plan.

Santa Clara Family Health Plan™

Delivery Methods Used:
Certified Mail-Return Receipt Requested
Secure Email

November 21, 2018

External Compliance Support
MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Court
San Diego, CA 92131

Santa Clara Family Health Plan (SCFHP) conducted a focus audit of the delegated functions conducted by MedImpact Healthcare Systems, Inc. The purpose of this audit is to assess MedImpact's compliance with the **National Committee on Quality Assurance (NCQA)** standard: MEM2 – Pharmacy Benefit Information, Element A. SCFHP reviewed all the samples and submitted supporting documents in the look back period between June 1, 2018 and November 20, 2018.

The below chart summarizes the results of SCFHP's review of MedImpact's compliance with NCQA standard MEM2 – Pharmacy Benefit Information on the Member Portal (Element A) for accuracy and quality.

Audit Standards	# Sampled	Compliant	Observation	Condition
Members can access the following in one session and information is legible, complete and allows the member to understand:				
1. Determine financial responsibility for a drug, based on pharmacy benefit.	30	30	0	0
2. Determine potential drug-drug interactions.	30	30	0	0
3. Determine a drug's common side effects and significant risks.	30	30	0	0
4. Determine the availability of generic substitution.	30	30	0	0

Audit Standards	# Sampled	Compliant	Observation	Condition
5. Find the location of an in-network pharmacy.	15	15	0	0
6. Conduct a Pharmacy proximity search based on zip codes.	15	15	0	0
7. Initiate the exceptions process.	3	3	0	0
8. Order a refill for an existing, unexpired mail-order prescription.	NA	NA	NA	NA
Overall Audit Score	**153**	**153**	**0**	**0**

There were no observations or conditions identified during the review. MedImpact, therefore, has been deemed compliant in all areas measured. Future audits will occur annually and the look back period may be up to 24 months.

If you have any questions about this report, please contact Dang Huynh at DHuynh@scfhp.com.

Sincerely,

Dang Huynh, PharmD
Pharmacy Manager
Santa Clara Family Health Plan

cc: Johanna Liu, Santa Clara Family Health Plan

Santa Clara Family Health Plan™

QIC - Quality & Accuracy Assessment of Pharmacy Benefit Information on Member Portal

Dang Huynh, PharmD

Accuracy of Pharmacy Benefit

Santa Clara Family Health Plan

Members can access the following in one session:	Total sample	Accuracy Goal Met	% Goal Met
1. Determine financial responsibility for a drug, based on pharmacy benefit	30	30	100%
2. Initiate the exceptions process	3	3	100%
3. Order a refill for an existing, unexpired mail-order prescription	NA	NA	NA
4. Find the location of an in-network pharmacy	15	15	100%
5. Conduct a Pharmacy proximity search based on zip codes	15	15	100%
6. Determine potential drug-drug interactions	30	30	100%
7. Determine a drug's common side effects and significant risks	30	30	100%
8. Determine the availability of generic substitution	30	30	100%
Total for Accuracy	153	153	100%

Quality of Web Site

Information is legible, complete and allows the member to understand:	Total sample	Accuracy Goal Met	% Goal Met
1. Determine financial responsibility for a drug, based on pharmacy benefit	30	30	100%
2. Initiate the exceptions process	3	3	100%
3. Order a refill for an existing, unexpired mail-order prescription	NA	NA	NA
4. Find the location of an in-network pharmacy	15	15	100%
5. Conduct a Pharmacy proximity search based on zip codes	15	15	100%
6. Determine potential drug-drug interactions	30	30	100%
7. Determine a drug's common side effects and significant risks	30	30	100%
8. Determine the availability of generic substitution	30	30	100%
Subtotal for Quality	153	153	100%

Quality of Web Site

Other items that may also reflect the quality of the web site:	Total sample	Accuracy Goal Met	% Goal Met
9. The contact number for assistance or chat are available on site	30	30	100%
10. The links move to the correct page	30	30	100%
11. No spelling errors identified	30	30	100%
Total for Quality	**243**	**243**	**100%**

Focus Audit MEM2, Element A

Assessed MedImpact's compliance with the National Committee on Quality Assurance (NCQA) standard: MEM2 – Pharmacy Benefit Information, Element A.

SCFHP reviewed all the samples and submitted supporting documents in the look back period between June 1, 2018 and November 20, 2018.

Findings:

No observations or conditions identified during the review.

SANTA CLARA FAMILY HEALTH PLAN

Pharmacy Benefit Information 2018: Telephone Accuracy and Quality Analysis

Prepared by: Tanya Nguyen, Director of Customer Service
For review and approval by the Quality Improvement Committee
December 5, 2018

I. Overview

Pharmaceutical benefits and drugs change periodically throughout the year. In an effort to best serve members, Santa Clara Family Health Plan (SCFHP) has a responsibility to ensure that members can contact the organization over the telephone and receive accurate, quality information on drugs, coverage, and cost.

SCFHP conducts monthly quality monitoring to assure the quality of the information provided to members related to pharmacy benefits. In addition, SCFHP also conducts an annual evaluation through the selection of certain call categories to identify opportunities to improve the quality and accuracy of the pharmacy benefit information provided by CSRs to members.

II. Methodology: Telephone

Annually, Santa Clara Family Health Plan audits the information provided to members over the telephone by its Customer Service Representatives (CSRs). The auditor randomly selects 10 calls during which a member has requested information on pharmacy benefits. The calls are checked for the ability for CSRs to provide accurate reflection of:

a. Financial responsibility per LIS level (copays)
b. Initiate the exceptions process
c. Order a refill for an existing mail-order prescription
d. Assistance to locate an in-network pharmacy
e. Assistance to conduct a pharmacy proximity search based on zip codes in Santa Clara County
f. Determine potential drug to drug interactions
g. Determine drug side effects and significant risks, and
h. Determine the availability of a generic substitution.

The audit will be performed on an annual basis by collecting data on the quality and accuracy of the pharmacy benefit information provided over the telephone (see Appendix A for audit sheets). The look-back period is 6 months for the initial audit and up to 24 months for the subsequent year audit.

Goal:

Accuracy: 100%

Quality: 100%

III. Data

Table 1: Accuracy and Quality of Pharmacy Benefit Information for financial responsibility, exceptions process, location of in-network pharmacy, conducting a proximity search, determining drug-drug interactions, common side effects, and the availability of generic substitutions.

Measure	Total Sample	Accuracy Goal Met			% Accuracy Goal Met	Quality Goal Met			% Quality Goal Met
Job Knowledge		**Yes**	**No**	**N/A**		**Yes**	**No**	**N/A**	
Measure: Factor 1 Financial responsibility									
1. Was the request initiated by member or member's rep?						10	0	0	100%
2. Did CSR respond correctly to member's financial responsibility (e.g. copay)?	10	10	0	0	100%	10	0	0	100%
3. Did CSR educate member about the financial benefit of filling 90 day supply when applicable?	10	10	0	0	100%				
4. Did CSR educate member that using a generic medication would lower member's financial responsibility?						0/0	0/0	0/0	0/0
5. Call Documentation: Did the CSR select the appropriate contact code(s)?						10	0	0	100%
Measure: Factor 2 Exceptions process									
1. Was the request initiated by member or member's rep?						10	0	0	100%
2. Did the CSR follow exception process?	10	10	0	0	100%	10	0	0	100%
3. Did the member agree to initiate exception process?						10	0	0	100%
4. If member agreed, did CSR initiate exception process while member/member's rep on the phone?	10	10	0	0	100%	10	0	0	100%
5. Did CSR inform member of the next step after submitting the exception request?	10	9	1	0	90%	9	0	1	100%
6. Was the exception request submitted for the correct medication in Med Access system?	10	10	0	0	100%				
7. Was the exception request submitted correctly (standard vs expedited) per member's request?	10	10	0	0	100%				

8. Call Documentation: Did the CSR select the appropriate contact code(s)?						7	3	0	70%
Measure	**Total Sample**	**Accuracy Goal Met**			**% Accuracy Goal Met**	**Quality Goal Met**			**% Quality Goal Met**
Job Knowledge		**Yes**	**No**	**N/A**		**Yes**	**No**	**N/A**	
Measure: Factor 3 Order a Refill for an existing prescription; SCHFP does not offer mail order services therefore this Factor NA.									
Measure: Factor 4 and 5 Location of in-network pharmacy, conducting a proximity search									
1. Was the request initiated by member or member's rep?						10	0	0	100%
2. Did the CSR locate and provide name, address, phone number, hours of operation of an in-network pharmacies correctly to the member? Including extended-day supply, compounding services, home delivery, etc.	10	10	0	0	100%				
3. Did the CSR assist member in conducting a proximity search for a network pharmacy based on zip code?						10	0	0	100%
4. If yes (question # 3), did CSR conduct a proximity search correctly per member's request?	10	10	0	0	100%				
5. Call Documentation: Did the CSR select the appropriate contact code(s)?						10	0	0	100%
Measure: Factor 6, 7, 8 Determining drug-drug interactions, common side effects, availability of generic substitutions									
1. Was the request initiated by member or member's rep?	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
2. Did the CSR transfer request to Pharmacy Helpdesk?	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
Call Documentation: Did the CSR select the appropriate contact code(s)?	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0

*Some questions related to both quality and accuracy and some related to one area or the other. If a cell is grey it does not relate to that area of review.

IV. Accuracy and Quality Analysis

SCFHP did not test the quality and accuracy of the ability for members to order a refill on an existing, mail-order prescription (Factor 3) because SCFHP does not offer a mail order service. This factor is not applicable for SCFHP. If Members wish to order from their in-network retail pharmacy by mail this is done with the retail pharmacy, if available.

For factor 1, 2, 4, 5, 6, 7 and 8, both accuracy and quality measures were audited. The greyscale in the tables indicate some questions were not required for accuracy and quality for some factors and were colored grey which are intentionally left unanswered.

Accuracy:

The measures for Factor 1, financial responsibility for a drug; Factor 4 and 5, location of in-network pharmacy and conducting a proximity search met the accuracy goal at 100%.

The following measures for Factor 2, exceptions process, met the accuracy goal of 100% in the area of Job Knowledge questions 2, 4, 6, and 7. For Job Knowledge question 5, 90% of the calls met the target goal. This is 10% below the target goal of 100%. For the plan of correction, the current job aid will be revised to include additional talking points for CSRs to cover with the member. One of the talking points will be to alert the member to the next steps after the submission of the exception request.

During the accuracy audit, none of the calls had an interaction in which the member asked about drug-drug interactions, common side effects, or the availability of generic substitutes Therefore, there is no data to report on Factor 6, 7 and 8.

Quality:

The measures for Factor 1 financial responsibility for a drug, met the quality goal at 100% for Job Knowledge questions 1, 2, and 5 as well as Call Documentation. None of the calls had an interaction in which CSR needed to educate the member that using a generic medication would lower member's financial responsibility since member have limited financial responsibility.

The measures for Factor 2, exceptions process, met the quality goal of 100% for Job Knowledge questions 1-5. Call Documentation for this factor met 70% of the target goal. For the plan of correction, the current job aid will be revised to include additional guidance in order to give CSRs the capability to choose the correct contact codes.

The measures for Factors 4 and 5, location of in-network pharmacies and proximity search, met the quality goal of 100% for Job Knowledge questions 1 and 3 as well as Call Documentation.

During the quality audit, none of the calls had an interaction in which the member asked about drug-drug interactions, common side effects, or the availability of generic substitutes. Therefore, there is no data to report on these factors.

Deficiencies:

Deficiency	Accuracy or Quality	Plan for Correction	Target Date of Completion	Re-audit Completed? Y/N	Re-audit Completion Date
Exceptions process (Factor 2, Job Knowledge # 5)	Accuracy: The CSR informs the member of the next step after submitting the exception request	The job aid will include additional talking points for CSRs to cover with the member.	November 30, 2018		
Exceptions process (Factor 2, Call Documentation)	Quality: The CSR selects the appropriate contact code to summarize the interaction.	The job aid will include additional guidance for CSRs to choose the correct contact codes.	November 30, 2018		

APPENDIX A

Audit Sheet #1

Reviewed by: **Date Reviewed:**

QNXT call number: **Call recording number:**

Table 1. Accuracy and Quality of Pharmacy Benefit Information over the Telephone for Factor 1 Financial Responsibility.

Factor 1 Financial Responsibility	Call # Date		Accuracy Goal Met	Quality Goal Met
Job Knowledge	Y/N	N/A	Y/N	Y/N
1. Was the request initiated by member or member's rep? Quality: The agent verifies personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did CSR respond correctly to member's financial responsibility (e.g. copay)?				
3. Did CSR educate member about the financial benefit of filling 90 day supply when applicable?				
4. Did CSR educate member that using a generic medication would lower member's financial responsibility?				
Call Documentation	Y/N	N/A	Y/N	Y/N
5. Did the CSR select the appropriate contact code(s)? Quality: For the call documentation, the CSR selected the appropriate contact code to summarize the interaction.				

Audit Sheet #2

Reviewed by: **Date Reviewed:**

QNXT call number: **Call recording number:**

Table 2. Accuracy and Quality of Pharmacy Benefit Information over the Telephone for Factor 2 Exceptions Process.

Factor 2 Exceptions Process	Call # Date		Accuracy Goal Met	Quality Goal Met
Job Knowledge	Y/N	N/A	Y/N	Y/N
1. Was the request initiated by member or member's rep? Quality: The agent verifies personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did the CSR follow exception process? Accuracy: The CSR accurately follows and completes all applicable steps of the exception submission process. Quality: The CSR ensures that the member understands all steps of the exception submission process.				
3. Did the member agree to initiate exception process? Quality: The CSR obtains verbal acknowledgement from the member to initiate the exception process.				
4. If member agreed, did CSR initiate exception process while member/member's rep on the phone? Accuracy: The CSR completes the exception process during the live call. Quality: The CSR confirms with the member that the exception request has been submitted during the live call.				
5. Did CSR inform member of next steps after exception request submission? Accuracy: The CSR informs the member of the next steps after submitting the exception request. Quality: The CSR verifies that the member understands the next steps after submitting the exception request.				
6. Was the exception request submitted for the correct medication in Med Access? Accuracy: The CSR correctly submits the exception request for the desired medication, dosage, etc.				
7. Was the exception request submitted correctly (standard vs expedited) per member's request? Accuracy: The CSR submits the request based on the member's request.				
Call Documentation	Y/N	N/A	Y/N	Y/N
8. Did the CSR select the appropriate contact code(s)? Quality: For the call documentation, the CSR selected the appropriate contact code to summarize the interaction.				

Audit Sheet #3

Audit Sheet #3

Reviewed by: **Date Reviewed:**

QNXT call number: **Call recording number:**

Table 3. Accuracy and Quality of Pharmacy Benefit Information over the Telephone for Factors 4 and 5 Finding the location of an in-network pharmacy and conducting a proximity search.

Factors 4 and 5 Finding the location of an in-network pharmacy and conducting a proximity search	Call # Date		Accuracy Goal Met	Quality Goal Met
Job Knowledge	Y/N	N/A	Y/N	Y/N
1. Was the request initiated by member or member's rep? Quality: The agent verifies personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did the CSR locate and provide name, address, phone number, hours of operation of an in-network pharmacies correctly to the member? Including extended-day supply, compounding services, home delivery, etc. Accuracy: The agent provides the name, address, phone number, and hours of operation for an in-network pharmacy when requested by the member.				
3. Did the CSR assist member in conducting a proximity search for a network pharmacy based on zip code? Quality: The CSR provides the name and details of a network pharmacy based on the member's desired zip code.				
4. If yes (question #3), did CSR conduct a proximity search correctly per member's request? Accuracy: The CSR provides a proximity search based on the member's desired location details, such as city or zip code.				
Call Documentation	Y/N	N/A	Y/N	Y/N
5. Did the CSR select the appropriate contact code(s)? Quality: For the call documentation, the CSR selected the appropriate contact code to summarize the interaction.				

Audit Sheet #4

Reviewed by: **Date Reviewed:**

QNXT call number: **Call recording number:**

Table 4. Accuracy and Quality of Pharmacy Benefit Information over the Telephone for Factors 6, 7, and 8 Determining drug-drug interactions, a drug's common side effects, and the availability of generic substitutes.

Factors 6, 7, and 8 Determining drug-drug interactions, a drug's common side effects, and the availability of generic substitutes.	Call # Date		Accuracy Goal Met	Quality Goal Met
Job Knowledge	Y/N	N/A	Y/N	Y/N
1. Was the request initiated by member or member's rep? Quality: The agent verifies personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did the CSR transfer request to Pharmacy Helpdesk? Accuracy: The CSR transfers a request regarding drug-drug interactions, common side effects, or the availability of generic substitutes to the Pharmacy Help Desk as appropriate.				
Call Documentation	Y/N	N/A	Y/N	Y/N
Did the CSR select the appropriate contact code(s)? Quality: For the call documentation, the CSR selects the appropriate contact code to summarize the interaction.				

Santa Clara Family Health Plan
Personalized Information on Health Plan Services:
Website and Telephone Functionality - 2018 Accuracy and Quality Analysis

Prepared by: Tanya Nguyen, Director of Customer Service
For review and approval by the Quality Improvement Committee
December 5, 2018

I. Overview

In order to best serve our members, it is important for members to have the ability to easily obtain personalized health plan information.

Santa Clara Family Health Plan (SCFHP) has the responsibility to provide access to accurate, quality personalized health information via the SCFHP website and the telephone. This includes the ability to request or reorder an SCFHP member ID card, to change primary care practitioners (PCPs), and to determine how and when to obtain referrals and/or authorizations for specific services.

SCFHP members have no financial responsibility beyond a copay for pharmacy benefits. There is no copay for medical services.

SCFHP ensures the availability of this information by:

1) Telephone – SCFHP Customer Service Representatives (CSRs) are trained to handle PCP changes, member ID card requests, and the determination of services requiring a referral or authorization and to address inquiries. CSRs are able to educate members on how to obtain specific services and/or an authorization; if there is a copay and the amount of the copay for pharmacy benefits and to offer assistance including the ability to initiate an Organization Determination on behalf of a member.
2) SCFHP Website – Members may submit requests for SCFHP member ID cards and to change PCPs via the SCFHP Website. The website includes a list of services requiring an authorization and instructions for obtaining an authorization.

SCFHP conducts monthly quality monitoring to assure the quality of the information provided to members. In addition, SCFHP also conducts an annual evaluation through the selection of certain call categories to identify opportunities to improve the quality and accuracy of the information provided by CSRs to members.

II. Methodology

A. Via Telephone

Annually, SCFHP audits Customer Service telephone calls to and from members. The auditor (Customer Service Quality Manager) randomly selects 20 member contacts based on select call categories of member requested information on determining how and when to obtain referrals and authorizations for specific services or for information on costs for pharmacy services. The auditor assesses the call to determine whether the member was able to obtain answers to their inquiries in one session, without the need to contact the Health Plan another time. To determine the quality and accuracy of member inquiries, the auditor listens to the recorded call and reviews the CSR's call documentation for completeness. The audit is performed on an annual basis by collecting and assessing data on the

completion of an evaluation form (see Appendix A for Audit Sheet). Data included in this analysis was captured from May 1, 2018 through October 31, 2018.

SCFHP members do not have any financial responsibility for covered services as long as members follow the plan's rules such as receiving services within the SCFHP network or contracted providers.

B. Via Web

Customer Service receives confirmation through Microsoft Outlook when a member completes a request to reorder an ID card or change a primary care practitioner. A dedicated staff person in the Customer Service department checks the e-mail inbox intermittently throughout each business day to assure a timely response to the member. The staff responds to the members request and documents the request in the QNXT call tracking system using appropriate contact codes.

SCFHP audits requests received via the Health Plan website for turnaround times to identify opportunities for improvement. However, there were no requests for ID cards or PCP change during the look-back period in the past 6 months. The auditor uses the test account to check the accuracy and quality of how and when to obtain referrals and authorization for specific services.

Goals:

Accuracy: 100%

Quality: 100%

Table 1: Website- Accuracy of information provided for referral and authorization

Evaluation Criteria	Total Sample	Accuracy Goal Met	% Goal Accuracy Goal Met
information is accurately showing if a referral and/or authorization is required for specific service			
1.The information on how and when to obtain a referral and authorization for medical services is populated correctly	5	5	100%
2. Information accurately reflect what services SCFHP would pay for and if there is any limits on the services	5	5	100%
3. Information accurately reflect what services are excluded or not covered by SCFHP	5	5	100%

Table 2: Website- Quality of information for referral and authorization

Evaluation Criteria	Total Sample	Accuracy Goal Met	% goal Accuracy Goal Met
Information is legible, complete and allows the member to understand			
1. The link for the member handbook moves to the correct page	5	5	100%
2. Detailed instructions are provided on what chapter/section of the member handbook to refer to on how and when to obtain referrals and authorizations for specific services	5	5	100%

III. Data

Table 1: Telephone interactions: Accuracy of information provided is assessed for the following.

Evaluation Criteria	Total Sample	Accuracy Goal Met			% Accuracy Goal Met
Job Knowledge		Yes	No	N/A	
1. Was the inquiry initiated by the member or member's representative?	20	20	0	0	100%
2. Did the CSR explain whether or not a service requires a referral and/or a prior authorization?	20	20	0	0	100%
3. If a service requires a prior authorization, whether CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination.	20	18	1	1	94.7%
4. If a service does not require a prior authorization, did the CSR explain how to locate a network provider to the member?	20	20	0	0	100%
Call Documentation		Yes	No	N/A	
1. Did the agent document call in the data base system and select appropriate contact code(s)?	20	20	0	0	100%
2. Did the CSR summarize accurately the service request or interaction in the data base system?	20	20	0	0	100%

Table 2: Telephone interactions: Quality of information is assessed for the following during accuracy review.

Evaluation Criteria	Total Sample	Quality Goal Met			% Quality Goal Met
Job Knowledge		**Yes**	**No**	**N/A**	
1. Was the inquiry initiated by the member or member's representative?	20	20	0	0	100%
2. Did the CSR explain whether or not a service requires a referral and/or a prior authorization?	20	20	0	0	100%
3. If a service requires a prior authorization, whether CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination.	20	20	0	0	100%
4. If a service does not require a prior authorization, did the CSR explain how to locate a network provider to the member?	20	20	0	0	100%
Call Documentation		**Yes**	**No**	**N/A**	
1. Did the agent document call in the data base system and select appropriate contact code(s)?	20	20	0	0	100%
2. Did the agent summarize accurately and clearly the service request or interaction in the data base system?	20	20	0	0	100%

III. Accuracy and Quality Analysis

A. Accuracy: Accuracy measures met the target goal of 100% for Job Knowledge evaluation criteria 1, 2 and 4 as well as Call Documentation criteria 1 and 2. For Job Knowledge evaluation criteria 3, accuracy measure met 94.7% which is 5.3% below the 100% target goal. During the audit of the telephone calls, in one of the calls, the CSR did not offer to initiate an Organization Determination for the member. It was noted that the CSR referred the member back to their treating physicians in order to have an authorization submitted for the specific services

The plan of correction involves retraining the CSR to provide the member the option to work with their physician or to have the CSR initiate an Organization Determination.

The current job aids will be updated to reflect this action step to improve upon the deficiencies, and all CSRs will attend a refresher training session for the authorization and referral inquiry handling process. The target date of completion is November 30, 2018.

Website: All of the website measures met the accuracy goal at 100%.

B. Quality: Quality measures met the goal at 100% of the target goal of 100% for both the Telephone and Website

Deficiency	Accuracy or Quality	Plan for Correction	Target Date of Completion	Re-audit Completed? Y/N	Re-audit Completion Date
CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination.	Accuracy: The agent explains that they can initiate and submit an organization determination or the member can work with their provider to submit an authorization.	Updated job aid to include this instruction and re-training for all CSRs.	November 30, 2018		

APPENDIX A

Audit Sheet

Reviewed by: **Date Reviewed:** **QNXT call number:**

Call recording number:

Accuracy and Quality of Personalized Information on Health Plan Services over the telephone

Measure: Determine how and when to obtain referrals and authorizations for specific services, as applicable.	**Call # Date**		**Accuracy Goal Met**	**Quality Goal Met**
Job Knowledge	**Y/N**	**N/A**	**Y/N**	**Y/N**
1. Was the inquiry initiated by the member or member's representative? Accuracy: The CSR confirmed who the caller was in relationship to the member. Quality: The CSR verified personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did the CSR explain whether or not a service requires a referral and/or a prior authorization? Accuracy: The CSR confirms whether or not the requested service requires an authorization. Quality: The CSR clearly explains whether or not the member needs prior authorization and/or verifies the status of the authorization if there is one on the member's file before obtaining the requested service.				
3. If a service requires a prior authorization, whether CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination. Accuracy: The CSR accurately explains how the member can obtain an authorization or referral. Quality: The CSR explains thoroughly how the member can obtain and offer to initiate an organization determination.				
4. If a service does not require a prior authorization, did the CSR explain how to locate a network provider to the member? Accuracy: The CSR accurately provides list of network provider to the member Quality: The CSRs provides list of network provider and offer to schedule an appointment with network providers				

Measure: Determine how and when to obtain referrals and authorizations for specific services, as applicable.	Call # Date		Accuracy Goal Met	Quality Goal Met
Call Documentation	**Y/N**	**N/A**	**Y/N**	**Y/N**
1. Did the agent document call in the data base system and select appropriate contact code(s)? Accuracy: The agent used the correct contact code for the interaction. Quality: The agent did not use incorrect contact codes that do not pertain to the interaction.				
2. Did the agent summarize accurately and clearly the service request or interaction in the data base system? Accuracy: The agent clearly documents all aspects of the interaction with the member. Quality: The agent's documentation is easy to understand by the auditor without the need for the auditor to listen to the call.				

Clinical Practice Guidelines 2018 Evaluation

Clinical and Preventative Guideline	Measure	CMC CY 2015 Baseline Rate	CMC CY 2016	CMC CY 2017	NCQA MA Benchmark	CY 2017 vs. Baseline CMC Comparison	MC CY 2015 Baseline Rate	MC CY 2016	MC CY 2017	NCQA MCAID Benchmark	CY 2017 vs. Baseline MC Comparison
Diabetes Clinical Guidelines	Comprehensive Diabetes Care - HbA1c Test	89.54%	91.24%	91.73%	10th Percentile	0.02	86.37%	88.32%	88.32%	50th Percentile	0.02
Diabetes Clinical Guidelines	Comprehensive Diabetes Care - HbA1c Poor	47.20%	32.85%	27.98%	25th Percentile	(0.19)	32.36%	37.23%	34.06%	75th Percentile	0.02
Diabetes Clinical Guidelines	Comprehensive Diabetes Care - HbA1c Control	44.04%	55.96%	60.58%	25th Percentile	0.17	60.10%	53.77%	54.50%	75th Percentile	(0.06)
Diabetes Clinical Guidelines	Comprehensive Diabetes Care - Eye Exam	53.28%	62.53%	72.26%	50th Percentile	0.19	51.90%	62.29%	63.02%	50th Percentile	0.11
Diabetes Clinical Guidelines	Comprehensive Diabetes Care - Med Attn Neph	96.67%	91.97%	91.73%	<10th Percentile	(0.05)	85.64%	88.81%	86.62%	<10th Percentile	0.01
Diabetes Clinical Guidelines	Comprehensive Diabetes Care - BP <140/90	31.87%	59.61%	58.39%	10th Percentile	0.27	37.96%	59.37%	62.53%	50th Percentile	0.25
Hypertension Clinical Guidelines	Controlling High Blood Pressure	29.17%	60.10%	67.40%	25th Percentile	0.38	36.01%	66.91%	65.94%	75th Percentile	0.30
Behavioral Health Guidelines	ADD Initiation Phase						35.45%		36.80%	10th Percentile	0.01
Behavioral Health Guidelines	ADD C&M Phase						32.77%		40.19%	10th Percentile	0.07
Child and Adolescent Preventative Guidelines	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life						74.45%	73.97%	72.75%	50th Percentile	(0.02)
Child and Adolescent Preventative Guidelines	Childhood Immunization Status - Combo 3						72.02%	77.37%	77.62%	75th Percentile	0.06
Child and Adolescent Preventative Guidelines	Immunizations for Adolescents - Combo 1						79.56%		83.45%	50th Percentile	0.04
Prenatal Preventative Guidelines	Prenatal Postpartum Care - Timeliness of Prenatal Care						79.56%	82.48%	83.70%	50th Percentile	0.04
Prenatal Preventative Guidelines	Prenatal Postpartum Care - Post Partum Care						64.23%	68.61%	69.10%	50th Percentile	0.05

Santa Clara Family Health Plan™

Member Satisfaction with Complex Case Management: 2018 Analysis

Quality Improvement Committee: December 5,2018

Author: Shawna Cagle, Manager, Case Management

Introduction

Santa Clara Family Health Plan (SCFHP) monitors Cal MediConnect (CMC) members' experience with the Complex Case Management (CCM) Program to ensure adequate satisfaction with program goals is achieved. Annually, SCFHP completes an analysis which incorporates member survey questions and member complaint categories related to the CCM program. This analysis allows the organization to formulate an action plan addressing low member satisfaction with (CCM) functions within SCFHP.

Member Satisfaction with CCM Processes

SCFHP measures member satisfaction with the CCM program through annual monitoring of complaints from members related to CCM processes and through the performance of a member satisfaction survey. All members enrolled in CCM are provided the opportunity to complete the survey within 30 days of their transition to a lower level of case management (CM) services. Each survey will have specifically identified look-back periods, specific questions/data elements and noted and will adhere to specific timeframes in which the outreach for each survey will be conducted. Surveys will be conducted via telephonic outreach to members. SCFHP will conduct an annual analysis of all member survey data.

Complex Case Management (CCM):

1. All members enrolled in CCM for 60 days or more will be included in the survey sample
2. All members who participated in CCM will be provided an opportunity to complete a Satisfaction Survey
3. CCM survey data will be collected from those who choose to participate
4. CCM survey data will be compiled and analyzed at least once during the look back period to support Population Health Impact Analysis
5. CM survey data will be published annually in April

Methodology

SCFHP CMC members who were enrolled in CCM for 60 days or more were provided telephonic outreach by CM care coordination staff not directly involved in their care. Survey responses were collected on an ongoing basis since the CCM program officially launched June 1, 2018. Case Management staff conducted two telephone outreach calls for each qualified member. Feedback data was documented in, and reported from, the CM software platform Essette. Answers to questions are scored on a 0-5 scale (0 = refused to answer and 5 = strongly agree, with highest score possible is 44.) Ten members were contacted, seven members completed the survey, and three members were unable to be contacted. The overall response rate was 70%.

Overall goal is to have members respond "agree" or "strongly agree" for questions 1-8 and "satisfied" or "very satisfied" for question 9 for a total score of 35 or better or 90% overall satisfaction. Members were also encouraged to provide comments and feedback. Members had the right to refuse to participate in all or parts of the survey.

