AGENDA

For a Regular Meeting of the

Santa Clara County Health Authority
Pharmacy and Therapeutics Committee

Thursday, December 13, 2018, 6:00-8:00 PM
Santa Clara Family Health Plan, Redwood Conference Room
6201 San Ignacio Blvd., San Jose, CA 95119

1.	**Introductions**	Dr. Lin	6:00	5 min.
2.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The Committee reserves the right to limit the duration of public comment period to 30 minutes	Dr. Lin	6:05	5 min.
3.	**Meeting Minutes** Review SCFHP 3Q2018 P&T minutes **Possible Action:** Approve minutes	Dr. Lin	6:10	3 min.
4.	**Plan Updates**			
	a. CMO Health Plan Updates	Dr. Nakahira	6:13	3 min.
	b. Appeals & Grievances	Mr. Breakbill	6:16	3 min.
	c. SCFHP/DHCS Global DUR	Dr. Otomo	6:19	2 min.
	d. DHCS Provider Enrollment (APL 17-019)	Dr. Huynh	6:21	2 min.
	e. California Assessment of Health Care Provider And Systems (CAHPS)	Dr. Liu	6:23	3 min.
	f. Emergency Supply Report 4Q2017 & 1Q2018	Dr. Nguyen	6:26	5 min.

Adjourn to Closed Session
Pursuant to Welfare and Institutions Code Section 14087.36 (w)

5.	**Metrics & Financial Updates**			
	a. Membership Report	Dr. Nakahira	6:31	2 min.
	b. Pharmacy Dashboard	Dr. Otomo	6:33	3 min.
	c. Drug Use Evaluation Results	Dr. McCarty	6:36	2 min.
	d. Drug Utilization & Spend	Dr. McCarty	6:38	10 min.
6.	**Discussion and Recommendations for Changes to SCFHP Cal MediConnect (CMC) Formulary & Coverage Determination Criteria**			
	a. MedImpact 3Q2018 P&T Meetings Minutes	Dr. Huynh	6:48	2 min.
	b. MedImpact 4Q2018 P&T Part D Actions		6:50	2 min.

Possible Action: Approve MedImpact Minutes & Actions

7. **Discussion and Recommendations for Changes to SCFHP Medi-Cal & Healthy Kids Formulary & Prior Authorization (PA) Criteria**			
a. Formulary Modifications **Possible Action:** Approve recommendations	Dr. Otomo	6:52	5 min.
b. DHCS Medi-Cal CDL Updates & Comparibility **Possible Action:** Approve recommendations	Dr. McCarty	6:57	10 min.
c. Prior Authorization Criteria	Dr. Nguyen	7:07	5 min.
i. New & Changes to Criteria 1. Amitiza 2. Humira			
ii. Annual Review 1. Zarxio **Possible Action:** Approve criteria	Dr. Nguyen	7:12	3 min.
8. **Discussion and Recommendations for Changes to SCFHP Medical Benefit Drug Prior Authorization Grid for SCFHP CMC, Medi-Cal, & Healthy Kids**			
a. Prior Authorization & Step Therapy Review **Possible Action:** Approve Medical Benefit PA Grid	Dr. Huynh	7:15	5 min.
9. **New Drugs and Class Reviews** a. Influenza (Xofluza) b. Oncology update (Tibsovo, Azedra, Poteligeo, Copiktra, Vizimpro, Libtayo) c. New entities d. Line extension e. Xarelto Update f. Asthma Update (Dupilumab) **informational only* g. Solriamfetol **informational only* h. Hemophilia Update (Hemlibra) **informational only* i. Expanded indications **informational only* **Possible Action:** Approve recommendations	Dr. McCarthy	7:20	35 min.

Reconvene in Open Session

10. **Discussion Items** New Brand and Generic Pipeline	Dr. McCarty	7:55	5 min.
11. **Adjournment** Next meeting Thursday, March 21, 2019	Dr. Lin	8:00	

Notice to the Public—Meeting Procedures

- Persons wishing to address the Committee on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.

- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify 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 Avenue, San Jose.