The below table shows how the survey questions meet the intent of PHM 5 Element F by showing a crosswalk between the question and the NCQA requirement:

Factor 1: Analyzing member feedback	
NCQA survey content requirements	**Question Mapping**
Information about the overall program	12) Overall, how satisfied are you with the Case Management Services you received?
The program staff	4) My case manager treated me with respect. 5) My case manager listened to what I had to say. 6) My case manager returned my phone calls in a timely manner.
Usefulness of the information disseminated	9) I better understand my disease or condition after being in the complex case management program. 8) My case manager involved me in discussing and planning my care. 7) My case manager helped me find the services that I needed.
Member's ability to adhere to recommendations	10) I am able to better manage my health and health care after being in the case management program.
Percentage for members indicating that the program helped them achieve health goals.	11) My situation is better because of my case manager's help.

Results

	Strongly Agree		Agree		Not Sure		Disagree		Strongly Disagree		Refused To Answer	Sample Size	90% Goal Met
	N	%	N	%	N	%	N	%	N	%	N		
My case manager treated me with respect.	6	86%	1	14%	0	0%	0	0%	0	0%	0	7	Y
My case manager listened to what I had to say.	5	71%	2	29%	0	0%	0	0%	0	0%	0	7	Y
My case manager returned my phone calls in a timely manner.	6	86%	1	14%	0	0%	0	0%	0	0%	0	7	Y
My case manager helped me find services that I needed	5	71%	0	0%	2	29%	0	0%	0	0%	0	7	N
I better understand my disease or condition after being in the case management program.	4	57%	1	14%	1	14%	1	14%	0	0%	0	7	N
I am able to better manage my health and health care after being in the case management program.	3	43%	2	29%	1	14%	1	14%	0	0%	0	7	N
My situation is better because of my case manager's help.	3	43%	2	29%	1	14%	1	14%	0	0%	0	7	N
	Very Satisfied		Satisfied		Somewhat Satisfied		Not at all satisfied		Refused to Answer				
Overall, how satisfied are you with the Case Management Services you received?	5		1		1		0		0			7	Y

Member Complaints Related to the CCM Program

The process for measuring member CCM complaints is through the Grievance and Appeals (G&A) department. Grievances files by members regarding the CCM Program are flagged "CCM" and reported directly to Case Management Department Leadership. CM Leadership works directly with G&A to resolve the grievance. CCM grievances are measured and reported annually. To date there have been (0) grievances for CCM services. The low volume is most likely due to the recent official implementation date of the CCM program in June of 2018 and the relatively low, but growing, volume of consenting enrollees.

Analysis

SCFHP sets performance goals for each measure and through the analysis process, identifies opportunities to improve member satisfaction with the CCM process. The quantitative analysis process includes a review of results and trends over time and compares those results against an established performance goal. The qualitative analysis process utilizes the trend data to identify potential root cause and barriers applicable to achieving the performance goal. The process incorporates opportunities and interventions to address the root cause.

a. Quantitative analysis

In conclusion, 100% of members stated they were overall satisfied or somewhat satisfied with the CCM Program, resulting in meeting the 90% goal for this measure.

- 100% percent of members believe that their assigned case manager treated them with respect and listened to what they had to say.
- 100% of members felt their assigned case manager returned phone calls in a timely manner.
- 71% of member believe that their case manager helped them find the services they needed. 29% stated they were unsure.
- 71-72% of members responded that they better understand their disease or condition, are better able to manage their health and their situation is better because of their case mangers help. 14% were not sure, and another 14% disagreed.

b. Qualitative analysis

- SCFHP did not meet the 90% performance goal in four areas:
    1. Help in finding services needed (71%)
    2. Increased understanding of the members' condition (71%)
    3. Improved ability to manage own health (72%)
    4. Improved overall health situation (72%)
- However, in areas 2-4, only one person answered that they "Disagreed". In area 1, two people answered "Not Sure" which equated to 28% of
- Although a small number of people surveyed expressed satisfaction, the performance rates indicate possible areas of improvement within the CCM program
- The survey data was presented and discussed at the Quality Improvement Committee (QIC) on October 10, 2018. The QIC was attended by multiple internal staff (representing Case Management, Quality Improvement, Provider Network Management and Compliance) as well as external physicians. The group discussed the four categories where the performance goal was not met. One issue was noted with the survey format, in which not all members can be reached telephonically and the survey content was not specific enough to evaluate areas of the program that need improvement. The 2019 survey will be updated to include more specificity and detailed questions. The CM team will also implement a paper/mailed survey. The group also noted that one member disagreed that they were better able to understand their disease and/or condition at the end of the program. It was noted that the Case Management team should evaluate the way in which they provide members information about their condition, including health education and other resource materials. This opportunity was selected for 2019 and the case management team will work to ensure trainings are scheduled for case management staff to review available materials and reinforce processes for educating members.

Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2019?	Date Initiated
Members do not understand their condition well enough and are not satisfied with the services provided because of inadequate provision of tools and materials assisting the member in self-management	Case Managers will have access to Health Education materials and resources that can be made available to Member and/ or Caregiver	Provide ongoing training to CCM Case Management Staff on health education materials, resources, and free/low-cost community programs available to members.	Y	January 2019
Not all members eligible to complete the Survey were reached by phone.	To format the survey into a paper questionnaire that can be mailed to the member.	Create a CCM Experience Survey document that can be mailed to the member directly through the Case Management Platform (Essette) Correspondence module.	Y	January 2019
Current survey questions lack enough detail to evaluate specific program areas that need improvement	Revise survey questions to identify specific areas of case management support member feel they need.	Configure additional questions within the current CCM Survey Assessment in Essette.	Y	January 2019

Member Satisfaction with the CCM Process Reporting

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee	December 5, 2018	

Continuity and Coordination of Medical Care: 2018 Analysis

Quality Improvement Committee: December 5, 2018

Author: Sandra Carlson, Director, Medical Management

Overview

Santa Clara Family Health Plan (SCFHP) monitors activities directed at improving continuity and coordination of medical care and takes action, as necessary, to improve the outcomes of the monitored activities. Annually, SCFHP reviews data associated with member movement between practitioners and member movement between settings. Through analysis, SCFHP identifies four opportunities for improvement. During 2018, the following opportunities were monitored for aspects of continuity and coordination of medical care:

- Measure 1: Primary Care Physician (PCP) Experience Survey (regarding continuity and coordination between primary and specialty care)
- Measure 2: Comprehensive Diabetes Care (CDC) Eye Exam Rate
- Measure 3: PCP Follow up After 30 days of Discharge Rate - HEDIS
- Measure 4: Plan All-Cause Readmissions (PCR) – HEDIS

	Name of Measure	Movement Across Settings?	Movement Across Practitioners?
Measure 1	Primary Care Physician (PCP) Experience Survey		**[X]**
Measure 2	Comprehensive Diabetes Care (CDC) Eye Exam Rate		**[X]**
Measure 3	PCP Follow up After 30 days of Discharge Rate	**[X]**	
Measure 4	Plan All-Cause Readmissions (PCR)	**[X]**	

SCFHP sets performance goals for each measure, and through the analysis process, identifies opportunities to improve the coordination and continuity of medical care between practitioners and settings. The quantitative analysis process includes a review of results and trends over time and compares those results against an established performance goal. The qualitative analysis process utilizes the trend data to identify potential root cause and barriers applicable against achieving the performance goal. The process incorporates opportunities and interventions to remediate negative impact that is a direct effect of the root cause. Calendar year 2018 is the first year that SCFHP has collected data for the purpose of the continuity and coordination of medical care NCQA analysis. For the purpose of this report, one year of data will be collected and presented for each measure. In the future, SCFHP will track and trend each measure over a three-year period.

I. Measure 1: Primary Care Physician (PCP) Experience Survey (regarding continuity and coordination between primary and specialty care)

a. Methodology

SCFHP conducts an annual PCP survey to assess experience with continuity and coordination of care between primary care and specialty care. A random sample of 59 PCPs were selected from a universe of 428. This universe was identified by reviewing all unique PCPs whose assigned patients visited a Specialist in the 2nd Quarter of 2018. The sample size was then calculated using a confidence level of 90% and a 10% margin of error. The survey was conducted telephonically in September 2018. To increase the response rate, three call attempts were made by SCFHP Personal Care Coordinator (PCC) staff over a span of two weeks. To increase the accuracy and meaningfulness of response, staff specifically asked to have the PCP complete the survey rather than office staff. PCPs were given the option to complete the survey telephonically, via fax or online using surveymonkey.com. The denominator for the survey is the number of responses received for each question for each authorization. The numerator for the survey is calculated for each question as follows:

1. **Question 3**: On a scale from 0 (not at all satisfied) to 10 (extremely satisfied) please rate your satisfaction with the overall continuity and coordination of care for your patients.
    a. Numerator: The number of providers who answered on a scale of 6-10.

2. **Question 4**: Please rate your satisfaction with hand-off of care from Specialty Care to Primary Care (0 = not at all satisfied, 10 = extremely satisfied)
    a. Numerator: The number of providers who answered on a scale of 6-10.

3. **Question 5**: How often do you receive information about YOUR patients from Specialty Care?
    a. Numerator: The number of providers who answered “Always” or “Frequently”

4. **Question 6**: Please rate the effectiveness of information you typically receive about care your patients received from Specialty Care.
    a. Numerator: The number of providers who answered “Very Effective” or “Effective”

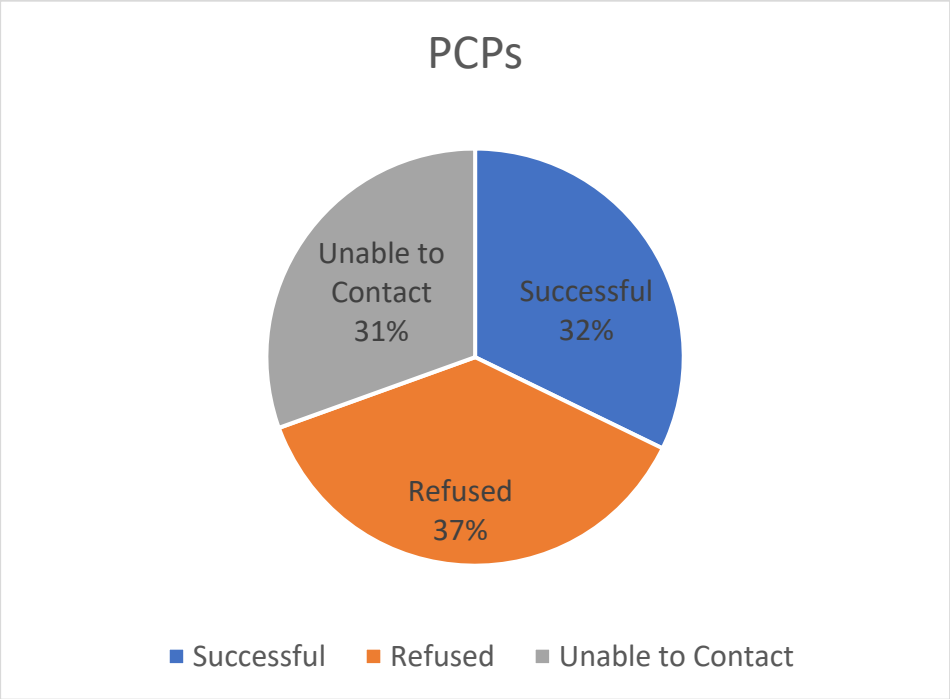
5. **Question 7**: Please rate the timeliness of information provided to you by Specialists/Consulting Physicians. (0 = Not at all timely, 10 = Extremely timely)
    a. Numerator: The number of providers who answered from 6-10.

6. **Question 8**: Please rate the usefulness of information provided to you by Specialists/Consulting Physicians. (0 = Not at all useful, 10 = Extremely useful)
    a. Numerator: The number of providers who answered from 6-10.

II. **Analysis**

a. Results

Response Rates:



Survey Question	Numerator	Denominator	Performance Rate	Performance Goal	Goal Met? (y/n)
3. Satisfaction of continuity and coordination of care for patients	18	18	100%	90%	Y
4. Satisfaction with hand-off of care from Specialty Care to Primary Care	19	19	100%	90%	Y
5. Frequency of receiving information about patients from Specialty Care	10	19	53%	90%	N
6. Effectiveness of information received about care patients received from Specialty Care	16	19	84%	90%	N
8. Timeliness of Information from Specialty Care	17	18	94%	90%	Y
9. Usefulness of Information from Specialty Care	18	18	100%	90%	Y

b. Quantitative analysis

100% of PCPs surveyed were generally satisfied with their patients' continuity and coordination of care and the process for hand-off between specialty and primary care. Additionally, 100% of PCPs reported that information from Specialty care was generally useful, and 94% reported that the information was generally timely. The performance goal was not met in two areas:

- Effectiveness of information from Specialty Care: 84% of PCPs surveyed reported that the information was generally effective
- Frequency of information from Specialty Care: 53% of PCPs surveyed reported that the information was provided frequently

c. Qualitative analysis

An initial barrier analysis was completed to identify opportunities and interventions to improve the rate of provider satisfaction with the effectiveness and frequency of information received from Specialty care. The analysis was completed at the Quality Improvement Committee, which is comprised of several internal staff (including representation from the Provider Network Management, Quality Improvement, and Medical Management) as well as external physicians. The group discussed that providers may not be as satisfied in these two areas due to the lack of Electronic Health Record (EHR) integration between providers.

2018 Barrier and Analysis Table

Barrier	Opportunity	Intervention	Selected for 2019?	Date Initiated
PCP and Specialists do not share electronic health records	Investigate and evaluate EHR products to allow for enhanced information sharing between providers and Specialists	Initiate RFP selection and Implementation for new product and train provider network on use	N	NA
PCPs (Referring Provider) do not receive communication back from the Specialist on follow up/appointment outcomes	Provide case management assistance to PCPs to help fill in information gaps not provided by the Specialist	Distribute an article in the Provider Newsletter to inform providers that they may call the Case	Y	March 31, 2019

Barrier	Opportunity	Intervention	Selected for 2019?	Date Initiated
		Management team for assistance obtaining supplemental information from Specialists regarding the members' care and related care needs		

III. Measure 2: Comprehensive Diabetes Care (CDC) Eye Exam Rate - HEDIS

a. Methodology

SCFHP monitors the Comprehensive Diabetes Care (CDC) Eye Exam HEDIS rate to assess the movement of diabetic patients between practitioners. This rate measures the percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. The HEDIS technical specifications are included in Appendix A for further detail regarding methodology. The rate provided is measured from 1/1/2017 – 12/31/2017 and reported for year 2018. SCFHP monitors this rate annually and sets performance goals based on previous year performance. In MY1 2016, a performance goal of 47.41% was set and in MY2 2017, the target goal was to maintain or exceed the goal from MY1 2016.

IV. Analysis

a. Results

Measure 1: CDC Eye Exam Rate	Numerator	Denominator	Rate	Performance Goal	Goal Met?
Measurement Y1 2016	257	411	62.53%	47.41%	Y
Measurement Y2 2017	297	411	72.26%	62.53%	Y

b. Quantitative analysis

In 2016, SCFHP was able to exceed its goal of having 47% of members with Type I or Type II completing an eye exam by almost 16 percentage points. In 2017, SCFHP aimed

to maintain the previous year performance rate of 62.53%. SCFHP exceeded the 62.53% rate by almost 10 percentage points. SCFHP continues to help our members improve in this measure by scheduling and completing an annual eye exam. The performance goals were met and therefore further qualitative analysis or opportunity for improvement is not required at this time.

V. Measure 3 PCP Follow up after 30 days of Discharge Rate

a. Methodology

On a quarterly basis, SCFHP monitors CMC members that have an acute inpatient hospital discharge and a follow-up visit within 30 days of discharge. A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Monitoring this measure is a requirement of all Medicare-Medicaid Plans (MMPs) under the "Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements". This state-specific measure, among others, supplement existing Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS®1 and HOS. Detailed methodology can be found in the following reporting requirements, pages CA-26 through CA-29 (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/CAReportingRequirements02282018.pdf). SCFHP reports this data to CMS and the State of California quarterly for evaluation. A performance goal for this measure is not prescribed by any regulatory agency. SCFHP's UM Management Leadership discussed and determined that an annual 90% follow-up rate was both a rigorous and attainable goal to strive for.

Measure 3 – Ambulatory Care Follow Up Visit 30 Days After Hospital Discharge

a. **Numerator definition**: Total number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the inpatient hospital stay.
b. **Denominator definition:** Total number of acute inpatient hospital discharges during the reporting period.
c. **Goal for comparison**: 90% of members with an acute inpatient hospital discharge within the reporting period have an ambulatory care follow-up visit within 30 days of discharge.

VI. Analysis

a. Results

Measure 3: Ambulatory Care Follow Up 30 Days After Discharge		Q1	Q2	Q3	Q4	2017 Total
Numerator	Total number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the hospital.	280	254	217	239	990
Denominator	Total number of hospital discharges.	345	331	271	315	1,262
	Rate:	**81%**	**77%**	**80%**	**76%**	**78%**

b. Quantitative analysis

The performance goal set for Measurement Year 1 (2017) of 90% was not met cumulatively for 2017, nor was it met at any point in Q1-Q4. Q1 and Q3 achieved the highest rates of 30 day follow-up visits with 81% and 80% respectively. Rates dipped back down in Q2 and Q4 by 4 percentage points. The 2017 cumulative rate of 78% shows that SCFHP is 12 percentage points away from meeting the goal of 90%. This gap indicates opportunities for improvement in the existing process of encouraging members to schedule and keep appointments with their physicians after discharge from an acute inpatient hospital stay.

c. Qualitative analysis

An initial barrier analysis was completed to identify opportunities and interventions to improve the rate of members receiving 30-day follow up. The analysis was completed at the Quality Improvement Committee, which is comprised of several internal staff (including representation from the Provider Network Management, Quality Improvement, and Medical Management) as well as external physicians. The group discussed that one reason members are not seen by their doctor within 30 days of discharge is because often the members' provider is not notified of the admission, let alone discharge. The group discussed how the plan currently receives notification of member admissions and what the process sis internally to help the member in scheduling an appointment with their PCP. One of the committee physicians recommended implementing a medication reconciliation program for discharged members, as medication reconciliation is a critical part of ambulatory care. Another suggestion to overcoming the barriers is to complete a trial program internally at SCFHP where case managers complete outbound calls to members discharged from a selected hospital. Based on results of the study, SCFHP could consider implementing more broadly.

Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2019?	Date Initiated
PCPs are not always aware that their patients are admitted to hospitals thru the ER	Improve acute and skilled admission notification to member's assigned PCP's	UM process improvements will include development and implementation of PCP admission notification letters at the time these admissions are received and entered into QNXT for Inpatient Concurrent review purposes	Y	March 2019

VII. Measure 4: Plan All-Cause Readmissions (PCR) HEDIS Rate

a. Methodology

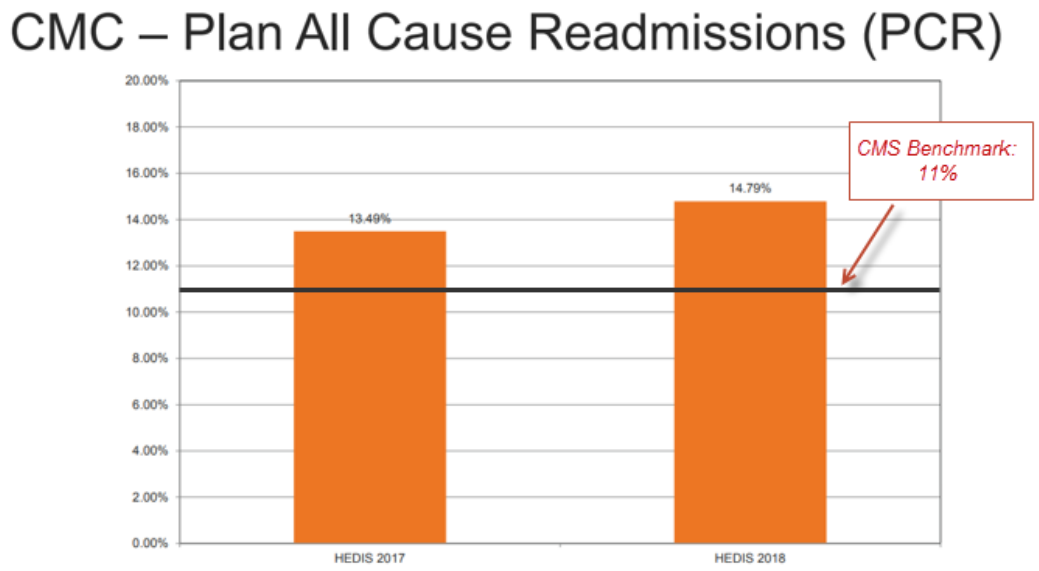
SCFHP monitors all-cause acute readmissions annually as part of HEDIS reporting and as part of the Quality Withhold data set. For Quality Withhold, Medicare and Medicaid withhold a percentage of capitation rates to incent MMPs to provide high quality care and conduct quality improvement. For members 18 years of age and older, this measure identifies the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. One of two different performance goals are determined by CMS benchmarks. CMS benchmarks are established using national data such that all MMPs across demonstrations are held to a consistent level of performance. The CMS benchmark for PCR is 11% and SCFHP has adopted this performance goal for the purposes of this analysis. Data for this measure is reported in the following categories:

- **Denominator**: Count of Index Hospital Stays (IHS)
  - *An IHS is defined as an acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year.*
- **Numerator**: Count of 30-Day Readmissions
  - *Defined as an acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.*
- **Expected Readmissions Rate**
  - **Performance Goal:** 11% (CMS Benchmark for 2018)

VIII. **Analysis**

a. Results

Measure 2: PCR Rate	Numerator	Denominator	Rate	Performance Goal	Goal Met?
Measurement Y1 2016	151	1,119	13.49%	11%	N
Measurement Y2 2017	183	1,246	14.79%	11%	N



b. Quantitative analysis

SCFHP missed the performance goal of 11% by 2.5 percentage points in 2017, and 3.8 percentage points in 2018. Overall, this means that readmissions within 30 days of discharge are increasing slightly. This change in 2017 indicates an opportunity to improve internal and external processes in place to prevent unplanned acute readmissions within 30 days of discharge.

c. Qualitative analysis

An initial barrier analysis was completed to identify opportunities and interventions to improve the rate of members readmitted within 30 days of discharge. The analysis was completed at the Quality Improvement Committee, which is comprised of several internal staff (including representation from the Provider Network Management, Quality Improvement, and Medical Management) as well as external physicians. The group agreed that readmissions are most likely to occur because of a lack of timely follow up care and noncompliance with/and or not receiving discharge instructions. The internal staff brought up the current SCFHP Transition of Care program and its limitation in scope as a potential internal process that could be improved to help decrease readmissions. Currently the program is only dedicated to one hospital in Santa Clara County. We receive near real-time

admissions from this hospital and the UM staff completes outreach calls and documents them in the case management system. The group discussed expanding this to other hospitals by finding more ways to collect real time notifications of discharges and expand the scope of outbound calls to discharges from other hospitals. The group also identified that a lack of coordination between the internal UM and CM departments may lead to disjointed care of members that are discharged.

2018 Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 20XX?	Date Initiated
Member may not remember to get ambulatory care or receive discharge instructions to reduce risk of readmissions	SCFHP to expand Transition of Care follow up Program to more hospitals within our contracted network.	SCFHP implement a more broad TOC program to complete follow up with calls to members within 72 hours of discharge	Y	April 2019
Disjointed communications between SCFHP UM and CM staff may lead to gaps in care after discharge	Re-evaluate and improve communication procedures between departments	Complete regular staff trainings on new and improved processes for coordination between UM and CM in terms of members recently discharged	Y	January 2019

Committee Review

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee	12/5/2018	The committee reviewed the analysis and recommendations. Approved interventions for measures 1, 2 and 4.

APPENDIX

Appendix A

HEDIS Technical Specifications for the Comprehensive Diabetes Care Eye Exam Rate

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review,* the member is removed from the sample and replaced by a member from the oversample. *Refer to General Guideline 20: Members in Hospice.*

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.

Event/ diagnosis

There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlinitide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empaglifozin-linagliptin • Empagliflozin-metformin • Glimepiride-pioglitazone	• Glimepiride-rosiglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone	• Metformin-saxagliptin • Metformin-sitagliptin • Sitagliptin-simvastatin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Dulaglutide • Exenatide	• Liraglutide	• Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitaglipin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

Administrative Specification

Denominator

The eligible population.

Note: *The eligible population for the HbA1c Control <7% for a Selected Population indicator is reported after required exclusions are applied.*

Required exclusions for HbA1c Control <7% for a Selected Population indicator

Exclude members who meet any of the following criteria:

- 65 years of age and older as of December 31 of the measurement year.
- *CABG.* Members who had CABG (CABG Value Set) in any setting during the measurement year or the year prior to the measurement year.
- *PCI*. Members who had PCI (PCI Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- *IVD.* Members who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
  - At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set).
  - At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).
- *Thoracic aortic aneurysm.* Members who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
  - At least one outpatient visit (Outpatient Value Set), with a diagnosis of thoracic aortic aneurysm (Thoracic Aortic Aneurysm Value Set).
  - At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of thoracic aortic aneurysm (Thoracic Aortic Aneurysm Value Set).
- Any of the following, in any setting, any time during the member's history through December 31 of the measurement year.
  - *Chronic heart failure*. A diagnosis of chronic heart failure (Chronic Heart Failure Value Set).
  - *Prior MI*. A diagnosis of MI (MI Value Set).
  - *ESRD*. ESRD (ESRD Value Set; ESRD Obsolete Value Set).
  - *Chronic kidney disease (stage 4)*. Stage 4 chronic kidney disease (CKD Stage 4 Value Set).
  - *Dementia*. A diagnosis of dementia (Dementia Value Set; Frontotemporal Dementia Value Set).
  - *Blindness*. A diagnosis of blindness (Blindness Value Set).
  - *Amputation (lower extremity)*. Lower extremity amputation (Lower Extremity Amputation Value Set).

Numerators

HbA1c Testing An HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

HbA1c Poor Control >9% Use codes in the HbA1c Tests Value Set to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Not compliant
HbA1c Level 7.0–9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

Note: *A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).*

HbA1c Control <8% Use codes in the HbA1c Tests Value Set to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Compliant
HbA1c Level 7.0–9.0 Value Set	Not compliant*
HbA1c Level Greater Than 9.0 Value Set	Not compliant

*****The CPT Category II code (3045F) in this value set indicates most recent HbA1c (HbA1c) level 7.0%–9.0% and is not specific enough to denote numerator compliance for this indicator. For members with this code, the organization must use other sources (laboratory data, hybrid reporting method) to identify the actual value and determine if the HbA1c result was <8%. Because providers assign the Category II code after reviewing test results, the date of service for the Category II code may not match the date of service for the HbA1c test found in other sources; if dates differ, use the date of service when the test was performed. The date of service for the Category II code and the test result must follow the requirements outlined in *General Guideline 35* (i.e., the dates of service for the code and the test result must be no more than seven days apart).

HbA1c Control <7% Use codes in the HbA1c Tests Value Set to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c

for a Selected Population

level is <7.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥7.0% or is missing a result, or if an HbA1c test was not performed during the measurement year.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Compliant
HbA1c Level 7.0–9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Not compliant

Note: *This indicator uses the eligible population with additional eligible population criteria (e.g., removing members with required exclusions).*

Eye Exam

Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- Bilateral eye enucleation anytime during the member's history through December 31 of the measurement year.

Any of the following meet criteria:

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set).
- Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the measurement year.
- Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening Negative Value Set billed by any provider type during the measurement year.

- Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) ***with*** a bilateral modifier (Bilateral Modifier Value Set).
- Two unilateral eye enucleations (Unilateral Eye Enucleation Left Value Set) with service dates 14 days or more apart. For example, if the service date for the first

unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.

- Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) ***and*** right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) on the same or different dates of service.

Medical Attention for Nephropathy

A nephropathy screening or monitoring test ***or*** evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year:

- A nephropathy screening or monitoring test (Urine Protein Tests Value Set).
- Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set).
- Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set).
- Evidence of ESRD (ESRD Value Set).
- Evidence of kidney transplant (Kidney Transplant Value Set).
- A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted).
- At least one ACE inhibitor or ARB dispensing event (ACE Inhibitor/ARB Medications List).

Note: *A process flow diagram is included at the end of this specification to help implement this measure.*

ACE Inhibitor/ARB Medications

Description	Prescription				
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril	• Enalapril • Fosinopril	• Lisinopril • Moexipril	• Perindopril • Quinapril	• Ramipril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Candesartan	• Eprosartan • Irbesartan	• Losartan • Olmesartan	• Telmisartan • Valsartan	
Antihypertensive combinations	• Aliskiren-valsartan • Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-perindopril • Amlodipine-telmisartan	• Amlodipine-valsartan • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan	• Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Sacubitril-valsartan • Trandolapril-verapamil		

BP Control <140/90 mm Hg

Use automated data to identify the most recent BP reading taken during an outpatient visit (Outpatient Value Set) or a nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.

The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than/Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80–89 Value Set	Diastolic compliant
Diastolic Greater Than/Equal To 90 Value Set	Diastolic not compliant

Exclusions *(optional)*

Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the *HbA1c Control (<7.0%) for a Selected Population* denominator.

If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

Hybrid Specification

Denominator

A systematic sample of 548 drawn from the eligible population for each product line. A sample size of 548 is based on the goal of achieving a sample of at least 411 for the HbA1c <7% denominator after required exclusions. The *HbA1c Control <7% for a Selected Population* indicator is not collected or reported for the Medicare product line. Organizations should use a sample size of 411 for the Medicare product line or if they do not report the *HbA1c Control <7% for a Selected Population* indicator.

Members who meet the required exclusion criteria for the *HbA1c Control <7% for a Selected Population* indicator are excluded from the denominator of the *HbA1c Control <7% for a Selected Population* indicator. Report this indicator as 548 minus the required exclusions.

If the sample drops below 411, use members from the oversample to maintain the MRSS. Members from the oversample should be added to the denominator for all measure indicators. If the oversample was underestimated and all oversample

members have been exhausted without satisfying the MRSS, per the *Guidelines for Calculations and Sampling*, the organization must contact NCQA to determine next steps.

Note: *The eligible population for the HbA1c Control <7% for a Selected Population indicator is reported after required exclusions are applied.*

The organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest rate among all the reported CDC indicators. The lowest rate for all reported indicators must be used when reducing the sample size.

If the organization chooses to reduce the sample size and report the *HbA1c Control <7% for a Selected Population* indicator, the sample size for this indicator must still be the appropriate sample size as specified in Table 2: Sample Sizes When Data Are Available on the Product Line Being Measured (in the *Guidelines for Calculations and Sampling*) after the required exclusions are removed.

Required exclusions for HbA1c Control <7% for a Selected Population

Administrative

Refer to *Administrative Specification* to identify required exclusions from administrative data.

Medical record

Exclude members who meet any of the following criteria:

- 65 years of age and older as of December 31 of the measurement year.
- *CABG.* Dated documentation of CABG in the measurement year or the year before the measurement year.
- *PCI.* Dated documentation of PCI in the measurement year or the year before the measurement year.
- *IVD.* Documentation of an IVD diagnosis. Look as far back as possible in the member's history through December 31 of the measurement year. Appropriate diagnoses include:
  - IVD.
  - Ischemic heart disease.
  - Angina.
  - Coronary atherosclerosis.
  - Coronary artery occlusion.
  - Cardiovascular disease.
  - Occlusion or stenosis of precerebral arteries (including basilar, carotid and vertebral arteries).
  - Atherosclerosis of renal artery.
  - Atherosclerosis of native arteries of the extremities.
  - Chronic total occlusion of artery of the extremities.
  - Arterial embolism and thrombosis.
  - Atheroembolism.

- *Thoracoabdominal or thoracic aortic aneurysm.* Documentation of thoracoabdominal aneurysm or thoracic aortic aneurysm. Look as far back as possible in the member's history through December 31 of the measurement year.
- *CHF.* Documentation of CHF or cardiomyopathy diagnosis. Look as far back as possible in the member's history through December 31 of the measurement year.
- *Prior MI.* Documentation of prior MI. Look as far back as possible in the member's history through December 31 of the measurement year.
- *ESRD.* Documentation of stage 5 chronic kidney disease, ESRD or dialysis. Look as far back as possible in the member's history through December 31 of the measurement year.
- *Chronic kidney disease (stage 4).* Documentation of stage 4 chronic kidney disease. Look as far back as possible in the member's history through December 31 of the measurement year.
- *Dementia.* Documentation of dementia. Look as far back as possible in the member's history through December 31 of the measurement year.
- *Blindness.* Documentation of blindness in one or both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- *Amputation (lower extremity).* Documentation of lower extremity amputation. Look as far back as possible in the member's history through December 31 of the measurement year.

Note: *For Hybrid reporting, search the medical record for required exclusions and apply them before determining if the member has a numerator hit. Organizations are not required to search for required exclusions if a member has an administrative hit for the indicator, but must exclude these members if they are discovered during medical record review.*

Numerators

HbA1c Testing An HbA1c test performed during the measurement year as identified by administrative data or medical record review.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. Count notation of the following in the medical record:

- A1c.
- HbA1c
- HgbA1c.
- Hemoglobin A1c.
- Glycohemoglobin A1c.
- Glycohemoglobin.
- Glycated hemoglobin.
- Glycosylated hemoglobin.

HbA1c Poor Control >9% The *most recent* HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through automated laboratory data or medical record review.

Note: *A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).*

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year.

The member is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

HbA1c Control <8%

The *most recent* HbA1c level (performed during the measurement year) is <8.0% as identified by automated laboratory data or medical record review.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥8.0% or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

HbA1c Control <7% for a Selected Population

The *most recent* HbA1c level (performed during the measurement year) is <7.0% as identified by automated laboratory data or medical record review.

Note: *This indicator uses the eligible population with additional eligible population criteria (i.e., removing members with comorbid conditions).*

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <7.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥7.0% or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Eye Exam

Screening or monitoring for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.
- Bilateral eye enucleation anytime during the member's history through December 31 of the measurement year.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.

- A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
- Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).
  – Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

Medical Attention for Nephropathy

A nephropathy screening or monitoring test during the measurement year ***or*** evidence of nephropathy during the measurement year, as documented through either administrative data or medical record review.

Note: *A process flow diagram is included at the end of this specification to help implement this measure.*

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

Any of the following meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy.

- A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet the criteria:
  – 24-hour urine for albumin or protein.
  – Timed urine for albumin or protein.
  – Spot urine (e.g., urine dipstick or test strip) for albumin or protein.
  – Urine for albumin/creatinine ratio.
  – 24-hour urine for total protein.
  – Random urine for protein/creatinine ratio.
- Documentation of a visit to a nephrologist.
- Documentation of a renal transplant.
- Documentation of medical attention for any of the following (no restriction on provider type):
  – Diabetic nephropathy.
  – ESRD.
  – Chronic renal failure (CRF).
  – Chronic kidney disease (CKD).
  – Renal insufficiency.
  – Proteinuria.
  – Albuminuria.
  – Renal dysfunction.
  – Acute renal failure (ARF).

- Dialysis, hemodialysis or peritoneal dialysis.

- Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include evidence that the member received ACE inhibitor/ARB therapy during the measurement year. Any of the following meet criteria:
  - Documentation that a prescription for an ACE inhibitor/ARB was written during the measurement year.
  - Documentation that a prescription for an ACE inhibitor/ARB was filled during the measurement year.
  - Documentation that the member took an ACE inhibitor/ARB during the measurement year.

BP Control <140/90 mm Hg The *most recent* BP level (taken during the measurement year) is <140/90 mm Hg, as documented through administrative data or medical record review.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record The organization should use the medical record from which it abstracts data for the other CDC indicators. If the organization does not abstract for other indicators, it should use the medical record of the provider that manages the member's diabetes. If that medical record does not contain a BP, the organization may use the medical record of another PCP or specialist from whom the member receives care.

To determine if BP is adequately controlled, the organization must identify the representative BP following the steps below.

Step 1 Identify the most recent BP reading noted during the measurement year. Do not include BP readings that meet the following criteria:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.
- Reported by or taken by the member.

Step 2 Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading when multiple readings are recorded for a single date.

The member is not numerator compliant if the BP does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (i.e., the systolic or diastolic level is missing).

Exclusions *(optional)*

Refer to *Administrative Specification* for exclusion criteria. Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year, ***and*** who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

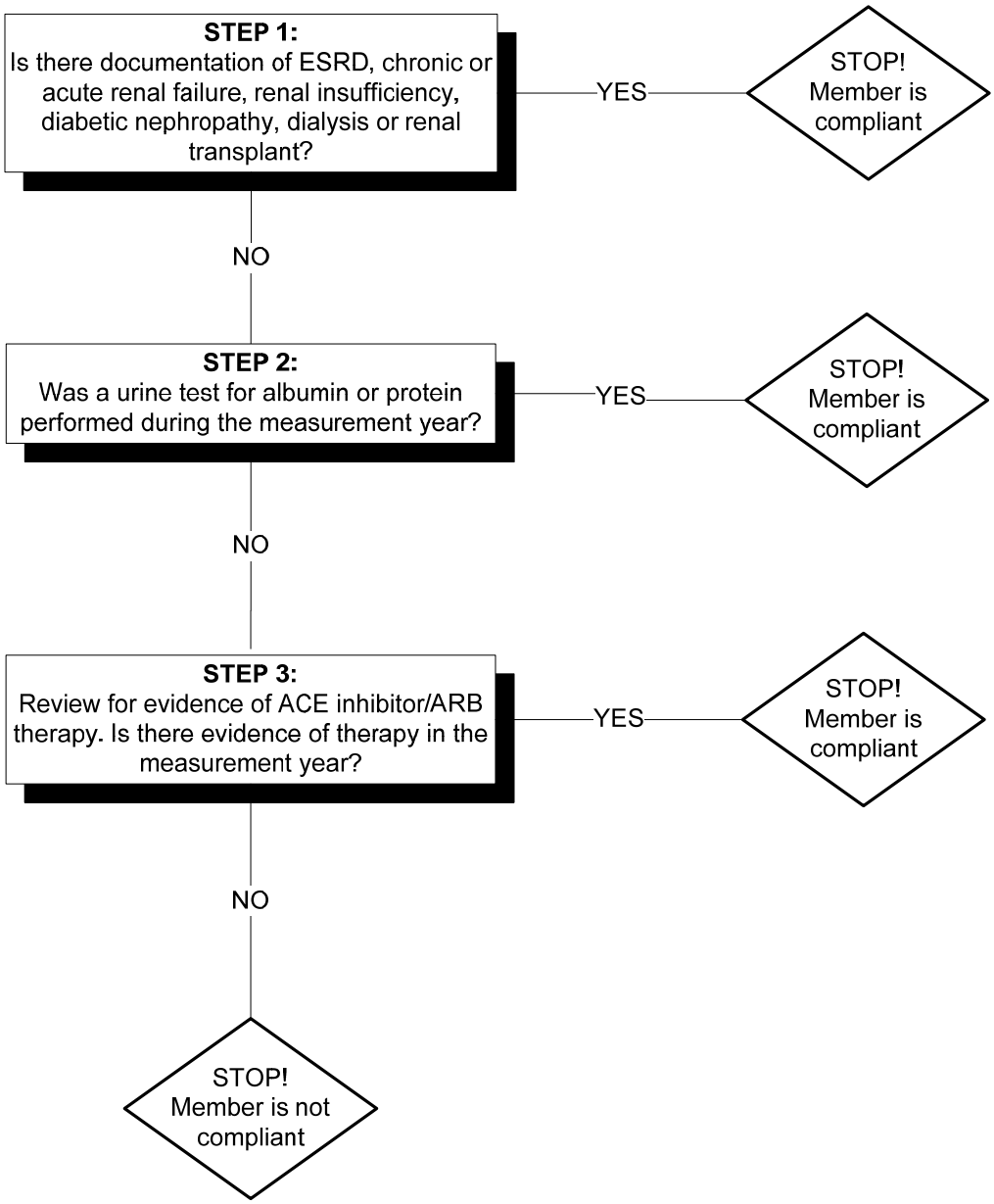
Note

- *Organizations may select a data collection method (Administrative vs. Hybrid) at the indicator level, but the method used for HbA1c testing and control rates must be consistent.*
- *Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.*
- *To facilitate HEDIS reporting the denominator for all rates (with the exception of the HbA1c Control (<7.0%) for a Selected Population must be the same. While an eye exam is not possible, services measured in the other indicators are important for members with bilateral eye enucleation. For these reasons bilateral eye enucleation is considered a numerator hit (rather than an optional exclusion).*
- *Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting the Eye Exam indicator; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of the Eye Exam indicator is to ensure that members with evidence of any type of retinopathy have an eye exam annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.*
- *If a combination of administrative, supplemental or hybrid data are used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.*
- *If an organization chooses to apply the optional exclusions, members must be numerator negative for at least one indicator, with the exception of HbA1c Poor Control (>9%). Remove members from the eligible population who are numerator negative for any indicator (other than for HbA1c Poor Control [>9%]) and substitute members from the oversample. Do not exclude members who are numerator compliant for all indicators except HbA1c Poor Control (>9%), because a lower rate indicates better performance for this indicator.*
- *When excluding BP readings from the BP Control <140/90 mm Hg indicator, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet or a change in medication. For example (this list is just for reference, and is not exhaustive):*
  - *A colonoscopy requires a change in diet (NPO on the day of procedure) and a medication change (a medication is taken to prep the colon).*
  - *Dialysis, infusions and chemotherapy are all therapeutic procedures that require a medication regimen.*
  - *A nebulizer treatment with albuterol is considered a therapeutic procedure that requires a medication regimen (the albuterol).*
  - *Injection of lidocaine prior to mole removal is considered a diagnostic procedure (if the mole is being tested) or a therapeutic procedure (if removal of the mole is the treatment) that requires a change in medication (lidocaine administered for pain control during the procedure).*

  A patient forgetting to take regular medications on the day of the procedure is not considered a required change in medication, and therefore the BP reading is eligible.

- *BP readings taken on the same day that the patient receives a common low-intensity or preventive procedure are eligible for use. For example, the following procedures are considered common low-intensity or preventive procedures (this list is just for reference, and is not exhaustive):*
  - *Vaccinations.*
  - *Injections (e.g., allergy, vitamin B-12, insulin, steroid, toradol, Depo-Provera, testosterone).*
  - *TB test.*
  - *IUD insertion.*
  - *Eye exam with dilating agents.*

Monitoring for Diabetic Nephropathy



Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CDC-1/2/3: Data Elements for Comprehensive Diabetes Care

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	*Each of the 7 rates*	*Each of the 7 rates*
Eligible population with required exclusions applied	*Each of the 7 rates*	*Each of the 7 rates*
Number of numerator events by administrative data in eligible population (before optional exclusions)		*Each of the 7 rates*
Current year's administrative rate (before optional exclusions)		*Each of the 7 rates*
Minimum required sample size (MRSS)		*Each of the 7 rates*
Oversampling rate		*Each of the 7 rates*
Number of oversample records		*Each of the 7 rates*
Number of numerator events by administrative data in MRSS		*Each of the 7 rates*
Administrative rate on MRSS		*Each of the 7 rates*
Number of original sample records excluded because of valid data errors		*Each of the 7 rates*
Number of optional administrative data records excluded		*Each of the 7 rates*
Number of optional medical records excluded		*Each of the 7 rates*
Number of employee/dependent medical records excluded		*Each of the 7 rates*
Number of HbA1c <7 required medical records excluded		*HbA1c <7 Rate*
Number of HbA1c <7 required administrative data records excluded		*HbA1c <7 Rate*
Records added from the oversample list		*Each of the 7 rates*
Denominator		*Each of the 7 rates*
Numerator events by administrative data	*Each of the 7 rates*	*Each of the 7 rates*
Numerator events by medical records		*Each of the 7 rates*
Numerator events by supplemental data	*Each of the 7 rates*	*Each of the 7 rates*
Reported rate	*Each of the 7 rates*	*Each of the 7 rates*
Lower 95% confidence interval	*Each of the 7 rates*	*Each of the 7 rates*
Upper 95% confidence interval	*Each of the 7 rates*	*Each of the 7 rates*

APPENDIX B

Plan All-Cause Readmissions (PCR)

SUMMARY OF CHANGES TO HEDIS 2018

- Added the Medicaid product line.
- Replaced all references to "Average Adjusted Probability of Readmission" with "Expected Readmissions Rate."
- Clarified the definition of "direct transfer": when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less.
- Clarified in step 2 of the denominator (acute-to-acute direct transfers) that stays are excluded if the direct transfer's discharge date is after December 1 of the measurement year.
- Clarified that the pregnancy required exclusion in step 4 of the denominator and step 3 of the numerator should be applied to female members.
- Added instructions to calculate the expected count of readmissions in step 6 of the Risk Adjustment Weighting.
- Added a note to step 3 of the numerator.
- Added a *Note* section.
- Added Count of Expected 30-day Readmissions as a data element to Table PCR-1 and Table PCR 2/3.

Description

For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator).
2. Count of 30-Day Readmissions (numerator).
3. Expected Readmissions Rate.

Note: *For commercial and Medicaid, report only members 18–64 years of age.*

Definitions

IHS	Index hospital stay. An acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.

Planned Hospital Stay	A hospital stay is considered planned if it meets criteria as described in step 5 (required exclusions) of the *Eligible Population*.

Members with High Frequency of Index Hospital Stays Medicaid members with four or more index hospital stays on or between January 1 and December 1 of the measurement year.

Classification Period 365 days prior to and including an Index Discharge Date.

Risk Adjustment Tables

Table	Table Description
HCC-Surg	Surgery codes for Risk Adjustment Determination
PCR-DischCC	Discharge Clinical Condition category codes for Risk Adjustment Determination
CC-Comorbid	Comorbid Clinical Condition category codes for Risk Adjustment Determination step 2
HCC–Rank	HCC rankings for Risk Adjustment Determination step 3
HCC-Comb	Combination HCCs for Risk Adjustment Determination step 5
PCR-MA-DischCC-Weight-Under65	MA and SNP primary discharge weights for Risk Adjustment Weighting step 2 for ages under 65
PCR-MA-DischCC-Weight-65plus	MA and SNP primary discharge weights for Risk Adjustment Weighting step 2 for ages 65 and older
PCR-Comm-DischCC-Weight	Commercial primary discharge weights for Risk Adjustment Weighting step 2
PCR-MD-DischCC-Weight	Medicaid primary discharge weights for Risk Adjustment Weighting step 2
PCR-MA-ComorbHCC-Weight-Under65	MA and SNP comorbidity weights for Risk Adjustment Weighting step 3 for ages under 65
PCR-MA-ComorbHCC-Weight-65plus	MA and SNP comorbidity weights for Risk Adjustment Weighting step 3 for ages 65 and older
PCR-Comm-ComorbHCC-Weight	Commercial comorbidity weights for Risk Adjustment Weighting step 3
PCR-MD-ComorbHCC-Weight-	Medicaid comorbidity weights for Risk Adjustment Weighting step 3
PCR-MA-OtherWeights-Under65	MA and SNP base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5 for ages under 65
PCR-MA-OtherWeights-65plus	MA and SNP base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5 for ages 65 and older
PCR-Comm-OtherWeights	Commercial base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5
PCR-MD-OtherWeights	Medicaid base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5

Note: *The risk adjustment tables will be released on November 1, 2017, and posted to www.ncqa.org.*

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 20: Members in Hospice.*

Product line Commercial, Medicare, Medicaid (report each product line separately).

For only Medicaid, report the following stratifications and total for each age category:

- Members with 1-3 Index Hospital Stays.
- Members with 4+ Index Hospital Stays.
- Total.

Ages	*For commercial,* ages 18–64 as of the Index Discharge Date. *For Medicare,* ages 18 and older as of the Index Discharge Date. *For Medicaid, 18–64 years as of the Index Discharge Date.*
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Anchor date	Index Discharge Date.
Benefit	Medical.
Event/ diagnosis	An acute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all acute inpatient discharges for members who had one or more discharges on or between January 1 and December 1 of the measurement year. Follow the steps below to identify acute inpatient stays.

Administrative Specification

Denominator The eligible population.

Step 1 Identify all acute inpatient discharges on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays.

The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).

Step 2 ***Acute-to-acute direct transfers:*** Keep the original admission date as the Index Admission Date, but use the direct transfer's discharge date as the Index Discharge Date.

A **direct transfer** is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify acute-to-acute direct transfers:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission and discharge dates for the stay.

Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the measurement year.

Step 3 Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4: Required exclusions Exclude hospital stays for the following reasons:

- The member died during the stay.
- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Note: *For hospital stays where there was an acute-to-acute direct transfer (identified in step 2), use both the original stay and the direct transfer stay to identify exclusions in this step.*

Step 5: Required exclusions For all acute inpatient discharges identified using steps 1–4, determine if there was a planned hospital stay within 30 days after the acute inpatient discharge. To identify planned hospital stays: identify all acute inpatient discharges on or between January 3 and December 31 of the measurement year:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.
4. Exclude any hospital stay as an Index Hospital Stay if the admission date of the ***first*** stay within 30 days meets any of the following criteria:
   - A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set).
   - A principal diagnosis of rehabilitation (Rehabilitation Value Set).
   - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set).
   - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

Note: *For hospital stays where there was an acute-to-acute direct transfer (identified in step 2), use only the original stay to identify planned hospital stays in this step (i.e., do not use diagnoses and procedures from the direct transfer stay).*

Example 1 For a member with the following acute inpatient stays, exclude stay 1 as an Index Hospital Stay.

- *Stay 1 (January 30–February 1 of the measurement year)*: Acute inpatient discharge with a principal diagnosis of COPD.
- *Stay 2 (February 5–7 of the measurement year)*: Acute inpatient discharge with a principal diagnosis of maintenance chemotherapy.

Example 2 For a member with the following acute inpatient stays, exclude stays 2 and 3 as Index Hospital Stays in the following scenario.

- *Stay 1 (January 15–17 of the measurement year):* Acute inpatient discharge with a principal diagnosis of diabetes.
- *Stay 2 (January 30–February 1 of the measurement year):* Acute inpatient discharge with a principal diagnosis of COPD.
- *Stay 3 (February 5–7 of the measurement year):* Acute inpatient discharge with an organ transplant.
- *Stay 4 (February 10–15 of the measurement year):* Acute inpatient discharge with a principal diagnosis of rehabilitation.

Step 6 Calculate continuous enrollment.

Step 7 Assign each acute inpatient stay to an age and stratification category using the *Reporting: Denominator* section. Refer to Table PCR-1, and Table PCR-2/3.

Risk Adjustment Determination

For each IHS, use the following steps to identify risk adjustment categories based on presence of surgeries, discharge condition, comorbidity, age and gender.

Surgeries Determine if the member underwent surgery during the inpatient stay. Download the list of codes from the NCQA website (Table HCC-Surg) and use it to identify surgeries. Consider an IHS to include a surgery if at least one procedure code in Table HCC-Surg is present from any provider between the admission and discharge dates.

Discharge Condition Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its primary discharge diagnosis, using Table PCR-DischCC. For acute-to-acute direct transfers, use the direct transfer's primary discharge diagnosis.

Exclude diagnoses that cannot be mapped to Table PCR-DischCC.

Comorbidities Refer to the *Utilization Risk Adjustment Determination* in the *Guidelines for Risk Adjusted Utilization Measures.*

Risk Adjustment Weighting

For each IHS, use the following steps to identify risk adjustment weights based on presence of surgeries, discharge condition, comorbidity, age and gender.

Note: *The final weights table will be released on November 1, 2017.*

Step 1 For each IHS with a surgery, link the surgery weight.

- *For Medicare product lines ages 18–64:* Use Table PCR-MA-OtherWeights-Under65.
- *For Medicare product lines ages 65 and older:* Use Table PCR-MA-OtherWeights-65plus.
- *For commercial product lines:* Use Table PCR-Comm-OtherWeights.
- *For Medicaid product lines:* Use Table PCR-Medicaid-OtherWeights.

Step 2 For each IHS with a discharge CC Category, link the primary discharge weights.

- *For Medicare product lines ages 18-64:* Use Table PCR-MA-DischCC-Weight-Under65.
- *For Medicare product lines ages 65 and older:* Use Table PCR-MA-DischCC-Weight-65plus.
- *For commercial product lines:* Use Table PCR-Comm-DischCC-Weight.
- *For Medicaid product lines:* Use Table PCR-Medicaid-DischCC-Weight.

Step 3 For each IHS with a comorbidity HCC Category, link the weights.

- *For Medicare product lines ages 18–64:* Use Table PCR-MA-ComorbHCC-Weight-Under65.
- *For Medicare product lines ages 65 and older:* Use Table PCR-MA-ComorbHCC-Weight-65plus.
- *For commercial product lines:* Use Table PCR-Comm-ComorbHCC-Weight.
- *For Medicaid product lines:* Use Table PCR-Medicaid-ComorbHCC-Weight.

Step 4 Link the age and gender weights for each IHS.

- *For Medicare product lines ages 18–64:* Use Table PCR-MA-OtherWeights-Under65.
- *For Medicare product lines ages 65 and older:* Use Table PCR-MA-OtherWeights-65plus.
- *For commercial product lines:* Use Table PCR-Comm-OtherWeights.
- *For Medicaid product lines:* Use Table PCR-Medicaid-OtherWeights.

Step 5 Identify the base risk weight.

- *For Medicare product lines ages 18–64:* Use Table PCR-MA-OtherWeights-Under65.
- *For Medicare product lines ages 65 and older:* Use Table PCR-MA-OtherWeights-65plus.
- *For commercial product lines:* Use Table PCR-Comm-OtherWeights to determine the base risk weight.
- *For Medicaid product lines:* Use Table PCR-Medicaid-OtherWeights to determine the base risk weight.

Step 6 Sum all weights associated with the IHS (i.e., presence of surgery, primary discharge diagnosis, comorbidities, age, gender and base risk weight).

Expected count of readmissions. Report the final expected count of readmissions for each age using the sum of all weights for each IHS from step 6. Round to four decimal places using the 0.5 rule and enter these values into the reporting table.

Expected count of readmissions = $e^{(\sum \text{WeightsForIHS})}$

Step 7 Use the formula below to calculate the Expected Readmissions Rate based on the sum of the weights for each IHS.

Expected Readmissions Rate = $\frac{e^{(\sum \text{WeightsForIHS})}}{1+e^{(\sum \text{WeightsForIHS})}}$

OR

Expected Readmissions Rate = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)]

Note: *"Exp" refers to the exponential or antilog function.*

Step 8 Use the formula below and the Expected Readmissions Rate calculated in step 7 to calculate the variance for each IHS.

Variance = Expected Readmissions Rate x (1 – Expected Readmissions Rate)

Example: If the Expected Readmissions Rate is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881476.

Note: *The variance is calculated at the IHS level. Organizations must sum the variances for each cohort and age when populating the Total Variance cells in the reporting tables.*

Sample Table: PCR—Risk Adjustment Weighting

Member ID*	Admiss. Counter	Base Risk Weight	Age	Gender	Age and Gender Weight	Surgical Weight	ICD-9 Diagnosis Code	Discharge CC		HCC-PCR		Sum of Weights	Expected Readmission Count	Expected Readmission Rate	Variance
								Category	Weight	Category	Weight				
1250	1	-1.08883	67	Female	0.1000	-0.2800	250.4	15	0.0700	20 25	0.1400 0.2000	-0.8600	0.4232	0.2976	0.2090
4010	1	-1.08883	50	Male	0.1200	NA	007.4	5	0.0300	NA	NA	-0.9400	0.3906	0.2811	0.2021
4010	2	-1.08883	50	Male	0.1200	NA	298.00	77	0.0600	5	0.0100	-0.5700	0.5655	0.3615	0.2308

*Each Member ID field with a value represents a unique IHS.

Numerator At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1 Identify all acute inpatient stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient admissions:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays. If an organization consolidates these stays into a single event (for any reason), the original distinct inpatient stays must be used.

Step 2 ***Acute-to-acute direct transfers:*** Keep the original admission date as the Index Admission Date, but use the direct transfer's discharge date as the Index Discharge Date.

A **direct transfer** is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify acute-to-acute direct transfers:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission and discharge dates for the stay.

Step 3 Exclude acute inpatient hospital admissions for female members with a principal diagnosis of pregnancy (Pregnancy Value Set) or a principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).

Note: *For hospital stays where there was an acute-to-acute direct transfer (identified in step 2), use both the original stay and the direct transfer stay to identify exclusions in this step.*

Step 4 For each IHS, determine if any of the acute inpatient stays have an admission date within 30 days after the Index Discharge Date.

Reporting: Denominator

Count the number of IHS' for each age and enter these values into the reporting table.

Reporting: Stratification (Medicaid only)

Step 1 Determine the member's number of index hospital stays in only the Medicaid product line. Report Medicaid index hospital stays for members in one of these categories:

- Member had 1-3 index hospital stays attributed to Medicaid.
- Member had 4+ index hospital stays attributed to Medicaid.

Step 2 Report Medicaid discharges based on the member's high frequency hospitalization status for each Medicaid index hospital stay.

Reporting: Risk Adjustment

Step 1 Calculate the expected readmissions rate for each IHS for each stratification (Medicaid only), each age group and the overall total.

Organizations must calculate the probability of readmission for each hospital stay within the applicable stratification and age group to calculate the average (which is reported to NCQA).

Step 2 Round to four decimal places using the .5 rule and enter these values into the reporting table.

Note: *Do not take the average of the cells in the reporting table.*

Example

- For commercial and Medicare:
  - Identify all IHS by 18–44 year-olds and calculate the expected readmissions rate.
  - Identify all IHS by 44–54 year-olds and calculate the expected readmissions rate.
  - Identify all IHS by all 55–64 year-olds and calculate the expected readmissions rate.
- For Medicaid, in the first stratification (members with 1-3 index hospital stays per year):
  - Identify all IHS by 18–44 year-olds and calculate the expected readmissions rate.
  - Identify all IHS by 44–54 year-olds and calculate the expected readmissions rate.
  - Identify all IHS by all 55–64 year-olds and calculate the expected readmissions rate.

Repeat for each subsequent stratification and age group.

Step 3 Calculate the total (sum) variance for each stratification (Medicaid only) and age.

Step 4 Round to four decimal places using the .5 rule and enter these values into the reporting table.

Reporting: Numerator

Count the number of observed IHS with a readmission within 30 days for each age and enter these values into the reporting table.

Reporting: Count of Expected Readmissions

Count the number of expected IHS with a readmission within 30 days for each age and enter these values into the reporting table.

Note

- *Because supplemental data may not be used to identify the eligible population, and the same events are used for the denominator and numerator, supplemental data may not be used for this measure.*

Table PCR-1: Plan All-Cause Readmissions Rates by Stratum (High Frequency Hospitalization) and Age (Medicaid, 18-64)

Stratum	Age	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Observed Readmission Rate(Num/Den)	Count of Expected 30-Day Readmissions	Expected Readmissions Rate (Expected Readmissions/Den)	Total Variance	O/E Ratio (Observed Readmissions/ Expected Readmissions)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
Index Stays for people with 1-3 Index Stays per Year	18-44									
Index Stays for people with 1-3 Index Stays per Year	45-54									
Index Stays for people with 1-3 Index Stays per Year	55-64									
Total, Index Stays for people with 1-3 Index Stays per Year	*Total*									
Index Stays for people with 4+ Index Stays per Year	18-44									
Index Stays for peopl	45-54									

Stratum	Age	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Observed Readmission Rate(Num/Den)	Count of Expected 30-Day Readmissions	Expected Readmissions Rate (Expected Readmissions/Den)	Total Variance	O/E Ratio (Observed Readmissions/ Expected Readmissions)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
e with 4+ Index Stays per Year										
Index Stays for people with 4+ Index Stays per Year Disability	55-64									
Total, Index Stays for people with 4+ Index Stays per Year Disability	Total									
Total	18-44									
Total	45-54									
Total	55-64									
Total	Total									

Table PCR-A-2/3: Plan All-Cause Readmissions Rates by Age and Risk Adjustment (commercial and Medicare)

Age	Count of Index Stays (Denominator)	Count of Observed 30-Day Readmissions (Numerator)	Observed Readmissions Rate (Num/Den)	Count of Expected 30-Day Readmissions	Expected Readmissions Rate (Expected Readmissions /Den)	Total Variance (O/E)	O/E Ratio (Observed Readmissions/Expected Readmissions)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
18-44									
45-54									
55-64									
Total									

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Health Homes Program**	**Policy No.:**	QI.28
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	× Medi-Cal	□ Healthy Kids	□ CMC

I. Purpose

The Health Homes Program (HHP) offers coordinated care to individuals with multiple chronic health conditions, including mental health, substance use disorders and those experiencing homelessness. The HHP is a team-based clinical approach that includes the member, their providers, and family members (when appropriate). The HHP builds linkages to community supports and resources, as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses.

The Medi-Cal HHP offers comprehensive, high quality health care for eligible Santa Clara Family Health (SCFHP) Plan Medi-Cal members. The purpose of this policy is to identify all of the HHP requirements for SCFHP and selected Community-Based Care Management Entities (CB-CMEs). SCFHP will work with selected CB-CMEs to facilitate care planning, care coordination, care transitions, and housing navigation services. SCFHP will utilize communication and reporting capabilities to perform health promotion, encounter reporting, and quality of care reporting. Selected CB-CMEs will serve as the community-based entity with responsibilities that will ensure members receive access to HHP services.