- This agenda and meeting documents are available at www.scfhp.com

Meeting Minutes

Regular Meeting of the
Santa Clara County Health Authority d.b.a. Santa Clara Family Health Plan
OPEN SESSION - **Pharmacy & Therapeutics Committee**
Thursday, September 20, 2018
6:00 PM - 8:00 PM
6201 San Ignacio Avenue San Jose, CA 95119

MINUTES

Voting Committee Members	Specialty	Present (Y or N)
Jimmy Lin, MD	Internal Medicine	N
Hao Bui, BS, PharmD	Community Pharmacy (Walgreens)	N
Minh Thai, MD	Family Practice	N
Amara Balakrishnan, MD	Pediatrics	Y
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	N
Xuan Cung, PharmD	Pharmacy Supervisor (VHP)	Y
Johanna Liu, PharmD, MBA	SCFHP Director of Quality and Pharmacy	N
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	N

	Topic and Discussion	Follow-Up Action
1	**Introductions**	
	The meeting convened at 6:15 PM.	
2	**Public Comment**	
	No public comment.	
3	**Past Meeting Minutes**	
	The SCFHP 2Q2018 P&T Minutes from June 21, 2018 were reviewed by the Committee as submitted. One minor correction on the address in	Upon motion duly made and seconded, the SCFHP 2Q2018 P&T Minutes from June 21, 2018

	Health Plan Updates section. Address should be 6201 San Ignacio Avenue, not 50 Great Oaks.	were approved as corrected 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 has moved to the new building on 6201 San Ignacio Avenue. Completed first CMS audit. Health Plan delegates to MedImpact and there were findings. Policy and procedure changes are being made to address this. Approximately 40 findings, close to national average of 36 findings.	
	Appeals & Grievances Dr. Huynh presented the Appeals & Grievances report Q3 2017 through Q2 2018. Slight decrease in Medi-Cal appeals. Downward trend. Committee requested to know what happened in March 2018. Majority were upheld (49%), 33%.	
	SCFHP Global DUR Dr. Huynh presented and update on Global DUR. Health Plan will be running reports similar to DHCS DUR team. Evaluating medications in our population.	
	Annual Charter Review Dr. Robertson presented the Pharmacy committee charter for annual review. No changes made to the charter.	
	Hepatitis C Policy Update Dr. Huynh presented an update on the Hepatitis C policy. Policy update was effective on July 1st. Main change is not looking at fibrosis score. Age requirement is 12 years and up.	
	2019 CMC Transition Fill Policy For state covered drugs, the plan will apply transition of care logic to non-Part D drugs. The logic is similar to the Part D functionality and allows new enrollees a transition fill for a defined period of time for a specific day supply limit (e.g., 31 day supply). The plan will ensure that in the retail setting, the transition policy provides for up to a one-time, temporary 1 month's supply day fill(unless the enrollee presents with a prescription written for less than 31 days in which case the plan must allow multiple fills to provide up to a total of 31 days of medication). The plan will ensure that in the long-term care setting, the transition policy provides for a 1 month supply day fill consistent with the	Upon motion duly made and seconded, 2019 CMC Transition Fill Policy was approved as presented.