II. Policy

SCFHP will be responsible for the overall administration of the HHP. SCFHP will have oversight of the CB-CMEs and their performance. CB-CMEs will provide all members with access to the same level of HHP service, in accordance with the tier/risk grouping that is appropriate for members' needs and HHP service requirements. SCFHP will perform regular auditing and monitoring activities to ensure that all HHP services are delivered according to the contract signed by the selected CB-CMEs and SCFHP. SCFHP will select and assess the readiness of community organizations to serve as CB-CMEs. Selected entities will need to provide all core services of the HHP, including:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports
- Housing Navigation

I. SCFHP Responsibilities:

a. Maintain the HHP infrastructure with contracted CB-CMEs and ensure that the roles and division of responsibility between the CB-CME and SCFHP are clearly identified
b. Ensure that the CB-CME has the capacity to provide assigned HHP members with a multi-disciplinary care team

i. SCFHP will encourage participation of member care team members who are not on the multi-disciplinary care team (such as a member's PCP or Specialist)

c. Share information with CB-CMEs to assist with identifying patients and providing HHP services; data sharing agreements will be established with selected CB-CMEs and SCFHP:
   i. SCFHP will notify CB-CME of inpatient admissions and ED visits/discharges
   ii. SCFHP will share each member's health history with assigned CB-CMEs
   iii. Data will be exchanged between CB-CME and SCFHP to better track CMS-required quality measures and state-specific measures, including health status and outcomes data for the DHCS evaluation process

d. Identify, review and prioritize HHP eligible members by tier/risk grouping and assign members to CB-CMEs
   i. Identify members through the DHCS-provided Targeted Engagement List (TEL), internal TEL, and member/provider referrals
   ii. Group members according to a tier structure, which should correlate with the member's risk grouping and intensity of services needed

e. Reduce the duplication of services to the member by verifying eligible members' involvement in other case management programs (e.g., Whole Person Care)

f. Develop CB-CME training tools as needed, as well as coordinate trainings to strengthen skills for CB-CMEs in conjunction with HHP

g. Develop and administer payment structure for CB-CMEs
   i. Payment structure may consider the payments received from DHCS, member's tier/risk grouping and any other supplemental funding

h. Prepare SCFHP's Customer Service, Nurse Advice Line, and other staff as necessary to ensure HHP members' needs can be addressed

II. **CB-CME Responsibilities**

a. CB-CMEs retain overall responsibility for all duties that the CB-CME has agreed to perform for SCFHP, as defined in the contract between the CB-CME and SCFHP
   i. CB-CME will perform all seven core services to the HHP-eligible member, as defined in the DHCS HHP Program Guide

b. Complete a readiness assessment as developed by SCFHP
   i. If services are insufficient, CB-CME will work with SCFHP to fulfill the readiness gaps prior to enrolling members

c. Ensure that providers with experience servicing frequent utilizers of health services and those experiencing homelessness, are available as needed per AB 361 requirements

d. Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate

e. Ensure assigned HHP members receive access to HHP services including completing a patient-centered health action plan (HAP) within 90 days of enrollment
   i. Maintain a strong and direct connection to the PCP and ensure PCP's participation in HAP development and ongoing coordination
   ii. Assess the HHP member's physical, behavioral, substance use, palliative, trauma-informed care, and social services need using screenings and assessments with standardized tools

f. Maintain a multi-disciplinary care team to provide outreach and enrollment
   i. CB-CME will utilize assigned member lists provided by SCFHP to complete outreach and enrollment
   ii. Ensure needs are met based on the member's HAP and the tiered structure outlined by SCFHP

g. Utilize existing health information technology (HIT) to collect and share data to SCFHP
   i. If CB-CME does not have adequate technology, CB-CME will work with SCFHP to determine how information will be shared for HHP services and reporting purposes

h. CB-CME will attend required trainings for the HHP
i. CB-CME may utilize community health workers to conduct outreach and other services as appropriate

I. References

- Department of Health Care Services. (2018). *Medi-Cal Health Homes Program-Program Guide.* Sacramento, CA
- Department of Health Care Services. (2018). *All Plan Letter 18-012.* Sacramento, CA: Managed Care Quality and Monitoring Division.
- Legislative Counsel's Digest. (2013). *AB-361 Medi-Cal: Health Homes for Medi-Cal Enrollees and Section 1115 Waiver Demonstration Population with Chronic and Complex Conditions.* Sacramento, CA: Marjorie Swartz.

II. 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	Quality Improvement Committee		

Santa Clara Family Health Plan™

Assessment of Provider Network Adequacy 2018

Prepared by: Carmen Switzer, Provider Network Access Manager

For review and approval by the Quality Improvement Committee

December 5, 2018

Introduction

SCFHP monitors the adequacy of its provider network for access, availability, member experience and also annually reviews and analyzes data to identify opportunities for improvement.

Opportunities to improve provider network adequacy are identified and prioritized based on an evaluation of member experience, availability of providers, accessibility of services and out of network requests for services.

Availability Assessment (NET 1)

The availability assessment showed that time or distance gaps for Geriatric, Clinical Social Workers and Addiction Medicine providers.

Provider Type	Members with Access	Members without Access	% with no Access	Standard	Goal	Met/Not Met
Primary Care Providers						
Geriatrics	**6,753**	**750**	**10%**	10 miles/15 miles or 30 min	100%	Not Met
High Volume Behavioral Health Providers						
Clinical Social Worker	**7,203**	**300**	**4%**	15 miles or 30 min	100%	Not Met
Other Providers						
Addiction Medicine	**7,000**	**503**	**7%**	15 miles or 30 min	100%	Not Met

Accessibility Assessment (NET 2)

The accessibility of network providers were assessed in the NET 2 report. The network accessibility tables in the next few slides will show the provider types that did not meet SCFHP's performance goal of 90% on timely appointment access and after-hours.

I. Primary Care Provider

Provider Type	# Surveyed	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Family Medicine	218	70	48	90%	No	69%	NA	NA
Internal Medicine	260	80	50	90%	No	63%	NA	NA

Standard: Urgent Care

Provider Type	# Surveyed	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Geriatrics	5	1	0	90%	No	0%	NA	NA

Standard: Non-Urgent/Routine Care

After-Hours

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
PCP (N=498)	401	176	90%	No	44%	74%	-30%

Standard: Call back within 30-minutes or less

Accessibility Assessment (NET 2)

II. High Impact and High Volume Specialist

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Cardiology (N=131)	34	24	90%	No	71%	73%	-2%
Oncology (N=73)	16	9	90%	No	56%	New Measure	NA
Gynecology (N=138)	21	17	90%	No	81%	New Measure	NA

Standard: Urgent Care

Provider Group	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Cardiology (N=131)	40	28	90%	No	70%	72%	-2%
Oncology (N=73)	16	8	90%	No	50%	New Measure	NA

Standard: Non-Urgent/Routine Care

Accessibility Assessment (NET 2)

Santa Clara Family Health Plan

III. Behavioral Health

a. Psychiatry-High Volume / Prescribers

Standard	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Initial Routine Visit within 10-days	6	4	90%	No	67%	New Measure	NA
Urgent Care within 48-hours	4	1	90%	No	25%	New Measure	NA
Non-Life Threatening Emergency within 6-hours	6	0	90%	No	0%	New Measure	NA

b. Psychology / Non-Prescribers

Standard	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Non-Life Threatening Emergency within 6-hours	1	0	90%	No	0%	New Measure	NA

c. Non-Physician Mental Health / Non-Prescribers

Standard	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Initial Routine Visit within 10-days	7	3	90%	No	43%	New Measure	NA
Urgent Care within 48-hours	5	4	90%	No	80%	New Measure	NA
Non-Life Threatening Emergency within 6-hours	6	1	90%	No	17%	New Measure	NA

Accessibility Assessment (NET 2)

BEHAVIORAL HEALTH MEMBER SATISFACTION SURVEY

Survey Sample Size

Category	Count
# to Survey	230
# of Respondents	57
# of Non-respondents	173
% Completed	25%

Behavioral Health Survey Results – "Access"

Measures	# Responded	# Always/Usually	Rate of Compliance	Goal	Goal Met
How often did you get an appointment as soon as you wanted? (Q7)	57	48	84%	90%	No
How often did you see someone as you wanted when you needed help right away? (Q8)	57	42	74%	90%	No

Both the Behavioral Health Survey and the CAHPS survey indict members are not getting appointments as quickly as they would like.

Grievance and Appeals

I. Grievances

Member Count = 7503

Grievance Category	Total Grievances	Per 1,000 members	Goal per 1,000 members	Goal Met	Total Grievances	Per 1,000 members	Goal per 1,000 members	Goal Met
	Non-Behavioral Health				Behavioral Health			
Access	18	2.4	5.0	Yes	0	0	5.0	Yes
Billing and Financial (related to network adequacy)	0	0	5.0	Yes	0	0	5.0	Yes
Total	18	2.4	5.0	Yes	0	0	5.0	Yes

Quantitative Analysis: The data showed that there were 18 access grievances on file from June 2017-June 2018 relevant to non-behavioral health providers and there were none for behavioral health providers.

II. Appeals

Member Count = 7503

Appeals Category	Total Appeals	Per 1,000 members	Goal per 1,000 members	Goal Met	Total Appeals	Per 1,000 members	Goal per 1,000 members	Goal Met
	Non-Behavioral Health				Behavioral Health			
Access	5	0.67	5.0	Yes	0	0	5.0	Yes
Billing and Financial (related to network adequacy)	0	0	5.0	Yes	0	0	5.0	Yes
Total	5	0.67	5.0	Yes	0	0	5.0	Yes

Quantitative analysis: The data showed that there were a total of 5 “access” appeals on file from June 2017-June 2018; all of which were pre-service appeals.

Out of Network Requests

SCFHP reviews out-of-network utilization activity on an annual basis to assess Cal-MediConnect members use of out-of-network providers.

Out of Network Data **Member Count = 7503**

Category	Total	Per 1,000 members	Threshold per 1,000 members	Goal Met	Total	Per 1,000 members	Threshold per 1,000 members	Goal Met
	Non-Behavioral Health				Behavioral Health			
Prior Authorizations (PA)	507	67	25	No	17	2	2	Yes
PA's Approved	470	63	25	No	17	2	2	Yes
PA's Denied	37	4	5	Yes	0	0	2	NA

Note: 312 of the out-of-network prior authorization (PA) requests for non-behavioral health services and approvals were for inpatient cases associated with one hospital (Regional Medical Center of San Jose); thus, by subtracting 312 from the PA total of 507, the PA per 1,000 members would be at 26, which is close to meeting SCFHP's threshold of 25 per 1,000 members; and additionally, SCFHP would have met the PA approval threshold at 21.

SCFHP is evaluating the need/consequences of a contractual agreement the Regional Medical Center of San Jose.

Conclusions and Interventions (Non-Behavioral Health):

1. SCFHP's provider network has a shortage of Geriatric providers in the South East area of Santa Clara County. SCFHP will continue to monitor contracting opportunities in this area.

2. The member grievance assessment showed long wait times for Physical Therapy (PT) in the city of San Jose; however, it appears after the Pacific Rim contract was executed on February 1, 2018, where services are offered in the San Jose area, access has improved.

3. The Accessibility of Provider Network analysis showed the provider types that were surveyed on access standards and did not meet the urgent care and/or non-urgent care/routine appointment standards. SCFHP's resurveys providers who were non-complaint with timely appointment standards, and if the provider shows continued non- compliance, they are required to complete SCFHP's training program.

Conclusion and Interventions (Behavioral Health Providers):

The Availability of Provider Network analysis (NET 1) showed that SCFHP's provider network has a shortage of Clinical Social Workers and Addiction Medicine providers in SE area of Santa Clara County. SCFHP has conducted provider outreach efforts in Gilroy and San Martin and there are 3 CSW's that are in the process of contracting with SCFHP.

SCFHP is in the process of identifying Addiction Medicine providers available to join SCFHP's provider network.

The Accessibility of Provider Network analysis (NET 2) showed that prescribing and non-prescribing behavioral health providers appear to have an issue with meeting the "non-life threatening emergency within 6- hours appointment" standard, which was identified through the "access" surveys that were conducted in measurement year 2018.

The resurveys were completed and the providers who showed continued non-compliance were contacted to complete SCFHP's access training program, of which two have successfully completed and the remaining providers are scheduled to complete the program.

SCFHP's goal is to ensure all non-compliant providers complete the access training program by the end of 2018.

OPPORTUNITIES:

Barrier	Opportunity	Intervention	Selected for 2018	Date Initiated
Timely access—PCP urgent appointments within 48-hours Lack of Knowledge of Appointment Access Standards	• Improve access to urgent care appointments	• Improve training materials • Conduct provider outreach(Training)	Yes	In Process
Timely Access—Behavioral Health non-life threatening emergency within 6-hours Lack of Knowledge of Access Standards, Lack of available BH providers	• Increase the number of BH providers within SCFHP's network • Educate BH providers on timely access standards	• Explore contracting opportunities to expand BH network • Improve training materials • Conduct provider outreach (Training)	Yes	In Process
After-Hours Access (return call within 30min or less)	• Improve after- hours access	• Improve training materials • Conduct provider outreach (Training)	Yes	In Process
Lack of Acute Care Facilities in San Jose County	• Increase Acute Care Facilities in San Jose County	• Contract with Regional Medical Center of San Jose County	Yes	In Process
Lack of Specific Providers in rural areas	• Improve Access to members	• Contract with PT provider • Contract with diagnostic center • Contract with eye care • Contract with home health provider	Yes	In Process
Lack of Providers in some rural areas; BH and Medical	• Increase Network providers in rural counties	• Monitor rural counties for additional practitioners	Yes	Ongoing

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee (QIC)		

PARTICIPANTS:

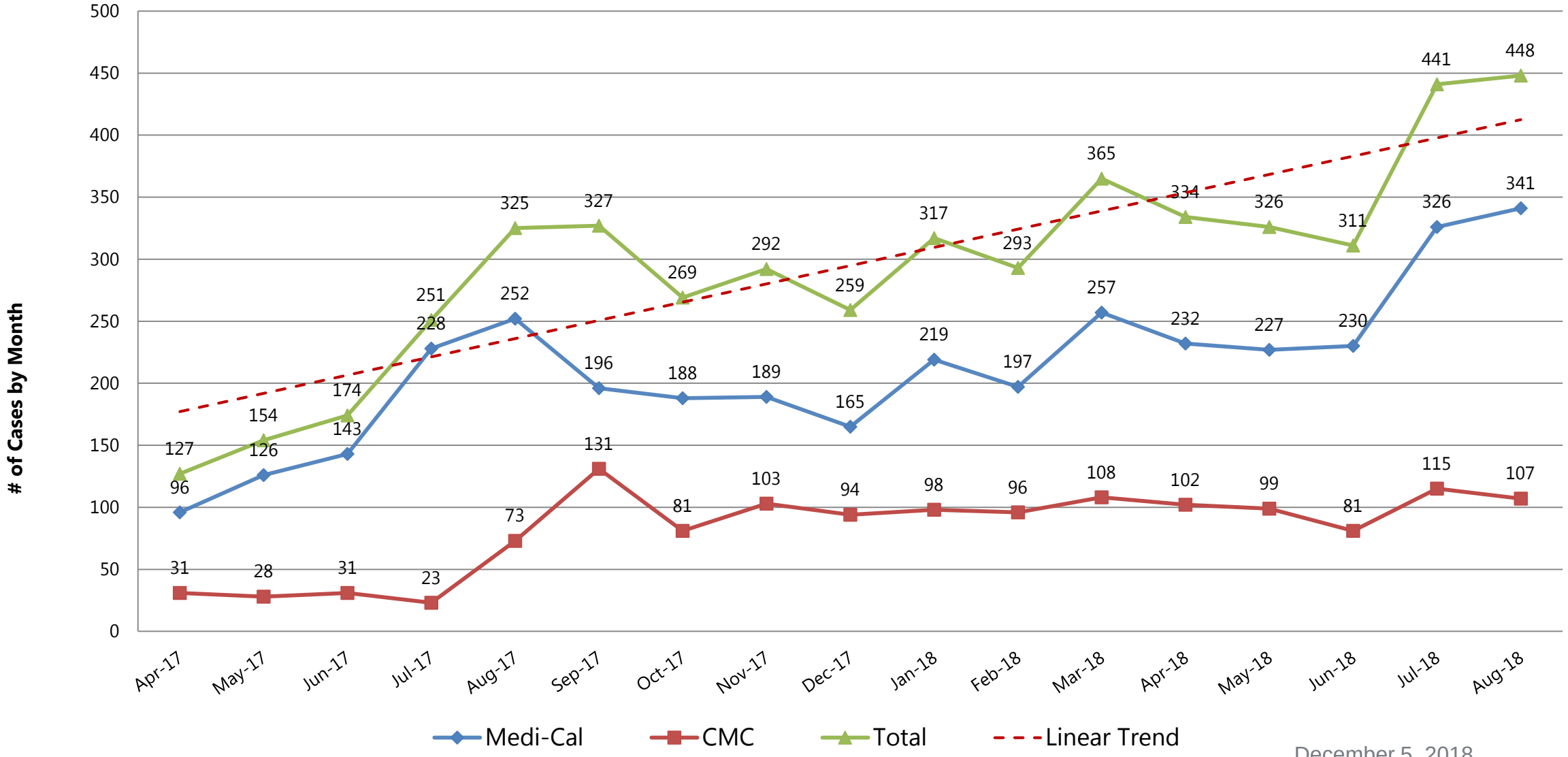
Provider Network Access Manager
Timely Access and Availability Work Group Behavioral Health
Quality Improvement
Grievance and Appeals
Provider Relations
Customer Service
Utilization Management

Santa Clara Family Health Plan™

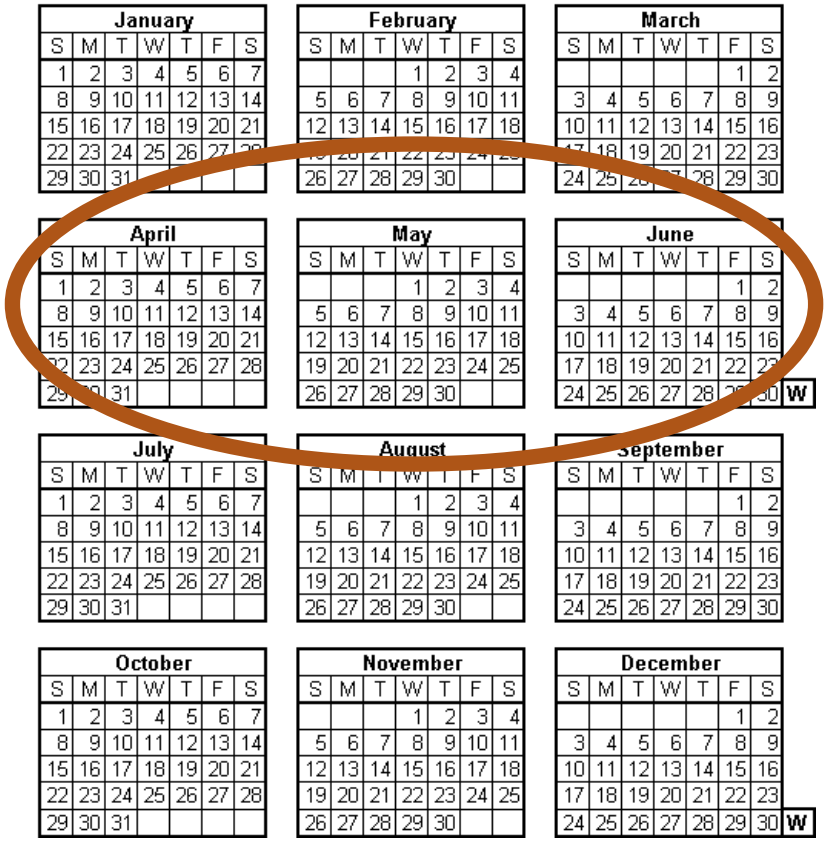
Quality Improvement Committee

Q3 2018 Reporting

G&A Department Caseload



Medi-Cal & Healthy Kids



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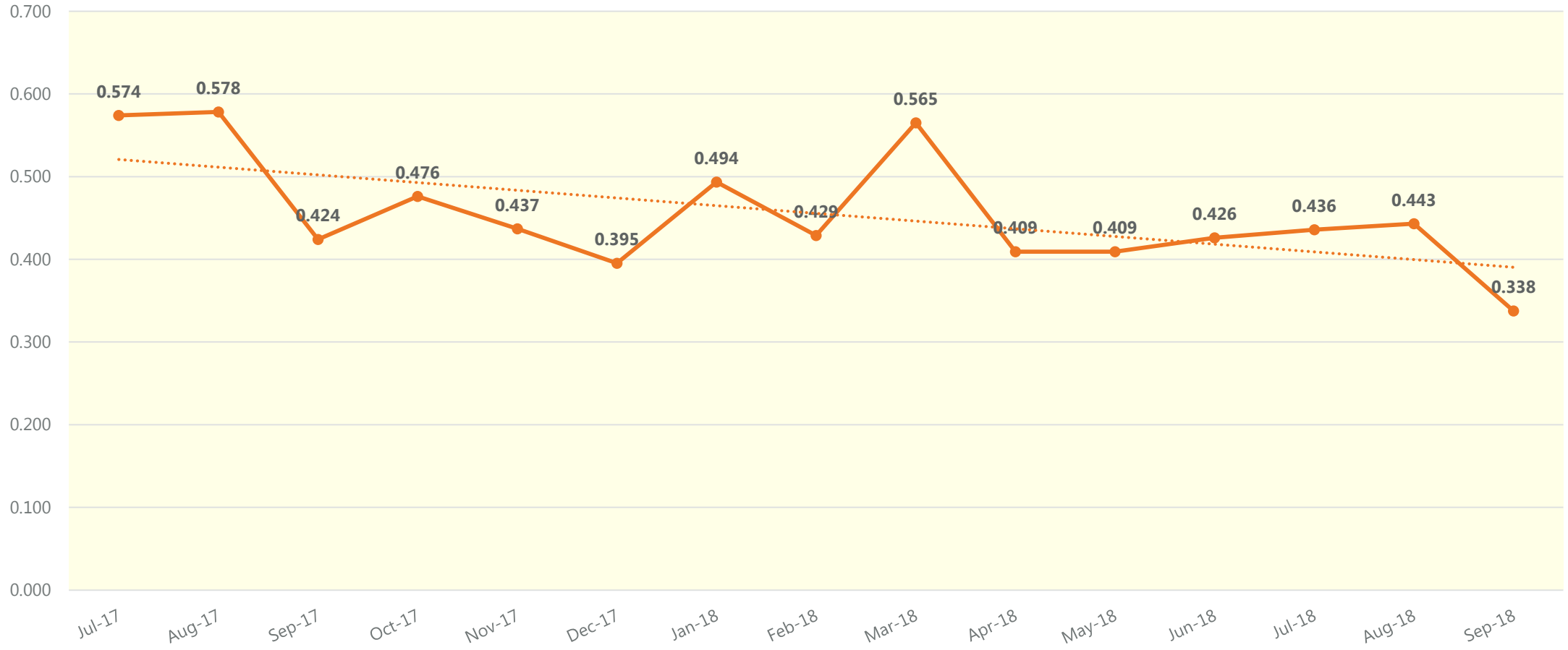
Q3 2018

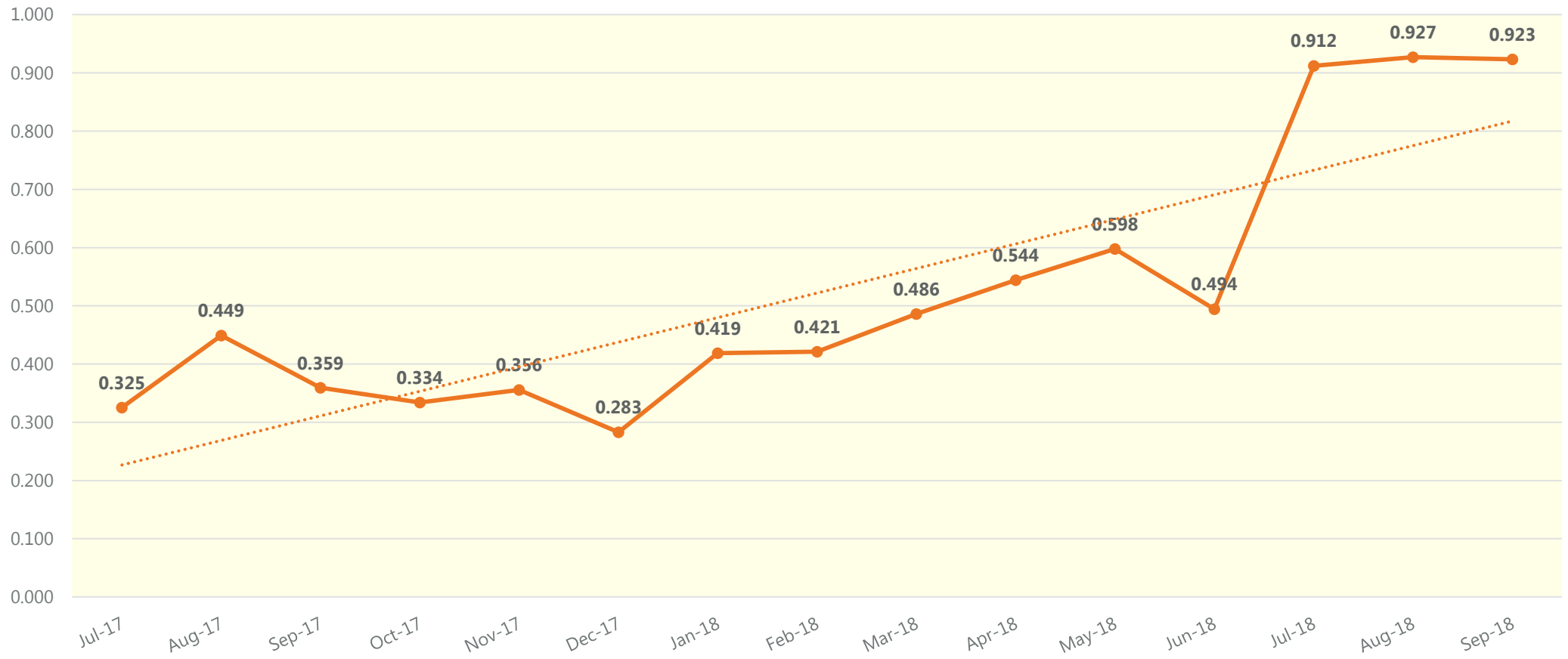
Q3 2017 – Q3 2018: Medi-Cal Appeals

Appeals Per 1000 Members



Q3 2017 – Q3 2018: Medi-Cal Grievances

Grievances Per 1000 Members

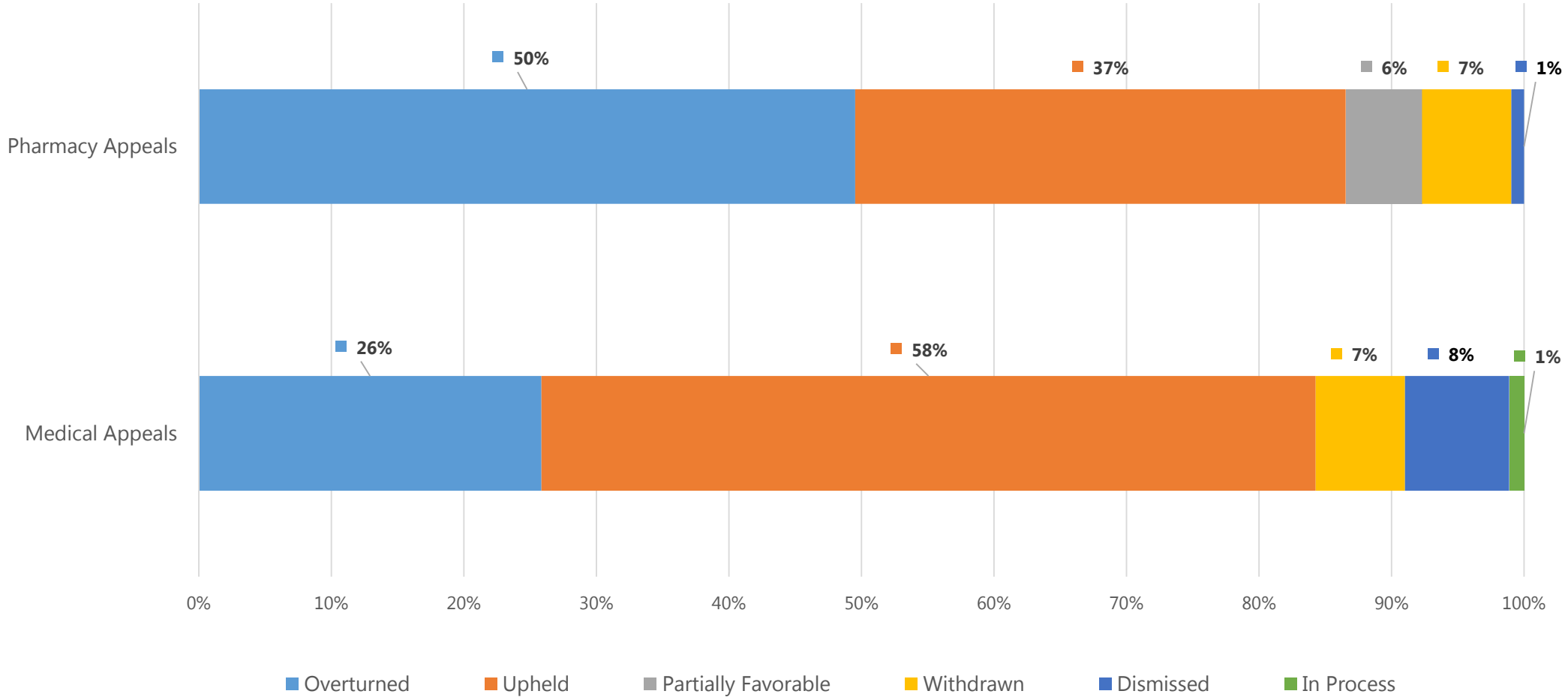


Q3 2017 – Q3 2018: Medi-Cal Rates per 1000

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Total Appeals	150	152	111	124	113	102	125	109	143	103	102	106	108	109	83
Healthy Kids Membership	2,633	2,618	2,243	2,288	2,321	2,447	3,209	3,250	3,415	3,454	3,220	3,196	3,278	3,187	3,163
Medi-Cal Membership	261,287	262,871	261,702	260,518	258,633	258,106	253,257	254,141	253,025	251,680	249,188	248,776	247,755	245,954	245,884
TOTAL Membership	263,920	265,489	263,945	262,806	260,954	260,553	256,466	257,391	256,440	255,134	252,408	251,972	251,033	249,141	249,047
Rate per 1000	**0.574**	**0.578**	**0.424**	**0.476**	**0.437**	**0.395**	**0.494**	**0.429**	**0.565**	**0.409**	**0.409**	**0.426**	**0.436**	**0.443**	**0.338**

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Total Grievances	85	118	94	87	92	73	106	107	123	137	149	123	226	228	227
Healthy Kids Membership	2,633	2,618	2,243	2,288	2,321	2,447	3,209	3,250	3,415	3,454	3,220	3,196	3,278	3,187	3,163
Medi-Cal Membership	261,287	262,871	261,702	260,518	258,633	258,106	253,257	254,141	253,025	251,680	249,188	248,776	247,755	245,954	245,884
TOTAL Membership	263,920	265,489	263,945	262,806	260,954	260,553	256,466	257,391	256,440	255,134	252,408	251,972	251,033	249,141	249,047
Rate per 1000	**0.325**	**0.449**	**0.359**	**0.334**	**0.356**	**0.283**	**0.419**	**0.421**	**0.486**	**0.544**	**0.598**	**0.494**	**0.912**	**0.927**	**0.923**

Q3 2018: Appeals by Determinations



Medi-Cal Timeliness: Standard Appeals

Appeals	Jul-18	Aug-18	Sep-18	Oct-18
Standard Appeals				
# of Standard Appeals received in reporting period	95	91	71	126
# of Standard Appeals resolved in reporting period	98	97	73	82
# of Acknowledgement Letters sent within 5 calendar days	89	87	59	122
% of Acknowledgement Letters sent within 5 calendar days	96.7%	87.9%	93.7%	98.4%
# of Upheld Standard Appeals in reporting period	47	47	41	36
% of Upheld Standard Appeals in reporting period	48.0%	48.5%	56.2%	43.9%
# Overturned Standard Appeals in reporting period	45	42	27	31
% Overturned Standard Appeals in reporting period	45.9%	43.3%	37.0%	37.8%
# of Standard Appeals where SCFHP requested a 14-day extension	2	2	0	0
# of Standard Appeals resolved within 30/44 calendar days	97	93	72	82
% of Standard Appeals resolved within 30/44 calendar days	99.0%	95.9%	98.6%	100.0%
# Withdrawn by Member/Representative or Provider	6	2	2	12
% Withdrawn by Member/Representative or Provider	6.1%	2.0%	2.7%	14.6%

STANDARD: 30 calendar days or as quickly as the member's health condition requires.

Medi-Cal Timeliness: Expedited Appeals

Expedited Appeals	Jul-18	Aug-18	Sep-18	Oct-18
# of Expedited Appeals received in reporting period	14	19	12	18
# of Expedited Appeals resolved in reporting period	14	17	12	16
# of Upheld Expedited Appeals in reporting period	5	4	5	6
% of Upheld Expedited Appeals in reporting period	35.7%	23.5%	41.7%	37.5%
# Overturned Expedited Appeals in reporting period	8	10	6	8
% Overturned Expedited Appeals in reporting period	57.1%	58.8%	50.0%	50.0%
# of Expedited Appeals Withdrawn by Member/Representative or Provider in reporting period	0	2	0	2
% of Expedited Appeals Withdrawn by Member/Representative or Provider in reporting period	0.0%	11.8%	0.0%	12.5%
# of Expedited Appeals downgraded to Standard in reporting period	15	16	11	15
# of Expedited Appeals Resolved within 72 Hours	13	15	9	13
% of Expedited Appeals Resolved within 72 hours	92.9%	88.2%	75.0%	81.3%
# of Expedited Appeals that received Oral Notification within 72 hours	13	12	8	9
% of Expedited Appeals that received Oral Notification within 72 hours	92.9%	80.0%	66.7%	64.3%
# of Expedited Appeals that received Resolution Letters within 72 hours	7	11	7	11
% of Expedited Appeals that received Resolution Letters within 72 hours	50.0%	84.6%	70.0%	73.3%

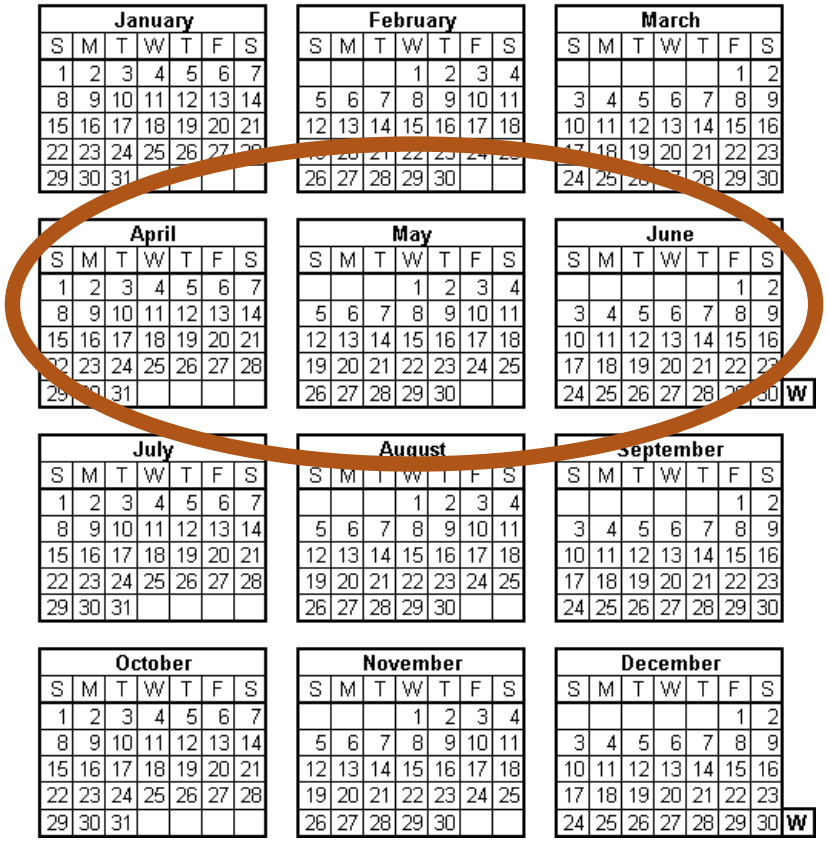
STANDARD: Within **72 hours** from the date that the appeal is received ,or as quickly as the member's health condition requires.

Medi-Cal Timeliness: Grievances

	Jul	Aug	Sept	Oct
Standard Grievances				
# of Grievances received in reporting period	204	220	209	193
# of Grievances resolved in the reporting period	114	238	183	222
# of Exempt Grievances received in reporting period	26	15	28	
# of Exempt Grievances resolved in reporting period	12	6	12	
# of Grievances Referred for PQI	132	131	139	35
# Grievances Withdrawn by Member/Representative	8	28	15	18
# of Grievances related to Access to Care	61	71	58	67
# of Grievances that received an Acknowledgement Letter within 5 Calendar days	183	221	177	215
% of Grievances that received an Acknowledgement Letter within 5 Calendar days	97.4%	92.7%	96.7%	96.9%
# of Grievances resolved within 30 days of receipt	111	228	178	212
% of Grievances resolved within 30 days	96.5%	95.4%	96.2%	94.5%
Expedited Grievances				
# of Expedited Grievances received in reporting period	10	6	8	5
# of Expedited Grievances resolved in reporting period	8	5	6	5
# of Expedited Grievances resolved within 72 hours	8	2	3	2
% of Expedited Grievances resolved within 72 hours	100.0%	33.3%	42.9%	28.6%
# of Expedited Grievances that received Oral Notification within 72 hours	8	5	5	3
% of Expedited Grievances that received Oral Notification within 72 hours	100.0%	83.3%	71.4%	60.0%
# of Expedited Grievances that received Resolution Letters within 72 hours	7	2	4	2
% of Expedited Grievances that received Resolution Letters within 72 hours	87.5%	33.3%	57.1%	28.6%

STANDARD: **30** calendar days or as quickly as the member's health condition requires.
EXPEDITED: Within **72 hours** from the date that the appeal is received, or as quickly as the member's health condition requires.

Cal Medi-Connect



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26	27	28	29	30		

March						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

April						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

May						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

June						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28		W

July						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

August						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

September						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

October						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

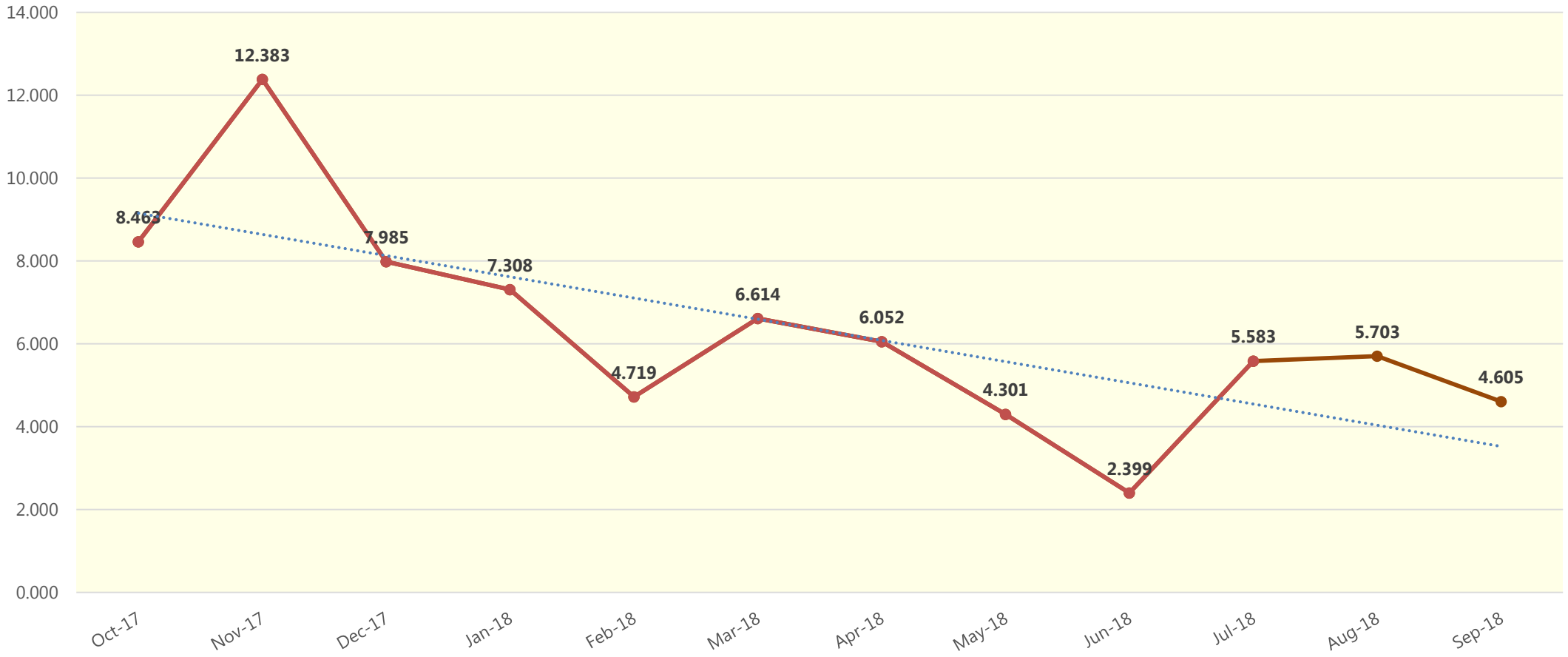
November						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

December						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

Q3 2018

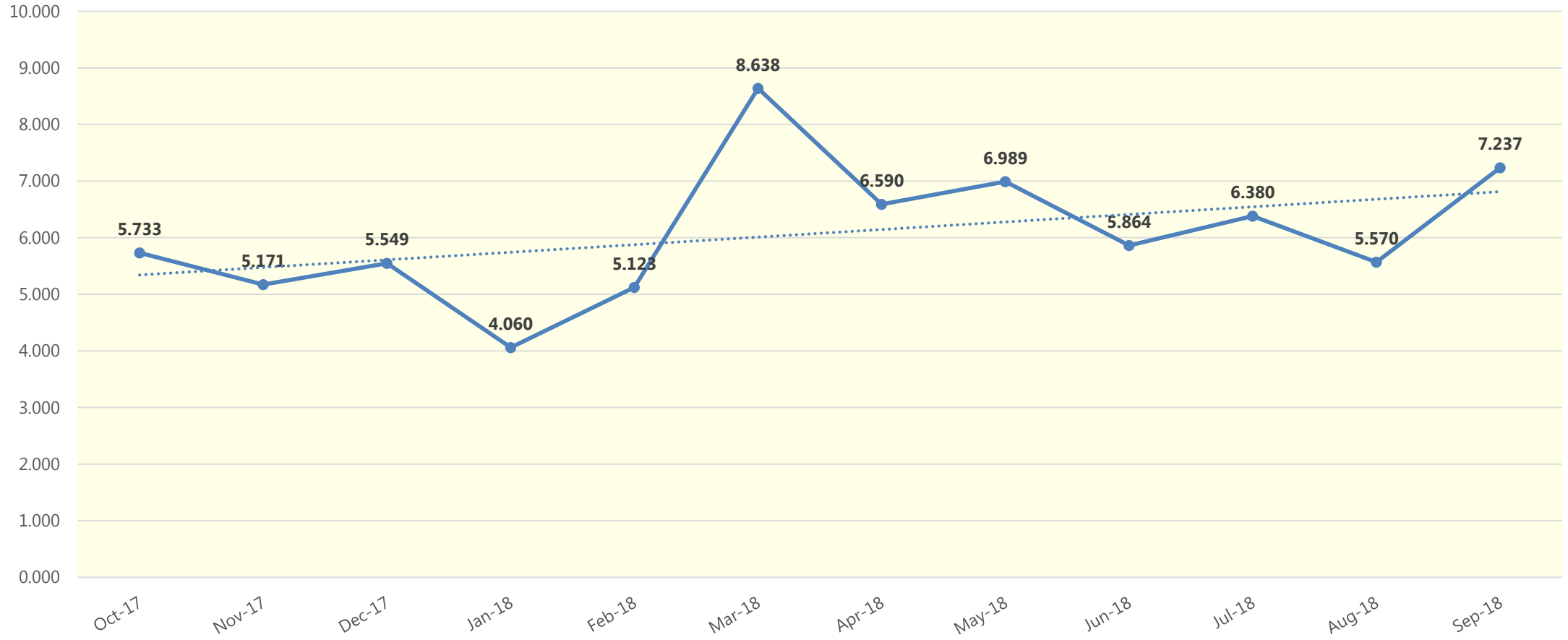
Q4 2017 – Q3 2018: CMC Appeals

Part C & D Appeals Per 1000 Members



Q4 2017 – Q3 2018: CMC Grievances

Grievances Per 1000 Members

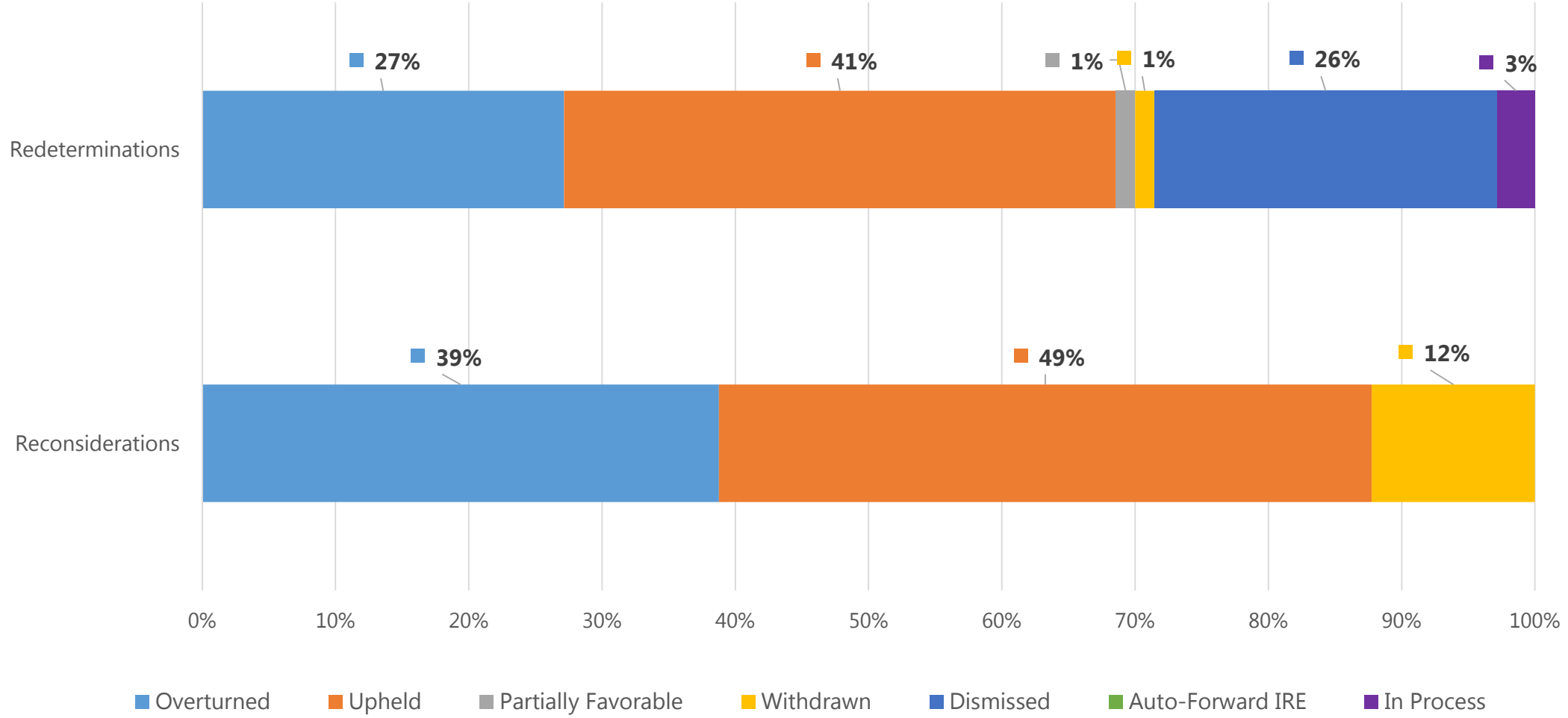


Q4 2017 – Q3 2018: CMC Rates per 1000

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Total Appeals	62	91	59	54	35	49	45	32	18	42	43	35
CMC Membership	7,326	7,349	7,389	7,389	7,417	7,409	7,435	7,440	7,503	7,523	7,540	7,600
Rate per 1000	**8.463**	**12.383**	**7.985**	**7.308**	**4.719**	**6.614**	**6.052**	**4.301**	**2.399**	**5.583**	**5.703**	**4.605**

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Total Grievances	42	38	41	30	38	64	49	52	44	48	42	55
CMC Membership	7,326	7,349	7,389	7,389	7,417	7,409	7,435	7,440	7,503	7,523	7,540	7,600
Rate per 1000	**5.733**	**5.171**	**5.549**	**4.060**	**5.123**	**8.638**	**6.590**	**6.989**	**5.864**	**6.380**	**5.570**	**7.237**

Q3 2018 Reconsiderations by Determination



CMC Timeliness: Standard Post-Service Reconsiderations

	Jul	Aug	Sept	Oct
Standard Post-Service Part C				
# of Standard Post-Service received during the reporting period	16	17	11	26
# of Standard Post-Service resolved in the reporting period	6	7	19	9
# of Standard Post-Service Reconsiderations resolved within 60 days	3	4	19	3
% of Standard Post-Service Reconsiderations resolved within 60 days	50.0%	57%	100.0%	33%
# Submitted to IRE within 5 calendar days	0	0	0	0
# of Standard Post-service Reconsideration Determinations Received from the IRE	1	0	0	0
# of Standard Post-Service Reconsideration Requests upheld by IRE	0	0	0	0
% of Standard Post-Service Reconsideration Requests Upheld by IRE	0%	n/a	n/a	n/a
# of Standard Post-Service Reconsiderations withdrawn by Member	0	0	0	0
# of Standard Post-Service Reconsiderations dismissed by Plan	1	0	4	3

STANDARD: Within **60 calendar days** of receipt

CMC Timeliness: Standard Pre-Service Reconsiderations

	Jul	Aug	Sept	Oct
Standard Pre-Service Part C				
# of Standard Pre-Service Reconsiderations received during the reporting period	9	4	6	10
# of Standard Pre-Service resolved in the reporting period	3	8	4	7
# of Standard Pre-Service Reconsiderations that received Acknowledgement Letters	8	4	7	9
# of Standard Pre-Service Reconsiderations that received Acknowledgement Letters within 5 days	8	3	6	8
% of Standard Pre-Service Reconsiderations that received Acknowledgement Letters within 5 days	100.0%	75.0%	86%	89%
# of Standard Pre-Service Reconsiderations where SCFHP requested a 14-Day Extension	0	0	0	
# of Standard Pre-Service Reconsiderations resolved within 30/44 Days	3	5	4	
% of Standard Pre-Service Reconsiderations resolved within 30/44 days	100%	63%	100%	0%
# of Standard Pre-Service Reconsiderations (upheld and untimely determinations) Submitted to IRE	5	0	0	0
# of Standard Pre-Service Reconsiderations Submitted to IRE within 5 calendar days	0	0	0	0
% of Standard Pre-Service Reconsiderations (Upheld and Untimely Determinations) Submitted to IRE within 5 days	0%	n/a	n/a	n/a
# of Standard Pre-service Reconsideration Determinations Received from the IRE	1	0	2	0
# of Standard Pre-Service Reconsideration Requests upheld by IRE	1	0	2	0
% of Standard Pre-Service Reconsideration Requests Upheld by IRE	100%	n/a	100.0%	n/a
# of Standard Pre-Service Requests withdrawn by member	0	0	0	1
# of Standard Pre-Service Requests dismissed by Plan	0	0	1	0

STANDARD: Within **30 calendar days** of receipt

CMC Timeliness: Expedited Reconsiderations

	Jul	Aug	Sept	Oct
Expedited Pre-Service Part C				
# of Expedited Pre-Service Reconsiderations received during the reporting period	2	4	0	1
# of Expedited Reconsiderations resolved in the reporting period	2	4	0	1
# of Expedited Pre-Service Reconsiderations resolved with oral notification to member within 72 Hours	2	3	0	0
% of Expedited Pre-Service Reconsiderations resolved with oral notification to member within 72 Hours	100.0%	75%	n/a	0%
# of Expedited Pre-Service Reconsiderations resolved with written notification to member within 72 Hours	2	4	0	1
% of Expedited Pre-Service Reconsiderations resolved with written notification to member within 72 Hours	100%	100%	n/a	100%
# of Expedited Pre-Service Reconsiderations Transitioned to Standard Determinations	1	2	0	1
% of Expedited Pre-Service Reconsiderations Transitioned to Standard Determinations	33%	50%	n/a	50%
# of Expedited Pre-Service Reconsiderations (upheld & untimely) Submitted to IRE Within 24-hours of decision	0	0	0	0
% Expedited Pre-Service Reconsiderations (upheld & untimely) submitted to IRE within 24-hours of decision	n/a	n/a	n/a	n/a
# of Expedited Pre-service Reconsideration Determinations Received from the IRE	1	0	0	0
# of Expedited Pre-Service Reconsiderations Upheld by IRE	1	0	0	0
% of Expedited Pre-Service Reconsiderations Upheld by IRE	100%	0.0%	0.0%	0.0%
# of Expedited Pre-Service Reconsiderations withdrawn by Member	0	0	0	0
# of Expedited Pre-Service Reconsiderations dismissed by Plan	0	0	0	0

STANDARD: Within **72 Hours** of receipt

CMC Timeliness: Standard Redeterminations

	Jul	Aug	Sept	Oct
Redeterminations, Part D				
Standard Part D				
# of Standard Redeterminations received during the reporting period	12	15	12	12
# of Standard Redeterminations resolved in the reporting period	11	15	10	13
# of Standard Redeterminations resolved within 7 calendar days	9	15	10	13
% of Standard Redeterminations resolved within 7 calendar days	81.8%	100%	100.0%	100%
% of Standard Redeterminations Upheld by IRE	0%	0%	0%	0%
# of Standard Redeterminations Withdrawn by member	2	0	1	1
# of Standard Determinations dismissed by Plan	0	0	0	0

STANDARD: Within **7 calendar days** of receipt

CMC Timeliness: Expedited Redeterminations

	Jul	Aug	Sept	Oct
Expedited Part D				
# of Expedited Redeterminations received during the reporting period	2	2	6	4
# of Expedited Redeterminations resolved in the reporting period	2	2	6	4
# of Expedited Redeterminations resolved with oral notification to member within 72 Hours	1	2	5	2
% of Expedited Redeterminations resolved with oral notification to member within 72 Hours	50%	100%	83%	50%
# of Expedited Redeterminations resolved with written notification to member within 72 hours	2	2	6	2
% of Expedited Redeterminations resolved with written notification to member within 72 hours	100%	100%	100%	50%
# of Expedited Redeterminations transitioned to Standard Determinations	0	0	0	0
% of Expedited Redeterminations transitioned to Standard Determinations	n/a	n/a	n/a	n/a
# of untimely Expedited Redeterminations submitted to IRE	0	0	0	0
# of untimely Expedited Redeterminations submitted to IRE within 24 hours of decision	0	0	0	0
% of Untimely Expedited Redeterminations Submitted to IRE within 24 Hours of decision	n/a	n/a	n/a	n/a
# of Expedited Redetermination Decisions Received from the IRE	0	0	0	0
% of Expedited Redeterminations Determinations Upheld by IRE	n/a	n/a	n/a	n/a
# of Expedited Redeterminations withdrawn by member	0	0	1	0
# of Expedited Redeterminations dismissed by Plan	0	0	0	0

STANDARD: Within **72 Hours** of receipt

CMC Timeliness: Part C Grievances

	Jul	Aug	Sept	Oct
Standard Grievances Part C				
# of Standard Grievances received during the reporting period	47	41	52	45
# of Standard Grievances resolved	29	52	43	55
# of Standard Grievances that received acknowledgement letters	40	46	49	46
# of Standard Grievances that received Acknowledgement Letters within 5 days	39	44	47	44
% of Standard Grievances that received Acknowledgement Letters within 5 days and were not resolved in ≤ 5 calendar days	98%	95.7%	95.9%	95.7%
# of Standard Grievances where SCFHP requested a 14-Day Extension	2	0	0	0
# of Standard Grievances resolved within 30/44 days	28	47	40	54
% of Standard Grievances resolved within 30/44 days	96.6%	96.2%	98%	98%
# Standard Grievances withdrawn by Member	0	1	6	1
# Standard Grievances dismissed by Plan	0	0	0	0
# of Standard Grievances referred for investigation of PQI	34	31	38	19
Expedited Grievances Part C				
# of Expedited Grievances received during the reporting period	0	0	0	0
# of Expedited Grievances resolved during the reporting period	0	0	0	0
# of Expedited Grievances resolved within 24 hours	0	0	0	0
% of Expedited Grievances resolved within 24 hours	n/a	n/a	n/a	n/a
# of Expedited Grievances withdrawn by Member	0	0	0	0

STANDARD: Within **30 calendar days** of receipt
EXPEDITED: Within **24 hours** of receipt

CMC Timeliness: Part D Grievances

	Jul	Aug	Sept	Oct
Standard Grievances Part D				
# of Standard Grievances received during the reporting period	1	1	3	2
# of Standard Grievances Resolved	2	1	2	2
# of Standard Grievances that received Acknowledgement Letters	1	1	2	3
# of Standard Grievances that received Acknowledgement Letters within 5 days	1	1	2	3
% of Standard Grievances that received Acknowledgement Letters within 5 days and were not resolved in ≤ 5 calendar days	100%	100.0%	100.0%	100.0%
# of Standard Grievances where SCFHP requested a 14-Day Extension	0	0	0	0
# of Standard Grievances resolved within 30/44 days	2	1	1	2
% of Standard Grievances resolved within 30/44 days	100%	n/a	50.0%	100.0%
# of Standard Grievances withdrawn by Member	0	0	0	0
# of Standard Grievances dismissed by Plan	0	0	0	0
Expedited Grievances Part D				
# of Expedited Grievances received during the reporting period	0	0	0	0
# of Expedited Grievances resolved in the reporting period	0	0	0	0
# of Expedited Grievances resolved within 24 hours	0	0	0	0
% of Expedited Grievances resolved within 24 hours	n/a	n/a	n/a	n/a
# Expedited Grievances withdrawn by Member	0	0	0	0

STANDARD: Within **30 calendar days** of receipt
EXPEDITED: Within **24 hours** of receipt

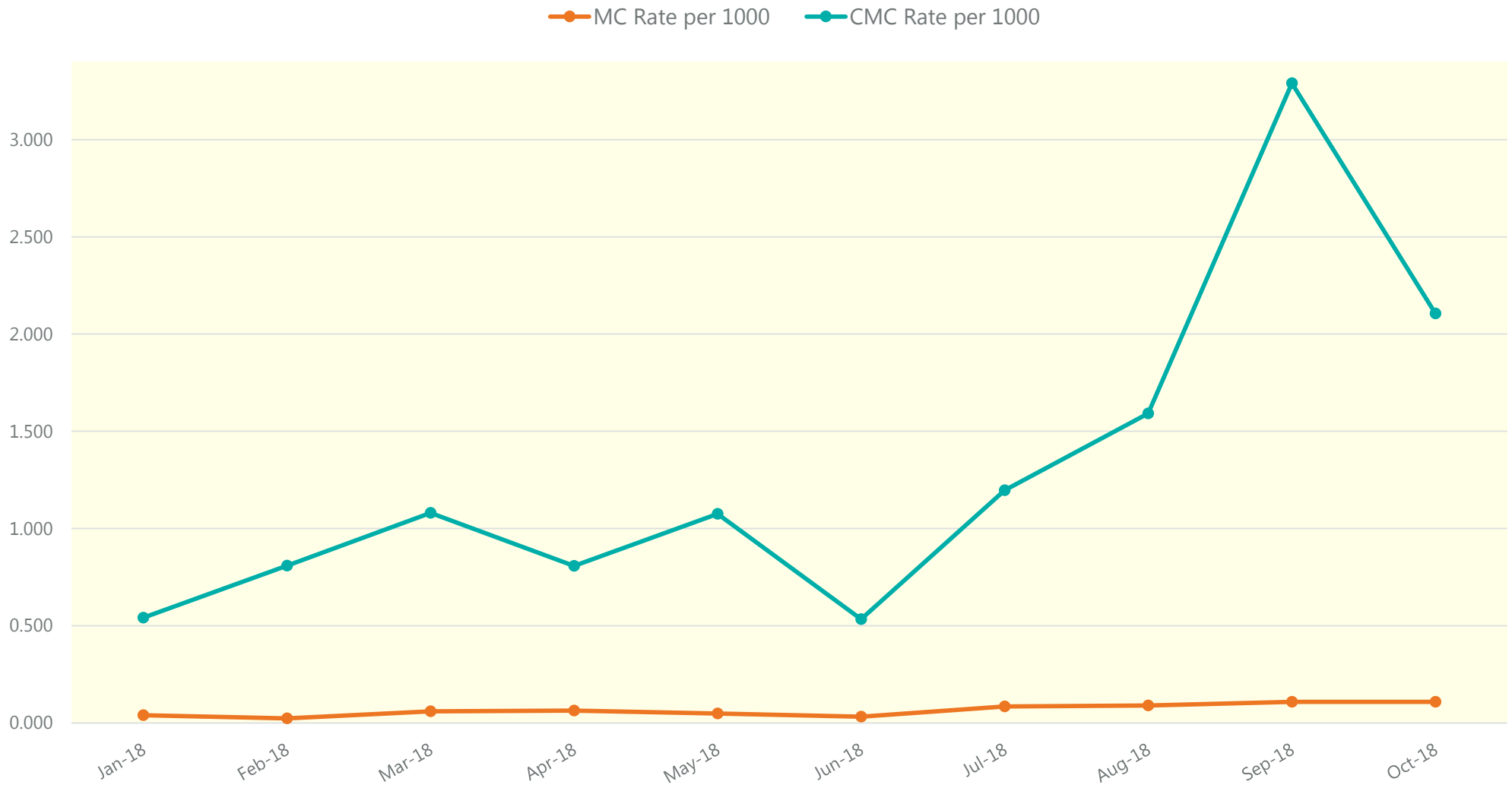
CHME Grievances

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Total CHME Grievances	10	6	15	16	12	8	21	22	27	27
Healthy Kids Membership	3,209	3,250	3,415	3,454	3,220	3,196	3,278	3,187	3,163	3,217
Medi-Cal Membership	253,257	254,141	253,025	251,680	249,188	248,776	247,755	245,954	245,884	244,493
TOTAL Membership	256,466	257,391	256,440	255,134	252,408	251,972	251,033	249,141	249,047	247,710
Rate per 1000	**0.039**	**0.023**	**0.058**	**0.063**	**0.048**	**0.032**	**0.084**	**0.088**	**0.108**	**0.109**

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Total CHME Grievances	4	6	8	6	8	4	9	12	25	16
CMC Membership	7,389	7,417	7,409	7,435	7,440	7,503	7,523	7,540	7,600	7,601
Rate per 1000	**0.541**	**0.809**	**1.080**	**0.807**	**1.075**	**0.533**	**1.196**	**1.592**	**3.289**	**2.105**

Totals 262 Complaints filed since 1/1/18

CHME Complaints: Rate per 1000



Santa Clara Family Health Plan™

Darryl Breakbill

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Santa Clara Family Health Plan™

2017 Health Outcomes Survey (HOS) Results – Cohort 20

Author(s): Mariana Ulloa, Quality Improvement Project Manager and Jamie Enke, Manager, Process Improvement

Health Outcomes Survey (HOS)

“The Medicare HOS is the first patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is to gather valid and reliable clinically meaningful data that have many uses, such as targeting quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans; helping beneficiaries make informed health care choices; and advancing the science of functional health outcomes measurement.”