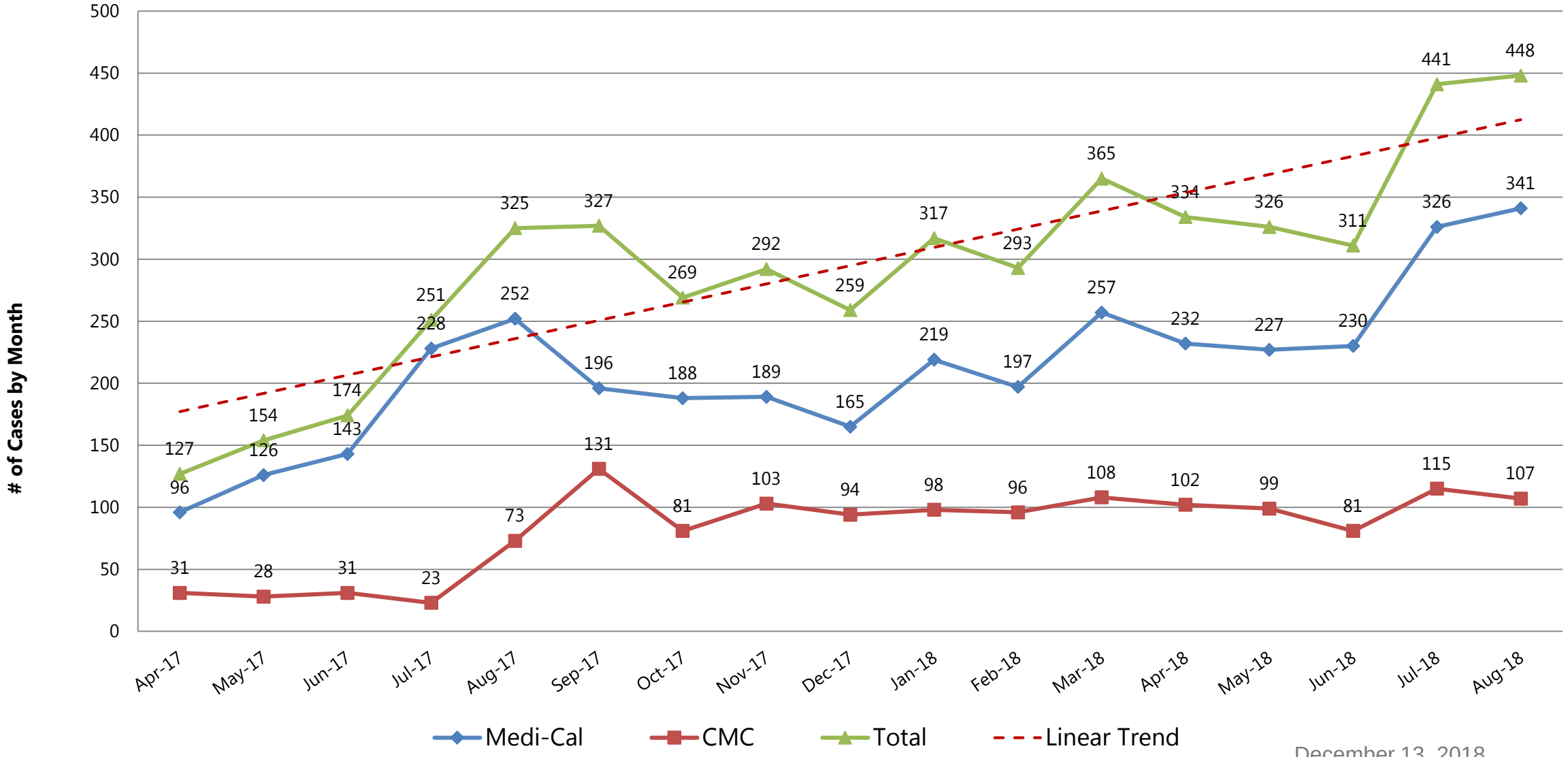
	applicable dispensing increment in the long-term care setting (unless the enrollee presents with a prescription written for less), with refills provided if needed during the first 90 days of a member's enrollment in a plan, beginning on the enrollee's effective date of coverage.	
	2019 CMC Opioid Strategy Dr. Huynh presented the 2019 CMC Opioid Strategy. In alignment with CDC recommendation. Soft edit is 90 or more at point of sale at pharmacy. Hard edit requires coverage determination. Seven day supply for new start. Pharmacist may override point of sale edit on concurrent opioid and benzo or if on two long lasting opioids from 2 or more prescribers.	
	Adjourn to Closed Session Committee adjourned to closed session at 6:43 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.	
	Drug Use Evaluation Results Dr. McCarty presented the Drug Use Evaluation Results 3Q18.	
	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 2Q2018 P&T minutes as well as the MedImpact 3Q2018 P&T Part D Actions.	Upon motion duly made and seconded the MedImpact 2Q2018 P&T Minutes, and MedImpact 3Q2018 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.	Upon motion duly made and seconded, formulary recommendations were approved as presented.
	Prior Authorization Criteria Dr. Duyen Nguyen presented the following PA criteria for approval by the committee: New and Changes to Criteria: 1. Retacrit 2. Hepatitis C 3. Humira 4. Enbrel 5. Myrbetriq 6. Nicotrol Annual Review (no changes): 1. Proventil 2. Emend 3. Penlac 4. Duragesic 5. Brand Name 6. Compounded Medications 7. Off-label 8. Opioid Reauthorization	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. Crysvita 2. Tavalisse 3. Doptelet 4. Palynziq 5. Epidiolex 6. Braftovi/Mektovi New Derivatives, Formulation, & Combinations: 1. Balcoltra 2. Jynarque 3. Osmolex ER 4. Yonsa	Upon motion duly made and seconded, all recommendations were approved as presented.