– www.HOSonline.org

HOS Overview

- Mandatory survey for all Medicare Advantage contracts (including Medicaid-Medicare Plans (MMPs))
- **Multi-year survey:**
  - Baseline survey
  - Follow up survey two years later
- **Data sources:**
  - Survey responses
  - HEDIS rates
- Includes a Physical and Mental Health Component Score
- Scores are adjusted for geographical differences and are presented as both an unadjusted and adjusted number
- The baseline and two-year follow up scores are used for the Medicare Star Ratings
- First Santa Clara Family Health Plan (SCFHP) Cohort was Cohort 19 (2016 Baseline)

HOS Timeline

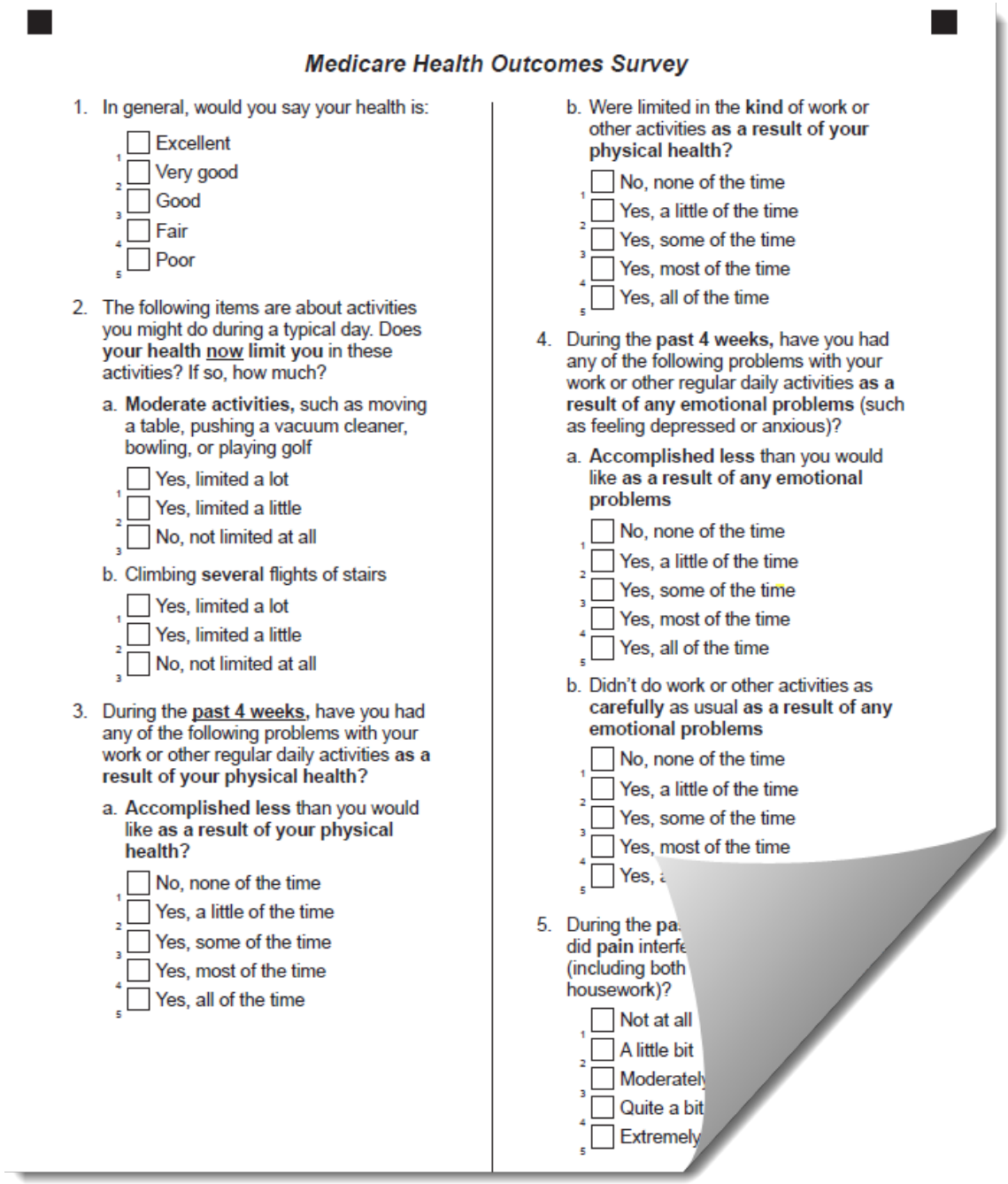
Cohort 19 and 20 Overview

- **2016 Baseline Report**
  - Cohort 19
  - Follow Up Report available Summer 2019

- **2017 Baseline Survey**
  - Cohort 20
  - Fielded from April through June of 2017
  - Follow Up Report available Summer 2020
  - Sample size:1,200
  - The survey was sent in English and Spanish and consists of 54 Questions
  - SCFHP received 345 responses (29.9 %) as compared to 275 (24.7%) in 2016.

- Analytical sample sizes after exclusions:
  - 280 in Cohort 20
  - 224 in Cohort 19

EXAMPLE:
Page 2 of HOS Survey



Medicare Health Outcomes Survey

1. In general, would you say your health is:
   - 1 ☐ Excellent
   - 2 ☐ Very good
   - 3 ☐ Good
   - 4 ☐ Fair
   - 5 ☐ Poor

2. The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?
   a. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
   - 1 ☐ Yes, limited a lot
   - 2 ☐ Yes, limited a little
   - 3 ☐ No, not limited at all

   b. Climbing **several** flights of stairs
   - 1 ☐ Yes, limited a lot
   - 2 ☐ Yes, limited a little
   - 3 ☐ No, not limited at all

3. During the **past 4 weeks,** have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**
   a. **Accomplished less** than you would like **as a result of your physical health?**
   - 1 ☐ No, none of the time
   - 2 ☐ Yes, a little of the time
   - 3 ☐ Yes, some of the time
   - 4 ☐ Yes, most of the time
   - 5 ☐ Yes, all of the time

   b. Were limited in the **kind** of work or other activities **as a result of your physical health?**
   - 1 ☐ No, none of the time
   - 2 ☐ Yes, a little of the time
   - 3 ☐ Yes, some of the time
   - 4 ☐ Yes, most of the time
   - 5 ☐ Yes, all of the time

4. During the **past 4 weeks,** have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?
   a. **Accomplished less** than you would like **as a result of any emotional problems**
   - 1 ☐ No, none of the time
   - 2 ☐ Yes, a little of the time
   - 3 ☐ Yes, some of the time
   - 4 ☐ Yes, most of the time
   - 5 ☐ Yes, all of the time

   b. Didn't do work or other activities as **carefully** as usual **as a result of any emotional problems**
   - 1 ☐ No, none of the time
   - 2 ☐ Yes, a little of the time
   - 3 ☐ Yes, some of the time
   - 4 ☐ Yes, most of the time
   - 5 ☐ Yes, a

5. During the pa
   did **pain** interfe
   (including both
   housework)?
   - 1 ☐ Not at all
   - 2 ☐ A little bit
   - 3 ☐ Moderately
   - 4 ☐ Quite a bit
   - 5 ☐ Extremely

HOS Timeline

Medicare HOS Survey Administration Timeline				
Year	Data Collection		Reports	
	Baseline	*Follow Up*	*Baseline*	*Follow Up*
2020	*Cohort 23*	*Cohort 21*	*Cohort 22*	*Cohort 20*
2019	*Cohort 22*	*Cohort 20*	*Cohort 21*	*Cohort 19*
2018	*Cohort 21*	*Cohort 19*	*Cohort 20*	*Cohort 18*
2017	*Cohort 20*	*Cohort 18*	*Cohort 19*	*Cohort 17*
2016	*Cohort 19*	*Cohort 17*	*Cohort 18*	*Cohort 16*

Health Outcomes Survey

Cohort 20 Results Overview

- **Cohort 20 Mean Results**
  - Adjusted Physical Component Summary (PCS) – 35.2
  - Adjusted Mental Health Component Summary (MCS) - 48.7
  - Rates adjusted for Geographical differences
  - For Cohort 20, SCFHP overall trended below Cohort 19, State and National levels in all overall scores.
  - Respondents to this baseline report will be resurveyed in Spring/Summer of 2019 with results available in 2020.

- **Future Expected Decrease**
  - Rates to decrease in follow up survey due to age-related effects on health status
    - PCS decreases at faster rate then MCS

Health Outcomes Survey

Cohort 20 Comparative Scores

- SCFHP adjusted PCS Score was 3.3 points lower than California MA and MMP scores
- SCFHP adjusted MCS score was 2.8 points lower than California MA and MMP scores

Table 1: *2017 Cohort 20 Baseline* Mean Unadjusted and Adjusted PCS and MCS Scores for MAO H7890, California and HOS Total†

	Unadjusted PCS Score (SD)	Adjusted PCS Score (SD)	Unadjusted MCS Score (SD)	Adjusted MCS Score (SD)
H7890	34.4 (12.2)	35.2 (5.7)	48.0 (11.8)	48.7 (5.1)
California	38.6 (12.4)	38.5 (6.9)	51.3 (11.5)	51.5 (5.7)
HOS Total	39.1 (12.6)	39.1 (7.1)	52.8 (11.0)	52.8 (5.7)

Health Outcomes Survey

Comparative Results-Cohorts 19 and 20

- SCFHP Cohort 20 Adjusted PCS Score was 1.2 points lower than Cohort 19 score.
- SCFHP Cohort 20 Adjusted MCS Score was 1 point lower than Cohort 19 score.

Table 2: Trends in Mean Unadjusted and Adjusted PCS and MCS Scores over Three Baseline Cohorts for MAO H7890

	Unadjusted PCS Score (SD)	Adjusted PCS Score (SD)	Unadjusted MCS Score (SD)	Adjusted MCS Score (SD)
2017 Cohort 20	34.4 (12.2)	35.2 (5.7)	48.0 (11.8)	48.7 (5.1)
2016 Cohort 19	36.3 (11.2)	36.4 (7.2)	49.1 (11.7)	49.7 (5.6)
2015 Cohort 18	NA	NA	NA	NA

NA in a row indicates that the MAO did not have results for that cohort.

Health Outcomes Survey

Cohort 20 Self Reported Health Status Results

- SCFHP scored lower than California in the top two categories of the General Health , Comparative Physical Health and Comparative Mental Health questions but higher in the bottom two categories.
- Questions are "**compared to one year ago**".

Table 5: *2017 Cohort 20 Baseline* Self-Rated General and Comparative Health Status for MAO H7890, California and HOS Total

	General Health		Comparative Physical Health		Comparative Mental Health	
	Excellent to Good*	Fair or Poor	Much Better to About the Same*	Slightly Worse or Much Worse	Much Better to About the Same*	Slightly Worse or Much Worse
H7890	46.9%	53.1%	60.9%	39.1%	75.5%	24.5%
California	65.8%	34.2%	70.0%	30.0%	84.3%	15.7%
HOS Total	71.1%	28.9%	73.3%	26.7%	87.0%	13.0%

* Categories for general health included "Excellent," "Very good," or "Good." Categories for comparative health included "Much better," "Slightly better," or "About the same."

Health Outcomes Survey

Cohort 20 Self Reported Health Status Results

- SCFHP Cohort 20 scores were lower than Cohort 19 scores in the top two categories of the General Health , Comparative Physical Health and Comparative Mental Health questions but higher in the bottom two categories.
- Questions are "**compared to one year ago**".

Table 6: Trends in Self-Rated General and Comparative Health Status Over Three Baseline Cohorts for MAO H7890

	General Health		Comparative Physical Health		Comparative Mental Health	
	Excellent to Good*	Fair or Poor	Much Better to About the Same*	Slightly Worse or Much Worse	Much Better to About the Same*	Slightly Worse or Much Worse
2017 Cohort 20	46.9%	53.1%	60.9%	39.1%	75.5%	24.5%
2016 Cohort 19	54.8%	45.2%	64.1%	35.9%	81.3%	18.7%
2015 Cohort 18	NA	NA	NA	NA	NA	NA

* Categories for general health included "Excellent," "Very good," or "Good." Categories for comparative health included "Much better," "Slightly better," or "About the same."
NA in a row indicates that the MAO did not have results for that cohort.

Health Outcomes Survey

HEDIS Measures in HOS

Four Effectiveness of Care measures from the Healthcare Effectiveness Data and Information Set (HEDIS) were included in HOS, Cohort 20:

- Management of Urinary Incontinence in Older Adults (MUI)
- Physical Activity in Older Adults (PAO)
- Fall Risk Management (FRM)
- Osteoporosis Testing in Older Women (OTO)

Health Outcomes Survey

HEDIS Results – Cohort 20

- SCFHP scored 1.78% lower than California in the PAO Advise rate and 11.52% lower in the OTO testing rates.

Table 3: 2017 NCQA HEDIS Rates for MAO H7890, California, CMS Region 9 and HOS Total†

	MUI Discuss Rate	MUI Treat Rate*	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate*	FRM Discuss Rate	FRM Manage Rate*	OTO Testing Rate
H7890	NA	NA	NA	59.07%	54.77%	36.26%	75.00%	54.68%
California	57.45%	44.43%	16.63%	57.55%	56.55%	36.60%	63.04%	66.20%
CMS Region 9	57.73%	45.18%	16.98%	57.27%	54.58%	36.92%	61.65%	69.41%
HOS Total	59.33%	45.44%	15.88%	55.70%	51.74%	36.50%	58.62%	74.24%

* Measures incorporated into the 2019 Medicare Star Ratings include the MAO 2017 Improving Bladder Control (MUI Treat Rate), Monitoring Physical Activity (PAO Advise Rate) and Reducing the Risk of Falling (FRM Manage Rate).
†See Appendix 3, Table 43 results for all MAOs in the state.

Health Outcomes Survey

HEDIS Findings – Cohort 20 compared to Cohort 19 Rates

- **SCFHP scored .73% lower in Cohort 20 in the PAO Advise rate**

Table 4: Trends in NCQA HEDIS Rates over Three Rounds of Data for MAO H7890

	MUI Discuss Rate	MUI Treat Rate*	MUI Impact Rate	PAO Discuss Rate	PAO Advise Rate*	FRM Discuss Rate	FRM Manage Rate*	OTO Testing Rate
2017 Round 20	NA	NA	NA	59.07%	54.77%	36.26%	75.00%	54.68%
2016 Round 19	NA	NA	NA	54.23%	55.50%	34.09%	NA	53.54%
2015 Round 18	NA	NA	NA	NA	NA	NA	NA	NA

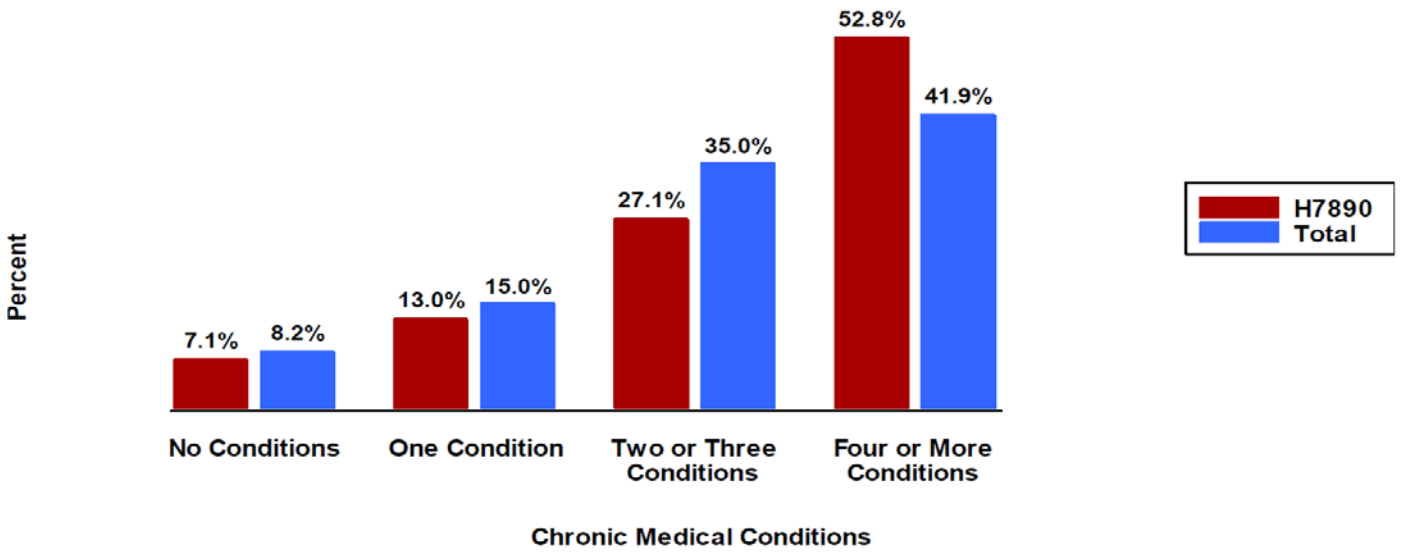
* Measures incorporated into the 2019 Medicare Star Ratings include the MAO 2017 Improving Bladder Control (MUI Treat Rate), Monitoring Physical Activity (PAO Advise Rate)., and Reducing the Risk of Falling (FRM Manage Rate).
NA in a row indicates that the MAO did not have results for that round.

Health Outcomes Survey

Chronic Conditions

SCFHP rated 7.9% lower than national percentages for 2-3 Chronic Conditions, but 10.9% higher for 4 or More Chronic Conditions.

Figure 10: *2017 Cohort 20 Baseline* Distribution of Chronic Medical Conditions for MAO H7890 and HOS Total



Health Outcomes Survey

Prevalence of Chronic Medical Conditions

SCFHP rated higher than national percentages for the top three Chronic Medical Conditions

Table 14: *2017 Cohort 20 Baseline* Prevalence of Chronic Medical Conditions for MAO H7890 and HOS Total

Medical Condition	MAO H7890 N (%)	HOS Total N (%)
Hypertension	185 (69.5%)	121,192 (66.7%)
Arthritis - Hip or Knee	143 (54.6%)	80,854 (44.7%)
Arthritis - Hand or Wrist	118 (45.6%)	66,753 (37.0%)
Diabetes	99 (37.6%)	51,342 (28.3%)
Sciatica	98 (37.7%)	46,984 (26.1%)
Other Heart Conditions	46 (17.8%)	38,083 (21.1%)
Osteoporosis	83 (32.2%)	37,129 (20.6%)
Depression	71 (27.3%)	36,369 (20.1%)
Pulmonary Disease	42 (16.0%)	33,561 (18.5%)
Any Cancer (except skin cancer)	25 (10.0%)	25,796 (14.7%)
Coronary Artery Disease	34 (12.9%)	23,268 (13.0%)
Congestive Heart Failure	31 (11.7%)	16,043 (8.9%)
Myocardial Infarction	17 (6.5%)	15,932 (8.8%)
Stroke	24 (9.1%)	14,720 (8.1%)
Gastrointestinal Disease	18 (7.0%)	9,598 (5.3%)

Health Outcomes Survey

Next Steps/Recommendations:

- Add Chinese as a language for the 2019 survey (Vietnamese is not available) to increase response rates.
- Incorporate HOS questions and or HOS wording as needed in the next round of HRA review for modification.
- Inform Case Management staff of HOS Cohort 20 findings

Santa Clara Family Health Plan™

2017 Health Outcomes Survey (HOS)Results

Authors-Mariana Ulloa -QI Project Manager, Jamie Enke-Process Improvement Manager

Santa Clara Family Health Plan™

Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2018 Results

Authors: Mariana Ulloa, Quality Improvement Project Manager, Jamie Enke, Manager, Process Improvement

CAHPS 2018

Overview

- CAHPS is a consumer satisfaction survey that the health plan is required to administer annually by the Centers for Medicare and Medicaid Services (CMS)
- Objective: gather information about member's experiences with, and ratings of, Santa Clara Family Health Plan (SCFHP)
- SCFHP contracts with DSS to conduct the survey
- Results available in the Fall and published by CMS
- Results impact CMS Star Ratings

CAHPS 2018

Methodology

- Conducted telephonically and by mail March – June 2018
  - 6 telephone calls
  - 2 mailings
- SCFHP mails two reminder postcards to members
- Sample size = 1600 CMC members
- Official survey sent in English and Spanish
- N/A result indicates not enough respondents to that question or the score had very low reliability.

CAHPS 2018

CAHPS 68 questions cover the following topics:

Part C

- Rating of Health Plan
- Rating of Health Care Quality
- Rating of Personal Doctor
- Rating of Specialist
- Customer Service
- Getting needed care
- Getting appointments and care quickly
- Doctor's communication skills
- Care Coordination

Part D

- Rating of Drug Plan
- Getting needed prescription drugs
- Annual Flu Vaccine
- Pneumonia Vaccination

CAHPS 2018

New in 2018

- Tested survey languages Chinese and Vietnamese (note: these results not available in official report)
- Quality and Marketing sent two reminder postcards in five threshold languages
- Added 800 member oversample to the standard 800 members of official survey
- Requested breakdown of results by Provider Group
- SCFHP response rate in 2018 was 26.1% (2017 response rate 29%, 2016 response rate 15.6%)
- The National response rate was 29.5% and the California response rate was 27.8%.
- Language analysis performed by DSS indicates adding Chinese and Vietnamese surveys would result in higher survey and Star ratings.

CAHPS 2018

DSS Language Analysis

Additional languages = significantly higher results

Chinese

- **Overall Ratings:**
  - *Rating of health care quality*
  - *Rating of personal doctor*
- **Individual Questions:**
  - *Getting seen within 15 min of appointment*
  - *Doctors have medical records*
  - *Doctors follow up with test results*
  - *Getting test results when needed*
  - *Pneumonia shot*

Vietnamese

- **Overall Ratings:**
  - *Getting needed prescription drugs*
- **Individual Questions**
  - *Doctors are informed about specialist care*
  - *Ease of getting prescribed medicines*
  - *Ease of filling prescriptions by mail*
  - *Annual flu vaccine*

CAHPS 2018

SCFHP's Overall Performance (Compared to 2017)

Significant Improvement

- Rating of Health Plan

Moderate Improvement

- Rating of Drug Plan
- Customer Service

About the Same

- Getting Needed Prescription drugs
- Getting needed care
- Getting appointments and care quickly
- Rating of personal doctor
- Rating of specialist
- Doctors who communicate well

Santa Clara Family Health Plan

CAHPS 2018

Opportunities Identified by DSS

Retain	Power
Items in this quadrant have a relatively small impact on the rating of the health plan but performance is above average. ***Simply maintain performance on these items.***	These items have a relatively large impact on the rating of the health plan and performance is above average. ***Promote and leverage strengths in this quadrant.***
Wait	**Opportunity**
These items are somewhat less important than those that fall on the right side of the chart and, relatively speaking, performance is below average. ***Dealing with these items can wait until more important items have been dealt with.***	Items in this quadrant have a relatively large impact on the rating of the health plan but performance is below average. ***Focus resources on improving processes that underlie these items.***

	Survey Measure	Score	Estimated Percentile[2]	Converted Mean
Power				
Q47	Drug plan overall[1]	90.08%	68th	87
Opportunity				
Q31	Specialist overall[1]	88.35%	11th	85
Q14	Dr. listened carefully	91.54%	5th	87
Q17	Personal doctor overall[1]	89.79%	6th	88
Q18	Dr. had medical records/info	93.62%	7th	88
Q15	Dr. showed respect	92.75%	6th	88
Q9	Health care overall[1]	80.15%	6th	80
Q16	Dr. spent enough time	89.25%	5th	82
Q13	Dr. provided clear explanations	90.06%	4th	84
Q42	Ease of getting prescribed Rx	91.71%	24th	86
Q44_Q46	Ease of filling Rx	93.79%	10th	88
Q26	Got help managing care	95.88%	47th	84
Wait				
Q23	Dr. discussed Rx medicines	81.11%	8th	79
Q35	CS courtesy/respect	90.61%	2nd	86
Q29	Got specialist appt.	71.88%	2nd	69
Q34	CS gave info./help needed	75.83%	2nd	74
Q8	Seen within 15 minutes of appt.	60.63%	22nd	58
Q20_Q21	Got test results	76.86%	2nd	74
Q32	Dr. informed about care	78.42%	5th	73
Q10	Got care/tests/treatment	78.93%	2nd	74
Q37	Easy to fill out forms	90.67%	5th	87
Q4	Got urgent care	74.21%	2nd	73
Q6	Got routine care	77.96%	3rd	74
Retain				
	None			

[1] Overall ratings are top 4 scores (7, 8, 9 and 10)

CAHPS 2018

Opportunities for Improvement

- Getting Needed Care*
- Getting Appointments and Care Quickly*
- Rating of Health Care Quality
- Rating of Health Plan*
- Customer Service*
- Getting Needed Prescription Drugs*
- Care Coordination

Although SCFHP improved in these areas over 2017, SCFHP is still below the national and/or average CA MMP average

Santa Clara Family Health Plan

CAHPS 2018

DSS Star Ratings Estimates:

5 Stars	Excellent performance
4 Stars	Above average performance
3 Stars	Average performance
2 Stars	Below average performance
1 Star	Poor performance

Reporting composite or item	Raw scores	Estimated adjusted scores	Estimated base Stars	Estimated final Stars	Estimated final Stars Including Chinese and Vietnamese
Ratings of Health Plan Responsiveness and Care					
Getting Needed Care	3.1515	74	★	★	★
Getting Appointments and Care Quickly	3.0531	71	★	★	★
Rating of Health Care Quality	8.0377	83	★★	★★	★★★
Rating of Health Plan	8.4783	84	★★★	★★★	★★★★
Customer Service	3.4771	84	★	★	★
Care Coordination	3.4188	81	★	★	★
Vaccines					
Annual Flu Vaccine	81.52%	82	★★★★★	★★★★★	★★★★★
Member Experience with Drug Plan					
Getting Needed Prescriptions Drugs	3.6038	87	★	★★	★★
Rating of Drug Plan	8.7185	85	★★★★	★★★★	★★★★★

CMS assigns Stars based on how well the contract performs relative to other contracts on the overall ratings, composite measures and the flu vaccination item. The following table summarizes the performance of the contract and the estimated stars for the 2018 data collection period:

CAHPS 2018

Next Steps

- Follow up with DSS to include Chinese and Vietnamese languages in official 2019 survey
- Meet with individual Provider Groups in Monthly Quality Meetings to gather feedback on improving scores and response rates for 2019
- Brainstorm internally with other departments on additional interventions to improve response rate and identify and implement actions to improve member satisfaction

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Initial Health Assessment (IHA)

Quality Improvement Department

Mai Chang, QI Manager

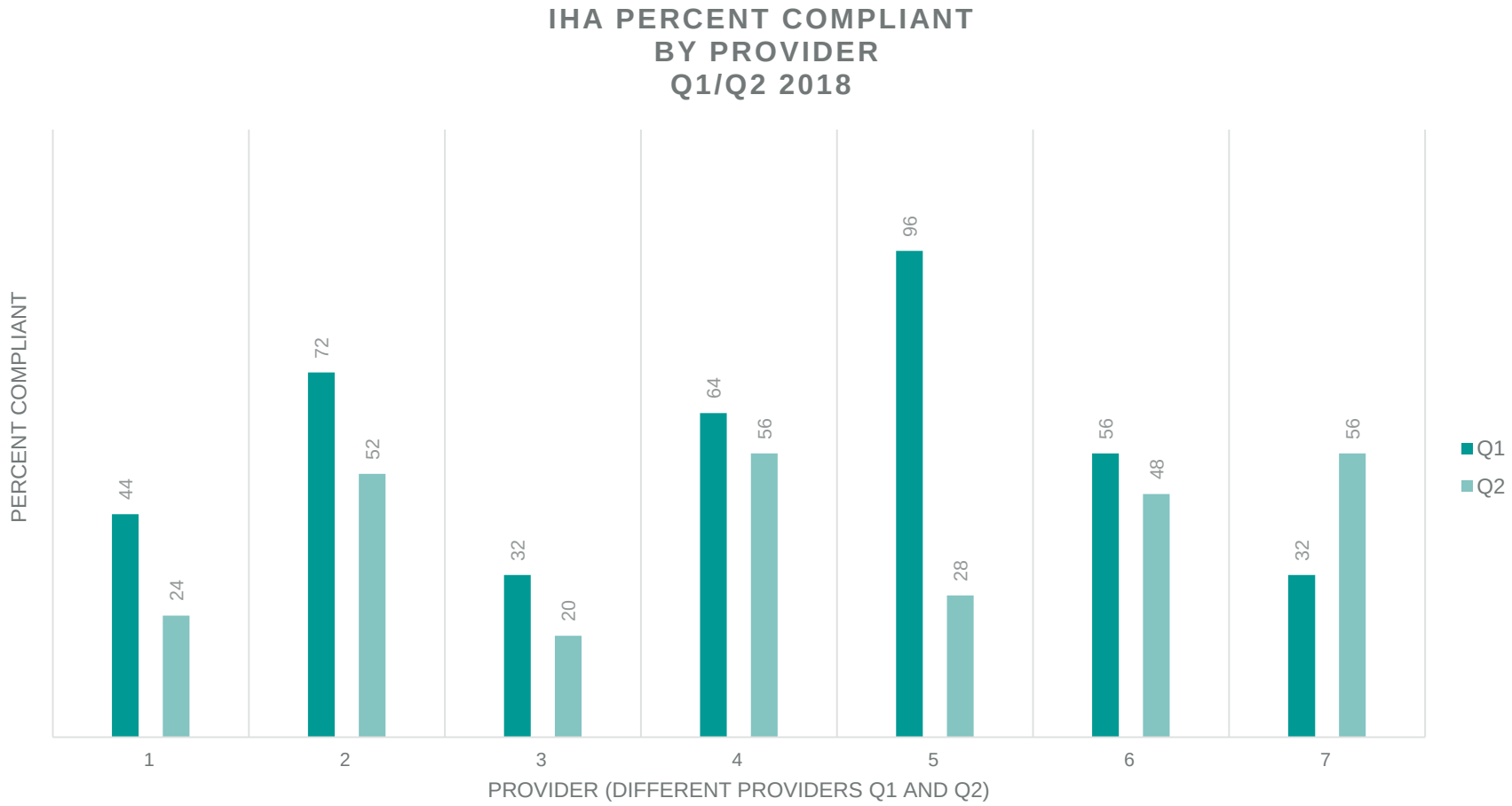
Initial Health Assessment (IHA)

Complete medical, social, and needs assessment in the first 120 days of plan enrollment

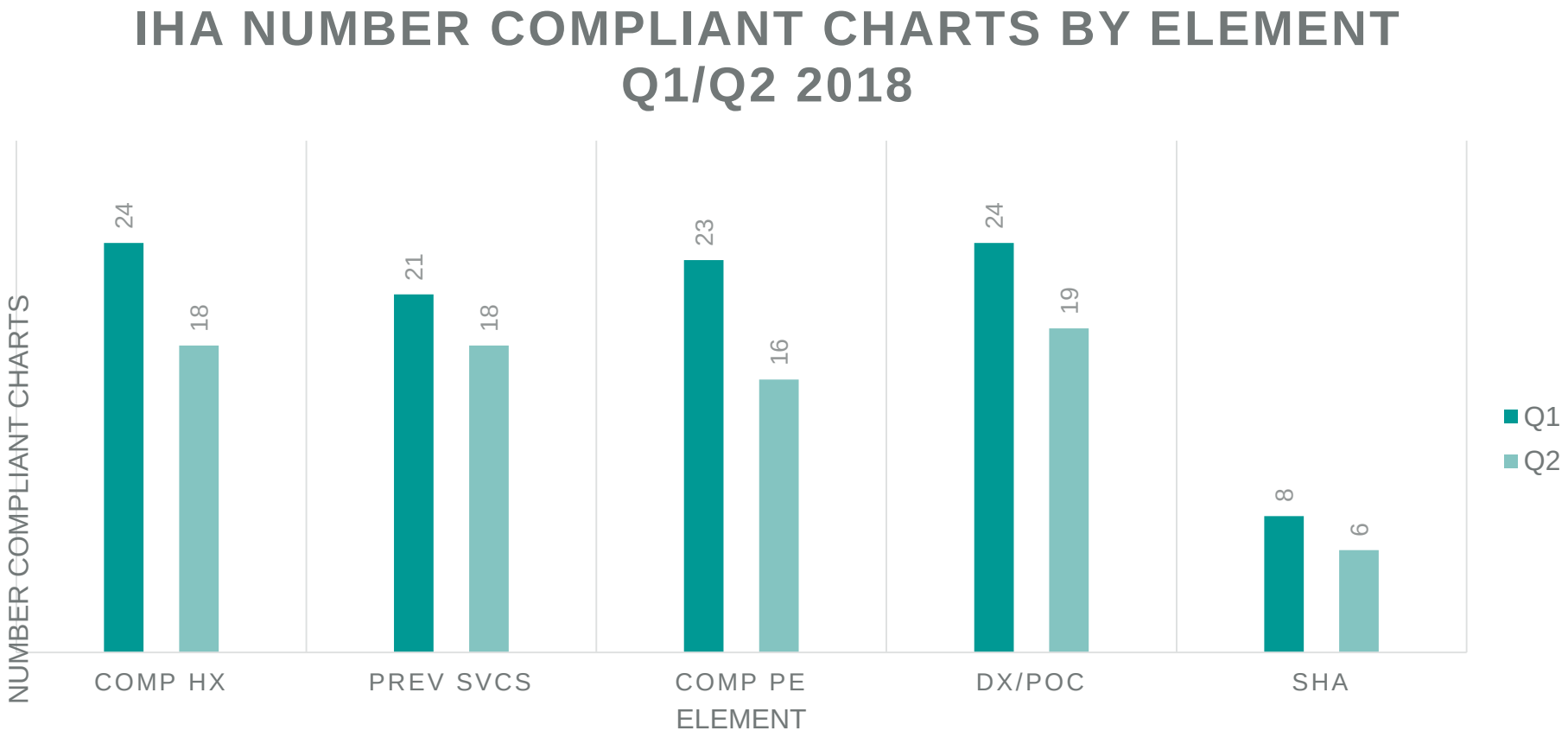
- **Five elements required for completion credit:**

1 - Comprehensive history
2 - Administration of preventive services (screenings, immunizations, etc.)
3 - Comprehensive physical and mental status exam
4 - Diagnosis and plan of care
5 - Staying Healthy Assessment (SHA) Questionnaire

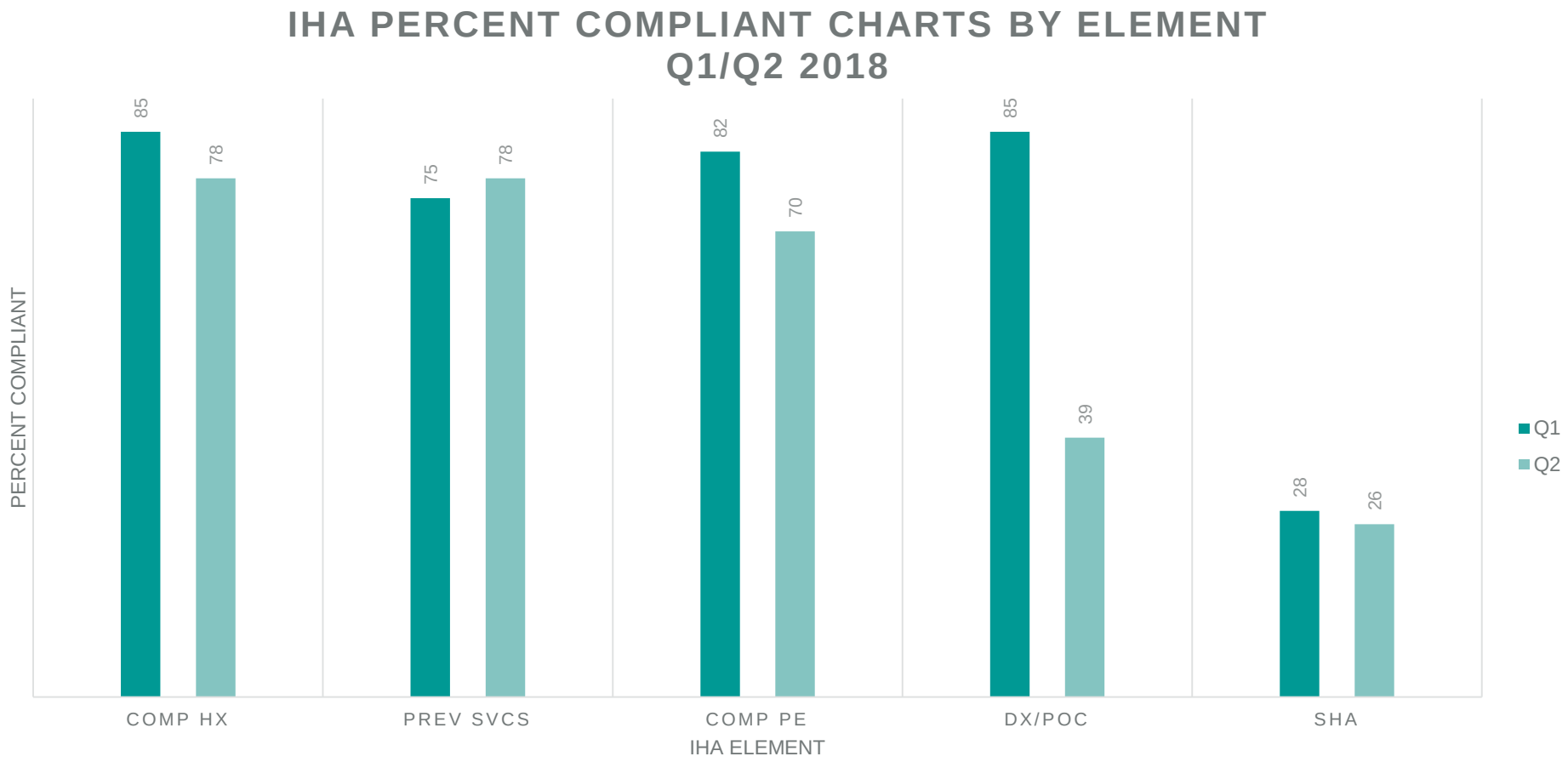
IHA – Percent Compliant by Provider



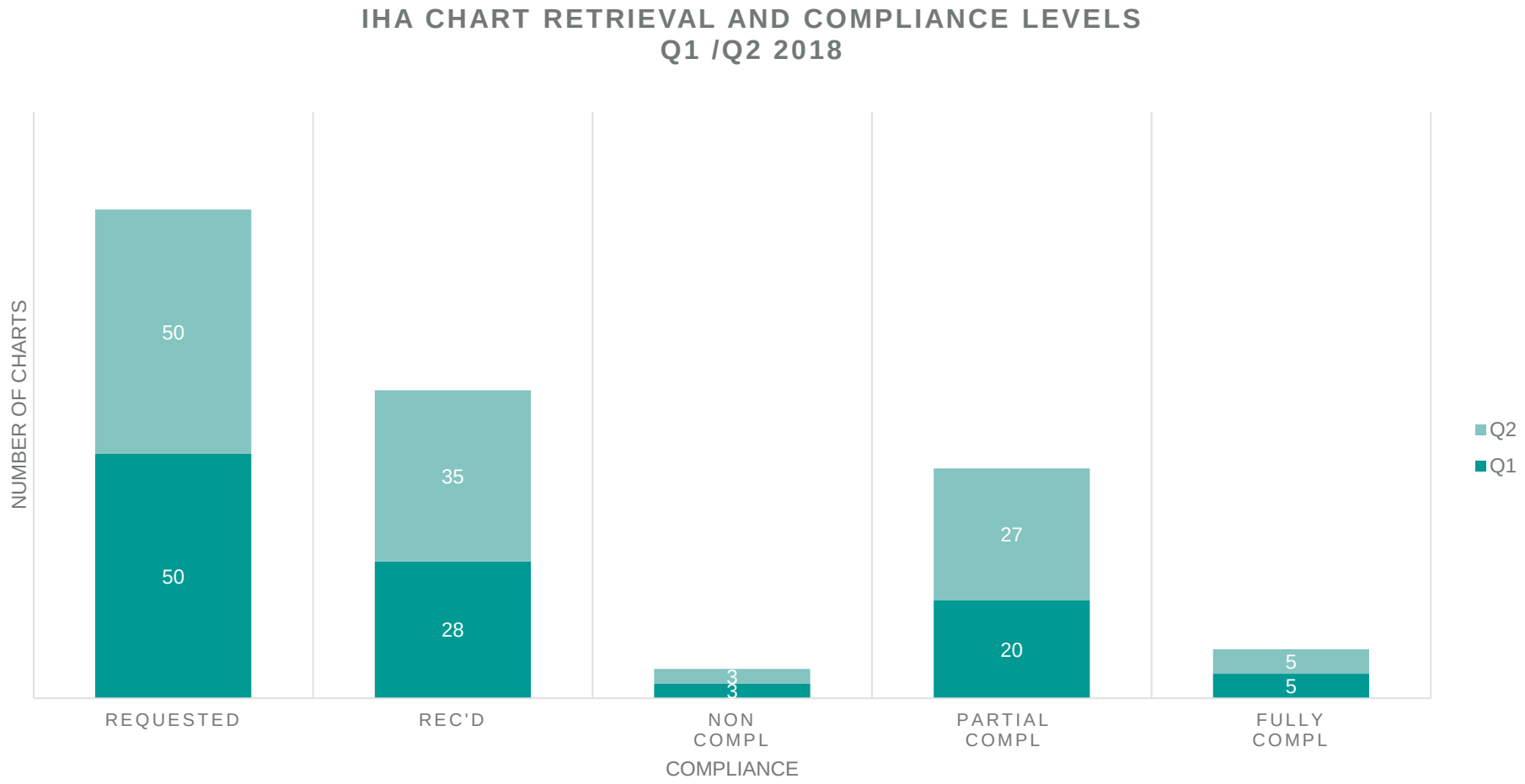
IHA – Number of Complaint Charts by Element



IHA – Percent Compliant Charts by Element



IHA Chart Retrieval and Compliance Levels



IHA Findings

SHA remains the element with the greatest opportunity for improvement (26-28% compliance).

- **Findings are not trendable, as different networks were reviewed**
  - **Q1 – 3 networks**
  - **Q2 – 1 network**
- **A small percentage of providers (28-43%) submitted fully compliant charts.**
- **The range of compliance was large**
  - **Q1 – 32 - 96%**
  - **Q2 – 20 – 56%**

IHA - Barriers

Provider:

- Providers do not:
- Check the SCFHP portal on a regular basis for newly assigned members
- Document attempted contacts to schedule appointments for new members
- Use the required SHA questionnaires or other state approved forms during IHAs

System:

- Discrepancies in IHA codes used for office visits within the 120 day timeframe
- Difficulty reaching MediCal members to schedule appointments
- Members change providers in the first 120 days
- Completing the SHA is time consuming and does not easily integrate with EMR systems
- Lack of training about all IHA requirements

IHA – Overcoming Barriers

Provider Education:

- Provider Portal use
- Required documentation, including outreach
- More efficient, effective use of the SHA
- Ongoing support and education based on provider feedback

System Improvement:

- IHA codes on Provider Resource page
- Difficulty reaching MediCal members to schedule appointments (**ongoing issue**)
- Members change providers in the first 120 days – Providers check Provider Portal regularly
- Provider Network Management will include information about IHA and the SHA in the provider training packet going out in 2019.

Questions?

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: October 3, 2018

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	17	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	16	
Number practitioners recredentialed within 36-month timeline	16	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 09/30/2018	247	

(For Quality of Care ONLY)	**Stanford**	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0
Total # of practitioners	1381	1041	714	758	398	117

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.

Actions Taken

1. All current network practitioners and providers were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. No currently credentialed practitioner or provider had an identified issue on any of the exclusion lists or licensing boards.
2. Staff education conducted regarding the recredentialing of practitioners within the required 36-month timeframe. Procedure review of mailing pre-populated recredentialing applications six months prior to due date reviewed.

Outcomes & Re-measurement

Weekly re-measurement will be conducted on recredentialing applications to measure compliance

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.

Santa Clara Family Health Plan

Regular Meeting of the
Santa Clara County Health Authority d.b.a. Santa Clara Family Health Plan
OPEN SESSION - **Pharmacy & Therapeutics Committee**
Thursday, June 21, 2018
6:00 PM - 8:00 PM
210 E. Hacienda Avenue Campbell, CA 95008

MINUTES

Voting Committee Members	Specialty	Present (Y or N)
Jimmy Lin, MD	Internal Medicine	Y
Hao Bui, BS, PharmD	Community Pharmacy (Walgreens)	N
Minh Thai, MD	Family Practice	N
Amara Balakrishnan, MD	Pediatrics	N
Peter Nguyen, MD	Family Practice	Y
Jesse Parashar-Rokicki, MD	Family Practice	Y
Narinder Singh, PharmD	Health System Pharmacy (SCVMC)	Y
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y
Dolly Goel, MD	VHP Chief Medical Officer	Y
Xuan Cung, PharmD	Pharmacy Supervisor (VHP)	Y
Johanna Liu, PharmD, MBA	SCFHP Director of Quality and Pharmacy	Y
Jeff Robertson, MD	SCFHP Chief Medical Officer	Y

Non-Voting Committee Members	Specialty	Present (Y or N)
Lily Boris, MD	SCFHP Medical Director	N
Caroline Alexander	SCFHP Administrative Assistant, Medical Management	Y
Tami Otomo, PharmD	SCFHP Clinical Pharmacist	Y
Duyen Nguyen, PharmD	SCFHP Clinical Pharmacist	Y
Dang Huynh, PharmD	SCFHP Pharmacy Manager	Y
Amy McCarty, PharmD	MedImpact Clinical Program Manager	Y
Tiffanie Pham, CPhT	SCFHP Pharmacy Coordinator	Y

	Topic and Discussion	Follow-Up Action
1	**Introductions**	
	The meeting convened at 6:07 PM.	
2	**Public Comment**	
	No public comment.	
3	**Past Meeting Minutes**	
	The SCFHP 1Q2018 P&T Minutes from March 15, 2018 were reviewed by the Committee as submitted.	Upon motion duly made and seconded, the SCFHP 1Q2018 P&T Minutes from March 15, 2018 were approved as

		submitted and will be forwarded to the QI Committee and Board of Directors.
4	**Plan Updates**	
	Health Plan Updates Dr. Robertson presented the Health Plan Updates. Santa Clara Family Health Plan is moving to the new building on 50 Great Oaks in July. Discussion was had and a vote taken regarding Pharmacy Committee meeting time on a move forward basis in the new building. Proposed start meeting at 6:30 p.m. or continue to meet at 6 pm. Committee voted and it was unanimous to continue meeting at 6 p.m. Health Plan is busy working towards NCQA accreditation. Review period started June 1st. Site visit will take place in February.	
	Appeals & Grievances Dr. Huynh presented the Appeals & Grievances report Q1 2018. There was a spike in Medi-Cal appeals from December 2017 to January 2018. Q1 2018 58% overturn rate, 23% upheld, 11% partially favorable, 7% withdrawn, and 1% dismissed. For CalMediConnect (CMC), Q12018 Part C&D appeals slight increase from January 2018 to March 2018. Redeterminations Q1 2018, 70% overturned, 27% upheld, 3% partially favorable, 0% dismissed.	
	SCFHP Global DUR Dr. Liu presented and update on Global DUR. Streamlined requirements for managed Medi-Cal plans. Retrospective DUR of opioids. Concomitant use of anticholinergics and antipsychotics. Will present at Pharmacy Committee to share updates.	
	Adjourn to Closed Session Committee adjourned to closed session at 6:30 p.m. to discuss the following items: Membership Report, Pharmacy Dashboard, Drug Use Evaluation Results, Drug Utilization & Spend, Recommendations for Changes to SCFHP Cal MediConnect Formulary and Prior Authorization Criteria, Recommendations for changes to Medi-Cal and Healthy Kids Formulary and Prior Authorization Criteria, DHCS Medi-Cal CDL Updates & Comparability, Prior Authorization Criteria and New Drugs.	
5	**Metrics & Financial Updates**	
	Membership Report Dr. Robertson presented the membership report.	
	Pharmacy Dashboard Dr. Otomo presented the Pharmacy Dashboard.	

Santa Clara Family Health Plan

	Drug Utilization & Spend Review Dr. McCarty presented the Drug Use Evaluation Results.	
	Drug Utilization & Spend Review Dr. McCarty presented the Spend and Trend Overview.	
6	**Discussion and Recommendations for changes to SCFHP Cal MediConnect Formulary & Prior Authorization Criteria**	
	Dr. Huynh presented an overview of the MedImpact 1Q2018 P&T minutes as well as the MedImpact 2Q2018 P&T Part D Actions.	Upon motion duly made and seconded the MedImpact 1Q2018 P&T Minutes, and MedImpact 2Q2018 P&T Part D Actions were approved as submitted.
7	**Discussion and Recommendations for Changes to SCFHP Medi-Cal & Healthy Kids Formulary & Prior Authorization Criteria**	
	Formulary Modifications Dr. Otomo presented the formulary changes since the last P&T meeting.	Upon motion duly made and seconded, formulary modifications were approved as presented.
	DHCS Medi-Cal CDL Updates & Comparability Dr. McCarty presented DHCS Medi-Cal CDL Updates & Comparability.	
	Prior Authorization Criteria Dr. Duyen Nguyen presented the following PA criteria for approval by the committee: 1. Diabetic Supplies 2. Androgel 3. Humira 4. Enbrel	Upon motion duly made and seconded, prior authorization criteria were approved as presented.
	New Drugs and Class Reviews Dr. McCarty presented the following new drug reviews: 1. Aimovig 2. Erleada 3. PCSK9 Inhibitors Line Extensions: 1. Noctiva 2. Sinuva 3. Sublocade 4. Lonhala Magnair	Upon motion duly made and seconded, all recommendations were approved as presented.

	5. Firvanq 6. Bonjesta 7. Zypitamag	
	Reconvene in Open Session Committee reconvened to open session at 7:50 p.m.	
8	**Discussion Items**	
	Update on New Drugs and Generic Pipeline Dr. McCarty presented the generic pipeline for 1Q2018. High impact drugs: Symdeko, Erleada, Trogarzo, Ilumya, Andexxa, Aimovig, Epidiolex, baricitinib, lorlatinib, Nuvaring, Adcirca, Remodulin, Letairis, Ampyra, Cialis, Tracleer, Kaletra and medium/low impact drugs: Delzicol, Onexton, Zortress, Acanya, Levitra, Androgel, Moviprep, Flector, Proventil HFA, Rapaflo.	
9	**Adjournment at 7:55 PM**	

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
October 17, 2018

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	Y
Ngon Hoang Dinh, DO	Head and Neck Surgery	Y
Indira Vemuri, MD	Pediatrics	Y
Dung Van Cai, MD	OB/GYN	Y
Habib Tobaggi, MD	Nephrology	Y
Jeff Robertson, MD, CMO	Managed Care	Y
Ali Alkoraishi, MD	Adult and Child Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	N
Lily Boris, MD	Medical Director	Y
Jana Castillo	Utilization Management Manager	Y
Sandra Carlson	Health Services Director	Y
Caroline Alexander	Administrative Assistant	N
Sherry Holm	Behavioral Health Director	N

ITEM	DISCUSSION	ACTION REQUIRED
I. /II. Introductions Review/Revision/Approval of Minutes	Meeting was started with a Quorum at 6:05 PM. There was a motion to approve the July 18, 2018 minutes.	Minutes approved as presented.
III. Public Comment	No public comment.	

ITEM	DISCUSSION	ACTION REQUIRED
IV. CEO Update	Dr. Robertson presented the CEO update. The health plan moved to new location on July 30th. Participated in CMS audit, now working on corrective actions. New Chief Medical Officer Laurie Nakahira starts on October 31st.	
V. Old Business/Follow up items	Ms. Castillo presented some follow up items from the July 18th UM committee meeting. Presented authorization data for gastric bypass as well as criteria for gastric bypass. Six authorizations were pulled for date range of June 1st to August 31st of 2018. Age range of members ranged from 26 to 59 years of age, BMI ranged from 39 to 63. Reviewed guidelines for Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy as well as with Gastric Bypass.	No action required.
VI. Action Items	a. Prior Authorization Grid approval Ms. Castillo presented the 2019 Prior Authorization Grid. New grid combines all lines of business. Created a separate grid for medications (2019 Medical Benefit Drug Prior Authorization Grid). b. UM Program Evaluation 2017 Cal MediConnect Ms. Castillo presented the 2017 UM Program Evaluation for Cal MediConnect. Santa Clara Family Health Plan evaluates its Utilization Management (UM) Program annually to determine their overall effectiveness, identify needed improvements, and assess progress toward improvement of annual goals. The annual evaluation is also used to identify goals, trends, work plan activities, and opportunities for improvement in the coming year. SCFHP has a UM Program that objectively monitors and evaluates appropriate UM services delivered to members which operates with the principles outlined in the program. 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.	Approved as presented. Approved as presented.

ITEM	DISCUSSION	ACTION REQUIRED
VII. Reports	The 2017 UM program evaluation resulted in program changes. The UM program and UM policies were described to have it available for members and providers, the UM staff description was updated as staffing changes and expansion were implemented in mid-2017, Practitioner and member satisfaction monitoring were included, and Behavioral Health staff involvement was defined. These changes are outlined in the 2018 Program description. They are made to meet regulatory requirement and to ensure effectiveness of the program structure. UM continues to strive to meet regulatory requirements that are written in the 2018 UM Program description and to meet goals described in the 2018 UM work plan a. Membership Dr. Robertson presented the update on membership. As of October, membership is at 255,311. Membership remains flat. b. UM Reports 2018 i. Dashboard Metrics Dr. Boris presented the Dashboard Metrics report. Monitoring compliance based on turnaround time. Divided by lines of business. For CMC line of business, at 99.5% of compliance for routine requests, 98.7% compliant for expedited/urgent requests, 96.8% compliant for retro requests. For Medi-Cal line of business, 98.7% compliant for routine, urgent 99.4 %, retro 99.3%. Have implemented outbound calls to members and providers. Call member and inform them authorization is approved, fax provider immediately with letter and follow up with a call. ii. Standard Utilization Metrics Data is for July 1, 2017 to June 30, 2018. For MediCal/non SPD, discharges per thousand is at 3.68, with average length of stay 3.55. For Medi-Cal SPD discharges per thousand are at 11.82. Average length of stay 4.83. For CMC population 6.11 days average length of stay. Discharges per thousand 267.7. For NCQA Medicaid Benchmark Comparisons, Non SPD fall at less than 10%, SPD falls at greater than 90%. Combined total is less than 50% percentile ranking for average length of stay. Medi-Cal SPD's 141.9 discharges per thousand, CMC is at 262.7 per thousand. Average length of stay is 4.83 for Medi-Cal SPD and 6.11 for CMC. Inpatient Readmissions Medi-Cal Non SPD is at 15.57%. SPD Inpatient Readmissions for Medi-Cal overall average of 21.71%. Readmissions on CMC at 16.5%. NCQA Benchmark comparison for CMC Readmissions: Ages 18 to 64 readmission rate of 24.01%; Ages 65+	

ITEM	DISCUSSION	ACTION REQUIRED
	readmission rate of 13.52%. For age 18 to 64, greater than 90th percentile ranking, age 65+, greater than 50th percentile ranking. (Lower rate indicates better performance). Frequency of selected procedures have ranged where they have been. c. HS 04.01 Reporting Quality Monitoring of Plan Auths, Denials etc. (Q3 18) Ms. Castillo presented the Q3 2018 Quality Monitoring Report. Santa Clara Family Health Plan (SCFHP) completed the 3nd quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations. For the 3nd Quarter review of 2018, the findings are as follows: A. For the dates of services and denials for July, August and September of CY 2018 were pulled in the 3rd quarter sampling year. a. 30 unique authorizations were pulled with a random sampling. i. 57% or 17/30 Medi-Cal LOB and 43% or 13/30 CMC LOB ii. Of the sample 100% or 30/30 were denials iii. Of the sample 40% or 12/30 were expedited request; 60% or 18/30 were standard request. 1. 100% or 12/12 of the expedited authorizations met regulatory turnaround time of 72 calendar hours 2. 89% or 16/18 of the standard authorizations met regulatory turnaround time, 11% or 2/18 are non-compliant with regulatory turnaround time (5 business days for Medi-Cal LOB and 14 calendar days for CMC LOB) iv. 67% or 20/30 are medical denials, 33% or 10/30 are administrative denials v. 93% or 28/30 of cases were denied by MD, 7% or 2/30 cases were denied by a pharmacist vi. 100% or 30/30 were provided member and provider notification. vii. 58% or 7/12 expedited authorizations were provided oral notifications to member. viii. 83% or 25/30 of the member letters are of member's preferred language. ix. 100% or 30/30 of the letters were readable and rationale for denial was provided. x. 97% or 29/30 of the letters included the criteria or EOC that the decision was based upon.	