	5. RoxyBond 6. Imvexxy 7. Intrarosa 8. Siklos Biosimilar: Retacrit & Fulphila HAE, haTTR and Continuous Glucose Monitoring	
	Reconvene in Open Session Committee reconvened to open session at 7:55 p.m.	
8	**Discussion Items**	
	Update on New Drugs and Generic Pipeline Dr. McCarty presented the generic pipeline for 3Q2018, 4Q2018, 1Q2019. High impact drugs: Letairis, Adcirca, Remodulin, Cialis, Tracleer, Byetta, Kaletra, Nuvaring and medium/low impact drugs: Acanya, Abastral, Levitra, Moviprep, Delzicol, Flector, Androgel, Astagraf XL, Onfi, Staxyn, Finacea Gel, Rapaflo, Canasa, Zyclara, Ranexa, Solodyn, Faslodex, and Tekturna.	
9	**Adjournment at 8:00 PM**	

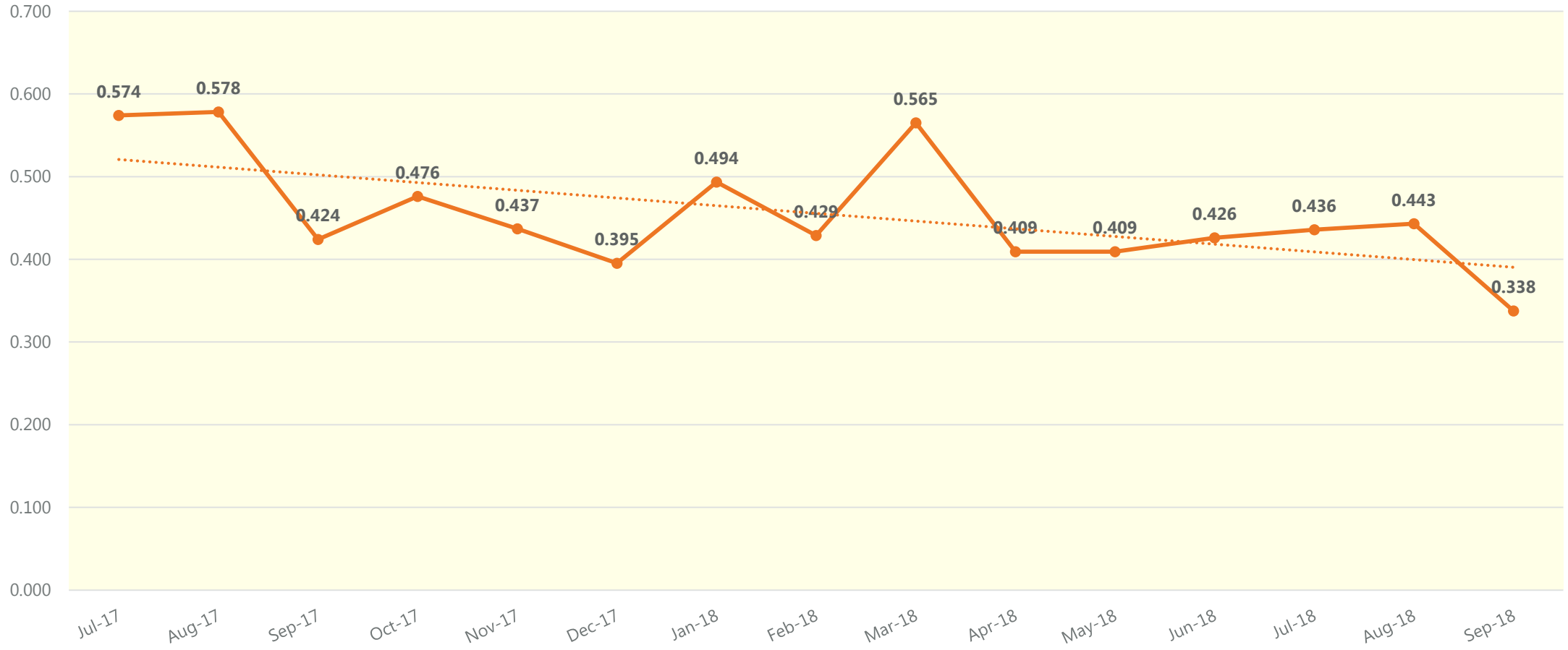
Plan Updates

G&A Department Caseload



Q3 2017 – Q3 2018: Medi-Cal Appeals

Appeals Per 1000 Members

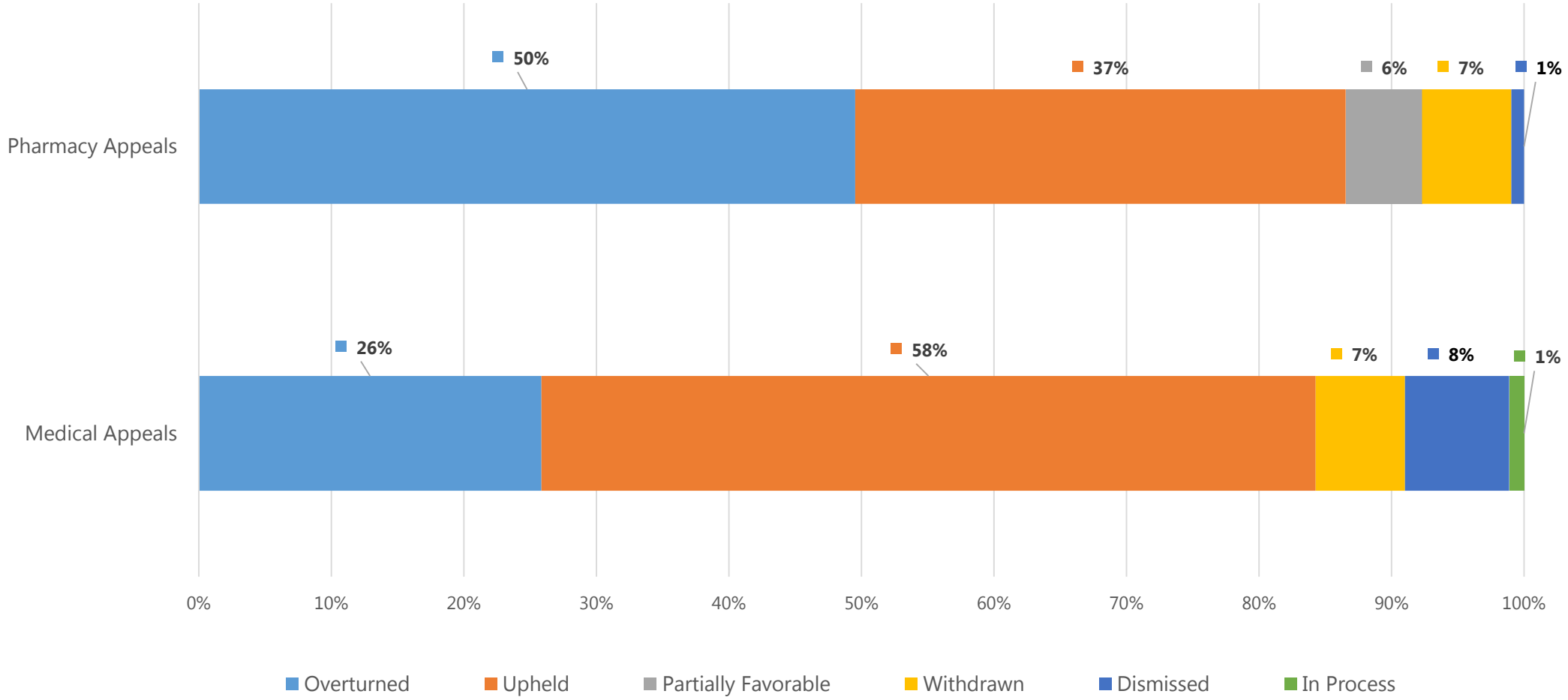


Q3 2017 – Q3 2018: Medi-Cal Rates per 1000