ITEM	DISCUSSION	ACTION REQUIRED
	xi. 100% or 30/30 of the letters included interpreter rights and instructions on how to contact CMO or Medical Director Manager of Utilization Management and Director of Health Services reviewed the findings of this audit and recommendations from that finding presented to UMC are as follows: • Provide staff training regarding oral notification to member following an expedited service authorization determination. • Provide staff training in managing regulatory turnaround time based on LOB. • Monitor other causes of untimeliness such as FDRs and escalate it to compliance. • Provide staff training in checking member's preferred language when sending member's UM letters. • Continue QA monitoring and reporting. d. Referral Tracking Ms. Castillo presented the Referral Tracking report for Q318. Not much claims authorization activity in August. Do a 3 month look back. 56.8% of authorizations have matched a claim for Cal Medi-Connect line of business. 55% of authorizations have matched a claim for Medi-Cal line of business. Do outbound calls to members to find out why the appointment was never attended or scheduled. Present to UM committee the findings. Dr. Tobaggi asked if there are members complaining they are not getting appointments and why we are doing these statistics. Dr. Boris explained DMHC requested data. e. Nurse Advice Line Stats Ms. Carlson presented the Nurse Advice Line Stats. Medi-Cal received 942 calls, Healthy Kids 15 calls, Cal MediConnect calls 45 during the third quarter of 2018 (September 2018 data not yet received). For Medi-Cal 31 triage dispositions rendered to call 911/EMS immediately. For Cal MediConnect, 4 triage dispositions were rendered to call 911/EMS immediately. For Health Kids, no triage dispositions rendered to call 911/EMS immediately. Highest volume for Triage Guidelines used for call types: Medi-Cal-CareNet Health Information only, Abdominal/Pelvic Pain, Abnormal vaginal bleeding, urinary symptoms (female), allergic reactions	

ITEM	DISCUSSION	ACTION REQUIRED
	Healthy Kids-CareNet Health Information only, Bites, Stings, Rash/Hives, Nasal allergies, Eye pus or discharge Cal MediConnect- CareNet Health Information only, BP Control problems, Insect bites/stings f. Interrater Reliability (Medical & Behavioral Health Q3) Twice a year staff is tested. Results are presented to UM Committee. For UM staff only 3 of 21 staff did not pass with score of 80% or higher. Most common reason was improper identification of required turnaround time for specific lines of business. Also lack of understanding for specific Care Coordinator guidelines and improper selection and application of clinical guidelines for medical review. The corrective action's plan after identifying the common findings are: • Mandatory remedial training and with retest for staff that were found non proficient within 1 month of the IRR test. Completed on 10/5/2018. • Continued training to all UM and MLTSS staff for all UM process and workflows to comply with regulatory standards. • UM management weekly monitoring as outlined in UM procedure and quarterly report to UM committee. Summary of the IRR remedial training: Attendees: All staff that were found non proficient in the IRR testing (1 coordinator and 2 licensed staff). Discussion topics: • Identification of lines of business • Regulatory turnaround time based on line of business • Care Coordinator Guidelines • UM Policy and procedure for Hierarchy of clinical criteria • Selection and application of clinical criteria, specifically MCG Retesting: 3 recreated hypothetical cases Scoring and passing score follows the same procedure as the IRR testing. All 3 staff that attended the remediation were re-tested and were found proficient. For behavioral health staff, 1 out of 3 staff did not pass with score of 80% or higher. Personal Care coordinator (PCC) was provided additional training on 9/27/18 and passed the re-test with a score of 90%. Retest was provided on 9/28/18. Findings were staff who are currently authorized to review/approve BH services through SCFHP express comfort in knowing the process/where to go for	

ITEM	DISCUSSION	ACTION REQUIRED
	clarification. While ongoing support throughout the department is provided, additional training is required for new PCC to review process of authorizations. This training was provided on 9/27/2018 and retesting completed on 9/28/2018. The corrective action's plan after identifying the common findings are: • Mandatory remedial training with post testing for all non-proficient staff • 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.	
VIII. Behavioral Health UM Reports	Dr. Boris presented the Dashboard Metrics reports for Behavioral Health. Divided by lines of business. For CMC line of business, at 100% of compliance for routine requests, 100% compliant for expedited/urgent requests, 100% compliant for retro requests. For Medi-Cal line of business, 95.3% compliant for routine, urgent 85.7 %, retro 98.8%. Have implemented outbound calls to members and providers.	Pull 6 months of data for LTSS and present at next UM committee meeting

ITEM	DISCUSSION	ACTION REQUIRED
IX. Adjournment	Meeting adjourned at 7:30 PM	

ITEM	DISCUSSION	ACTION REQUIRED
NEXT MEETING	The next meeting is scheduled for Wednesday, January 16, 2019, 6:30 PM	

Prepared by:

_____ Date _____
Caroline Alexander
Administrative Assistant

Reviewed and approved by:

_____ Date _____
Jimmy Lin, M.D.
Committee Chairperson

Santa Clara Family Health Plan™

QUALITY IMPROVEMENT

DASHBOARD

QUALITY IMPROVEMENT

DASHBOARD

Quarter 3 2018

Facility Site Review Timeliness	
Completed Timely	**100%**

Potential Quality of Care Issues	
Cases Opened	247
Cases Closed	75
% Closed	**30%**

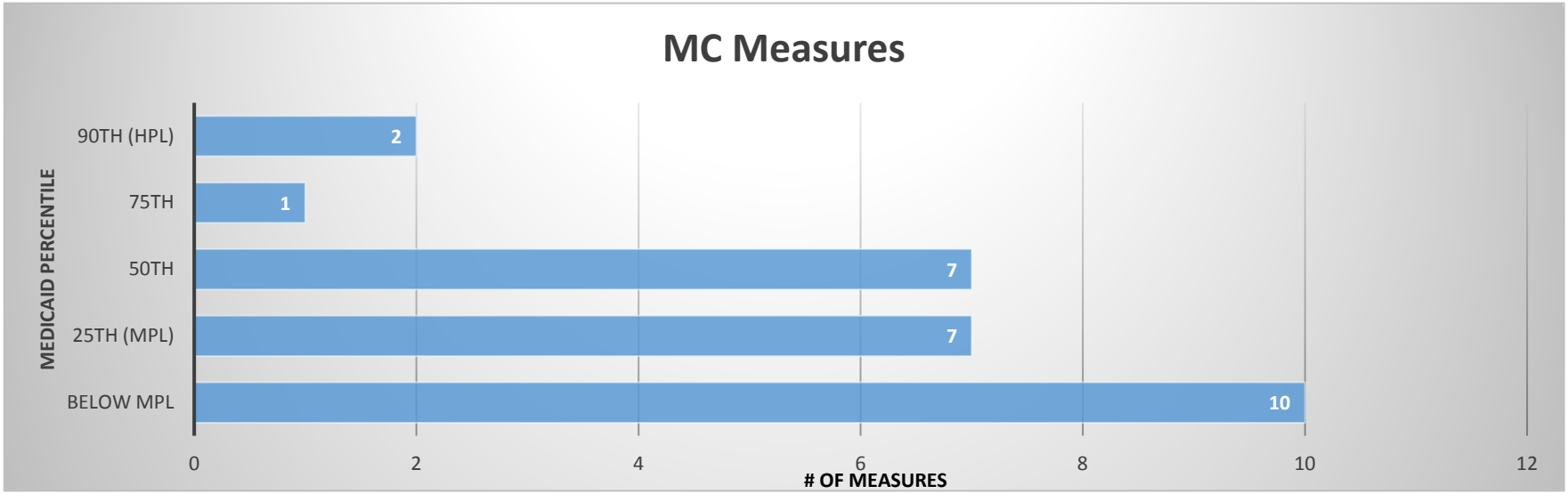
Initial Health Assessement	
# Enrolled	9770
# Completed	4315
% Completed	**44%**

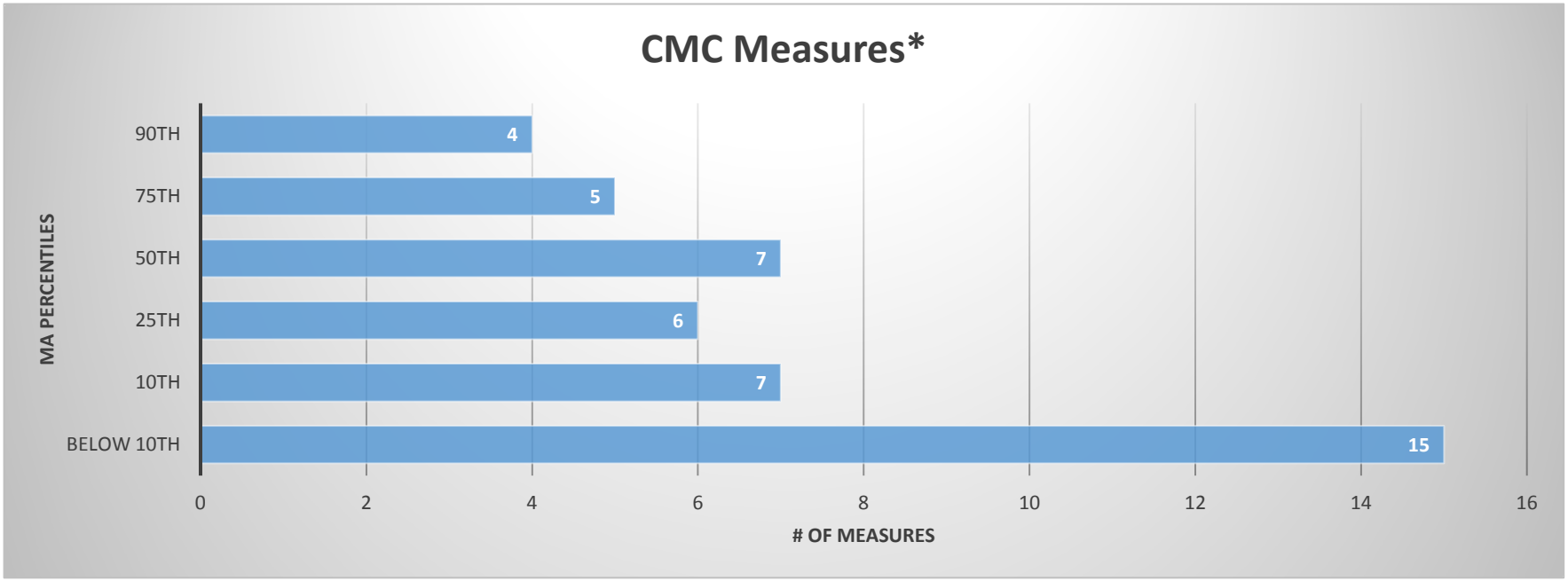
Gaps In Care	
Month	# Alerts Turned Off
September	49
October	326

QUALITY IMPROVEMENT

DASHBOARD - HEDIS - October 2018 (rolling 12 months from 8/30/18)

Santa Clara Family Health Plan™





**Measures are not held to MPL*

QUALITY IMPROVEMENT

DASHBOARD - HEDIS - Medi-Cal Rates

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Measure	Methodology	October 2018 Rate	October 2018 Percentile
Annual Monitoring for Patients on Persistent Medications ACE inhibitors or ARBs	ADMIN	88.61%	50th
Annual Monitoring for Patients on Persistent Medications Diuretics	ADMIN	89.41%	50th
Asthma Medication Ratio	ADMIN	88.88%	50th
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	ADMIN	46.22%	90th (HPL)
Breast Cancer Screening	ADMIN	63.28%	50th
Cervical Cancer Screening	HYBRID	52.77%	25th (MPL)
Childhood Immunization Status – Combo 3	HYBRID	34.99%	Below MPL
Children & Adolescents' Access to Primary Care Practitioners 12-24 Months*	ADMIN	94.18%	25th (MPL)
Children & Adolescents' Access to Primary Care Practitioners 25 Months – 6 Years*	ADMIN	86.52%	25th (MPL)
Children & Adolescents' Access to Primary Care Practitioners 7-11 Years*	ADMIN	88.91%	25th (MPL)
Children & Adolescents' Access to Primary Care Practitioners 12-19 Years *	ADMIN	85.63%	Below MPL
Comprehensive Diabetes Care Eye Exam (Retinal) Performed	HYBRID	57.30%	50th
Comprehensive Diabetes Care HbA1c Testing	HYBRID	86.53%	25th (MPL)
Comprehensive Diabetes Care HbA1c Poor Control (>9.0%)	HYBRID	55.35%	Below MPL
Comprehensive Diabetes Care HbA1c Control (<8.0%)	HYBRID	37.91%	Below MPL
Comprehensive Diabetes Care Medical Attn. for Nephropathy	HYBRID	87.63%	Below MPL
Comprehensive Diabetes Care Blood Pressure Control (<140/90 mm Hg)	HYBRID	0.00%	Below MPL
Controlling High Blood Pressure	HYBRID	0.00%	Below MPL
Immunizations for Adolescents - Combo 2^	HYBRID	40.96%	90th (HPL)
Medication Management for People with Asthma Medication Compliance 50% Total	ADMIN	31.65%	50th
Medication Management for People with Asthma Medication Compliance 75% Total	ADMIN	38.94%	50th
Prenatal & Postpartum Care Timeliness of Prenatal Care	HYBRID	65.48%	Below MPL
Prenatal & Postpartum Care Postpartum Care	HYBRID	61.82%	25th (MPL)
Use of Imaging Studies for Low Back Pain	ADMIN	76.05%	75th

Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents Counseling for Nutrition Total	HYBRID	30.06%	Below MPL
Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents Counseling for Physical Activity Total	HYBRID	13.70%	Below MPL
Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	HYBRID	71.50%	25th (MPL)

Percentile	Count
90th (HPL)	1
75th	1
50th	6
25th (MPL)	3
Below 10th	1

QUALITY IMPROVEMENT

DASHBOARD - HEDIS - Cal MediConnect (CMC) Rates

Santa Clara Family Health Plan™

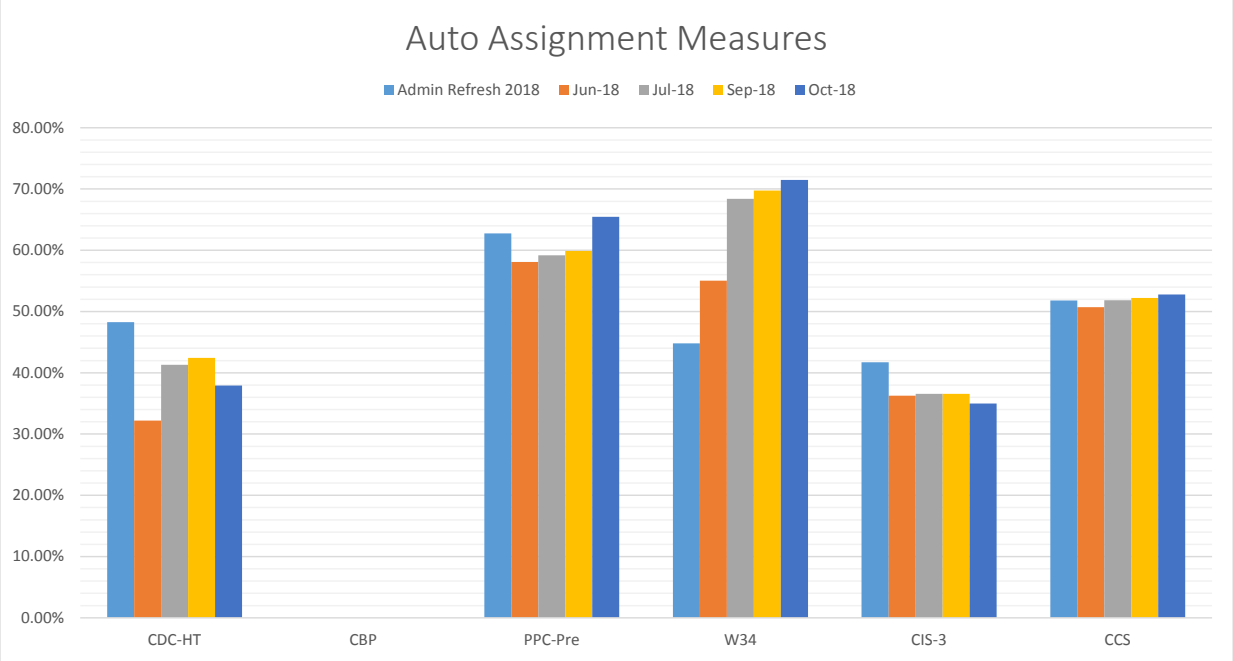
Measure	Methodology	October 2018 Rate	October 2018 Percentile
Controlling High Blood Pressure	HYBRID	0	Below MPL
Plan All-Cause Readmissions	ADMIN	15.60%	-
Follow up After Hospitalization for Mental Illness - 7 day follow up	ADMIN	30.77%	25th
Follow up After Hospitalization for Mental Illness - 30 day follow up	ADMIN	41.03%	25th
Adult BMI Assessment	HYBRID	39.48%	Below MPL
Breast Cancer Screening	ADMIN	60.43%	Below MPL
Colorectal Cancer Screening	HYBRID	50.27%	Below MPL
Non-Recommended PSA-Based Screening in Older Men	ADMIN	18.93%	90th
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	ADMIN	14.08%	Below MPL
Pharmacotherapy Management of COPD Exacerbation - systemic corticosteroid	ADMIN	71.01%	50th
Pharmacotherapy Management of COPD Exacerbation - bronchodilator	ADMIN	85.51%	75th
Persistence of Beta-Blocker Treatment after a Heart attack	ADMIN	96.15%	75th
Comprehensive Diabetes Care - HbA1c Testing	HYBRID	90.19%	Below MPL
Comprehensive Diabetes Care - HbA1c Control 8%	HYBRID	17.44%	Below MPL
Comprehensive Diabetes Care - HbA1c Poor Control	HYBRID	80.17%	Below MPL
Comprehensive Diabetes Care - Retinal Eye Exam	HYBRID	69.43%	25th
Comprehensive Diabetes Care - Medical Attention for Nephropathy	HYBRID	92.18%	Below MPL
Comprehensive Diabetes Care - Blood Pressure Controlled 140/90	HYBRID	19.89%	Below MPL
Disease Modifying Antirheumatic Drug Therapy for Rheumatoid Arthritis	ADMIN	89.53%	90th
Osteoporosis Management in Women Who Had a Fracture	ADMIN	26.83%	25th
Antidepressant Medication Management - Acute Phase	ADMIN	74.34%	50th
Antidepressant Medication Management - Continuation Phase	ADMIN	57.24%	50th
Potentially Harmful Drug-Disease Interactions in the Elderly - Falls + Tricyclic Antidepressants or Antipsychotics	ADMIN	41.13%	75th

Potentially Harmful Drug-Disease Interactions in the Elderly - Dementia + Tricyclic Antidepressants or Anticholinergic Agents	ADMIN	47.38%	25th
Potentially Harmful Drug-Disease Interactions in the Elderly - Chronic Renal Failure + Nonasprin NSAIDS or Cox-selective NSAIDs	ADMIN	5.16%	75th
Potentially Harmful Drug-Disease Interactions in the Elderly - Total	ADMIN	38.38%	50th
Use of High Risk Medications in the Elderly - One Prescription	ADMIN	21.04%	Below MPL
Use of High Risk Medications in the Elderly - At Least Two Prescriptions	ADMIN	12.18%	Below MPL
Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy Males 21-75	ADMIN	89.29%	90th
Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80% Males 21-75	ADMIN	78%	50th
Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy Females 40-75	ADMIN	70.15%	Below MPL
Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80% Females 40-75	ADMIN	65.96%	Below MPL
Statin Therapy for Patients with Diabetes - Received Statin Therapy	ADMIN	79.46%	90th
Statin Therapy for Patients with Diabetes - Received Statin Therapy	ADMIN	80.67%	75th
Adults Access to Preventive/Ambulatory Health Services 20-44	ADMIN	88.96%	25th
Adults Access to Preventive/Ambulatory Health Services 45-64	ADMIN	93.15%	Below MPL
Adults Access to Preventive/Ambulatory Health Services 65+	ADMIN	93.61%	Below MPL
Adults Access to Preventive/Ambulatory Health Services Total	ADMIN	93.34%	Below MPL
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment -Initiation Total	ADMIN	39.36%	50th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment -Engagement Total	ADMIN	3.19%	50th
Care of Older Adults - Advanced Care Planning	HYBRID	28.13%	Below MPL
Care of Older Adults - Medication Review	HYBRID	28.02%	Below MPL
Care of Older Adults - Functional Status Assessment	HYBRID	27.32%	Below MPL
Care of Older Adults - Pain Assessment	HYBRID	27.18%	Below MPL
Medication Reconciliation Post Discharge	HYBRID	3.44%	Below MPL

QUALITY IMPROVEMENT

DASHBOARD - HEDIS - Medi-Cal - Auto Assignment Measures - Administrative data only

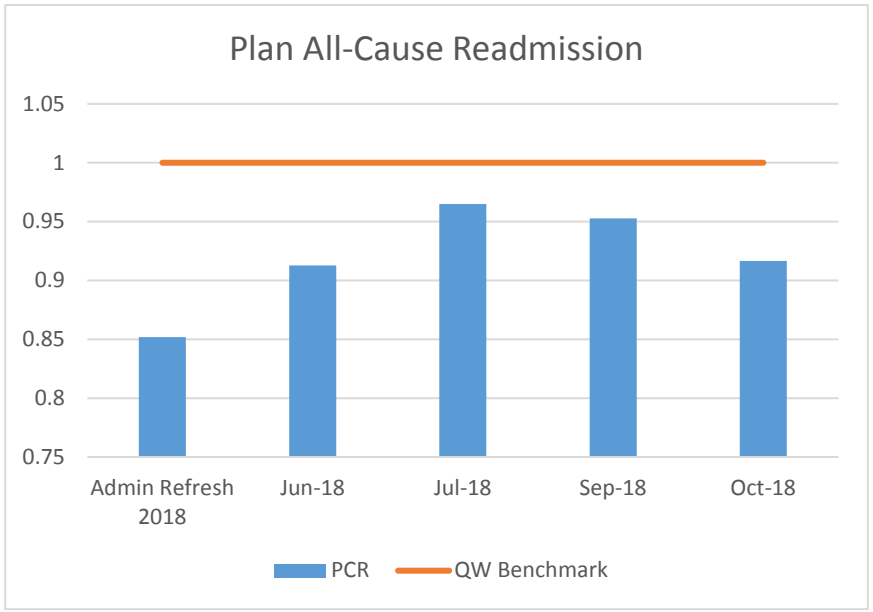
Admin Refresh Run data is based on Calendar Year 2017. Monthly Runs are on a rolling 12 month.

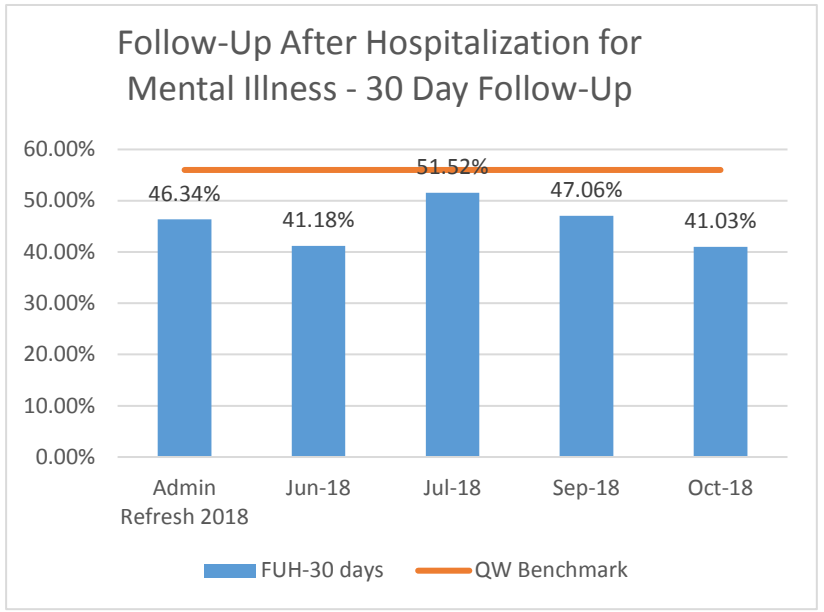


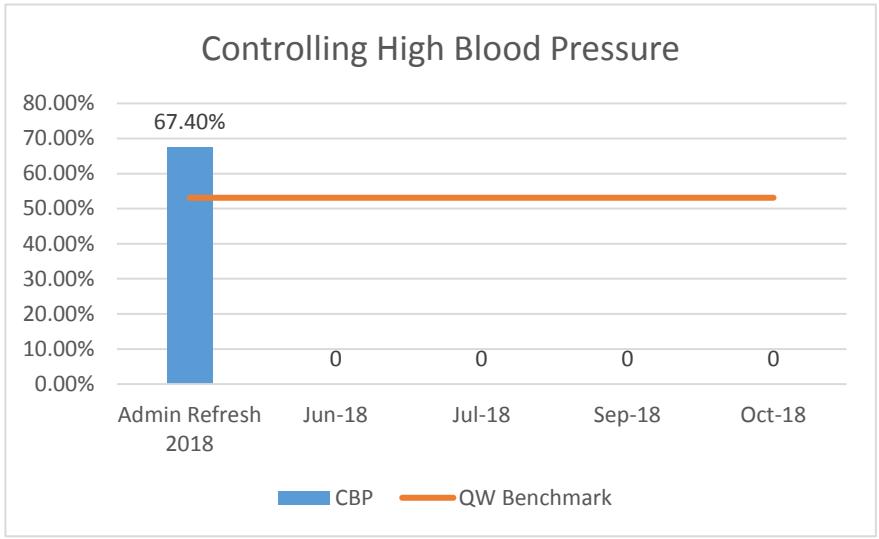
QUALITY IMPROVEMENT

DASHBOARD - HEDIS - CMC - Quality Withhold Measures

Admin Refresh Run data is based on Calendar Year 2017. Monthly Runs are on a rolling 12 month.







QUALITY IMPROVEMENT

DASHBOARD - CAHPS / HOS - CMC Only

Santa Clara Family Health Plan™

CAHPS Results					
Measure	**2016 Results**	**2017 Results**	**2018 Results**	**2018 CA MMP**	**Trend**
C03 - Annual Flu Vaccine	83%	77%	82%	69%	
C23 - Getting Needed Care	N/A	3.17	3.25	3.36	
C24 - Getting Appointments and Care Quickly	3.09	3.02	3.15	3.23	
C25 - Customer Service	N/A	N/A	3.52	3.64	
C26 - Rating of Health Care Quality	N/A	8.2	8.3	8.4	
C27 - Rating of Health Plan	8.3	8.2	8.4	8.6	
C28 - Care Coordination	N/A	3.5	3.47	3.5	
D07 - Rating of Drug Plan	8.4	8	8.4	8.5	
D08 - Getting Needed Prescription Drugs	N/A	N/A	3.63	3.63	

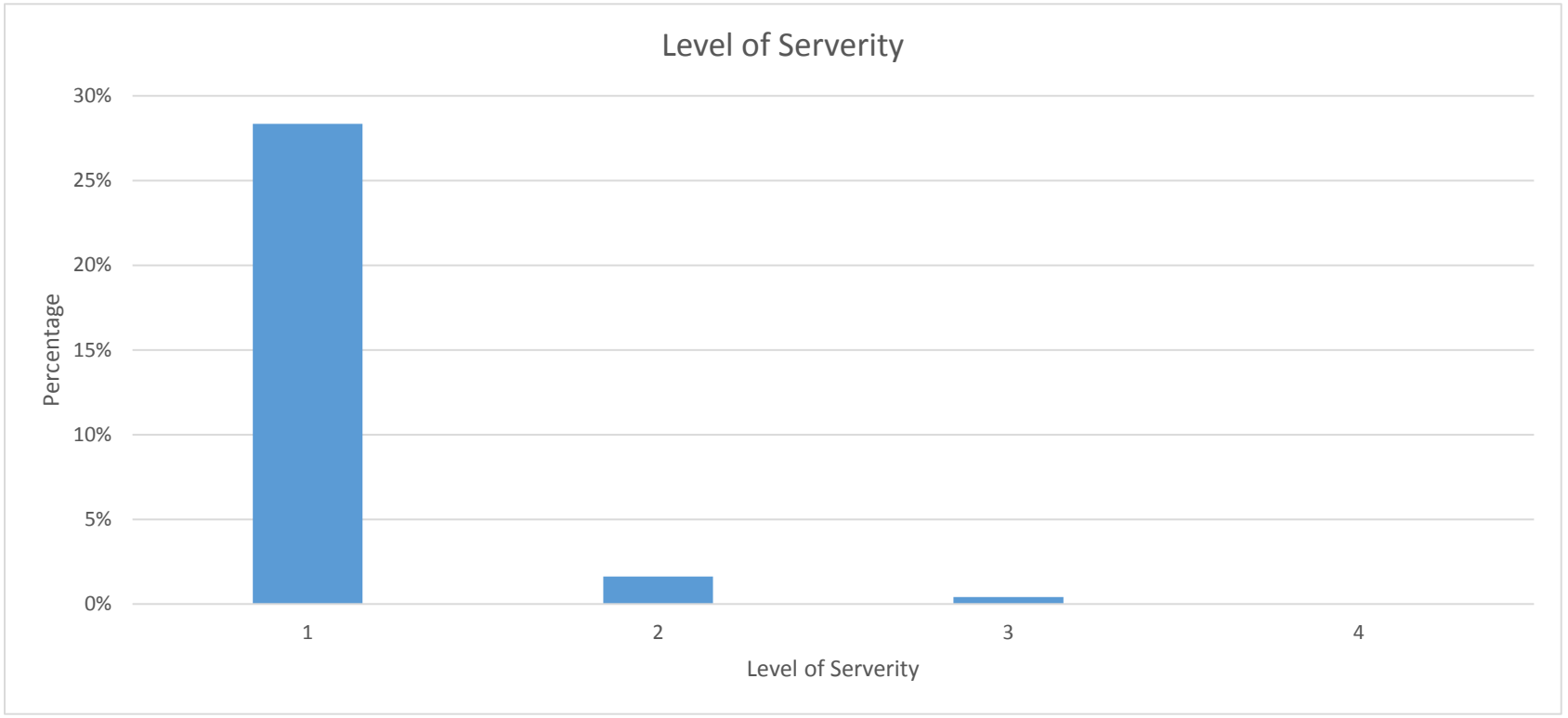
HOS Results			
Component	**2016 Results**	**2017 Results**	**2017 Baseline**
Physical Component Score	36.4	35.2	39.1
Mental Component Score	49.7	48.7	52.8
General Health			
Excellent to Good	54.8%	46.9%	71.1%
Fair to Poor	45.2%	53.1%	28.9%
Self- Rated Physical Health Compared to One Year Ago			
Much Better to About the Same	64.1%	60.9%	73.3%
Slightly Worse or Much Worse	35.9%	39.1%	26.7%
Self-Rated Mental Health Compared to One Year Ago			
Much Better to About the Same	81.30%	75.5%	87.0%
Slightly Worse or Much Worse	18.70%	24.5%	13.0%

QUALITY IMPROVEMENT

DASHBOARD - Potential Quality of Care (PQI) Issues

Quarter 3 2018

Potential Quality of Care Issues	
Cases Opened	247
Cases Closed	75
Percent Closed	**30%**



QUALITY IMPROVEMENT

DASHBOARD - Initial Health Assessment (IHA)

Santa Clara Family Health Plan™

SCFHP Completion - Q3 2018

Initial Health Assessment	July 2018	August 2018	September 2018	Total
# of members eligible for an IHA	3,302	3,344	3,124	9,770
# of IHA completed within 120 days of enrollment	1,525	1,442	1,348	4,315
% of IHA completed within 120 days of enrollment	46.2%	43.1%	43%	44%

Specific Network IHA Completion - Q2 2018

Initial Health Assessment	Network					
	10	20	30	40	50	60
# of members eligible for an IHA	523	5794	1046	306	1976	422
# of IHA completed within 120 days of enrollment	271	2412	648	171	920	229
% of IHA completed within 120 days of enrollment	51.82%	41.63%	61.95%	55.88%	46.56%	54.27%

QUALITY IMPROVEMENT

DASHBOARD - Quality Projects

Quarter 3 2018

Incentives - Medi-Cal

Incentive	Eligible Members	Incentive Received	Q3 Percentage
Controlling High Blood Pressure	821	14	2%
Childhood Immunization Status - Combo 3	343	12	3%
Comprehensive Diabetes Care - Nephropathy	212	2	1%

Prenatal Program

Incentive	Incentive Received
Gift Card	44
Carseat	31
Sleep Pod	27

Performance Improvement Project - Cal MediConnect

Individual Care Plan Completion

Study Indicator	Completion Goal	Quarter 2	Quarter 3
High risk members	63%	58.72%	66.93%
Low risk members	61.80%	57.09%	67.06%