	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**

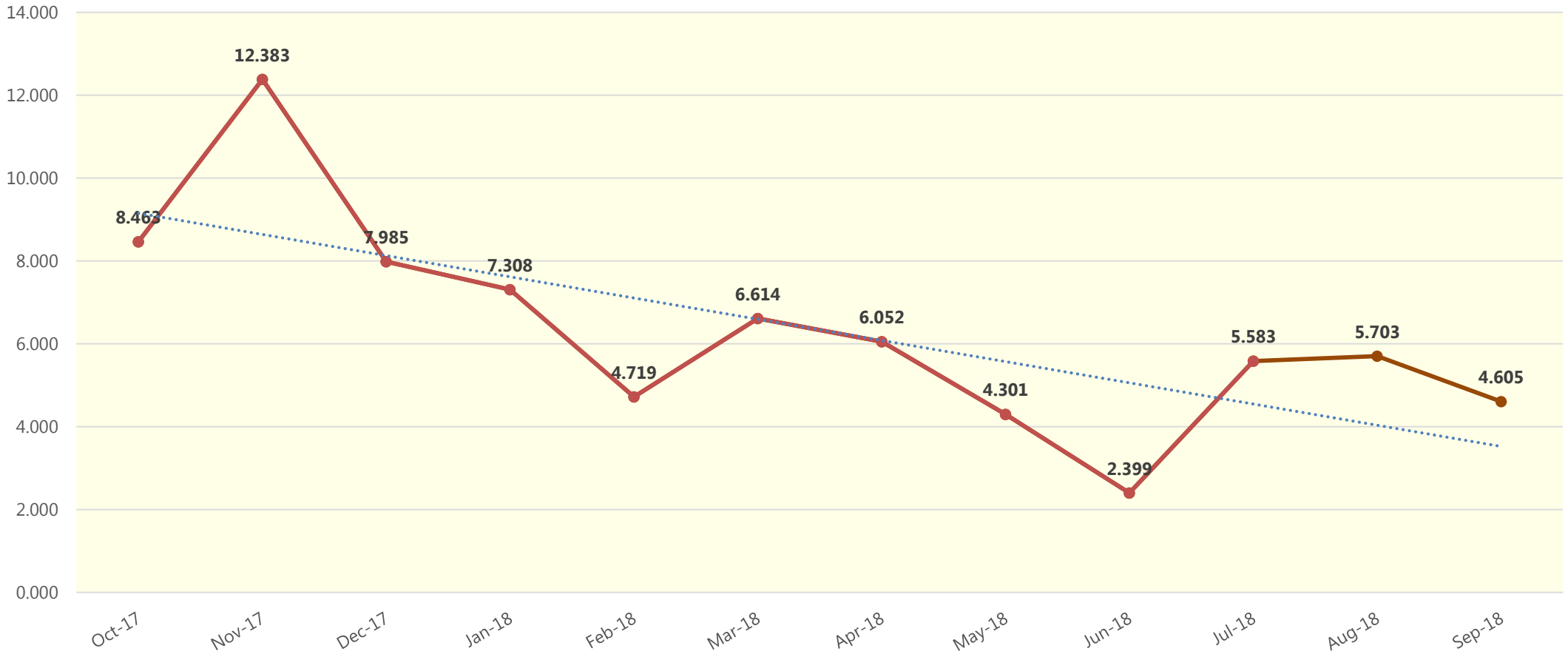
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Total Grievances	85	118	94	87	92	73	106	107	123	137	149	123	226	228	227
Healthy Kids Membership	2,633	2,618	2,243	2,288	2,321	2,447	3,209	3,250	3,415	3,454	3,220	3,196	3,278	3,187	3,163
Medi-Cal Membership	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



Q4 2017 – Q3 2018: CMC Appeals

Part C & D Appeals Per 1000 Members

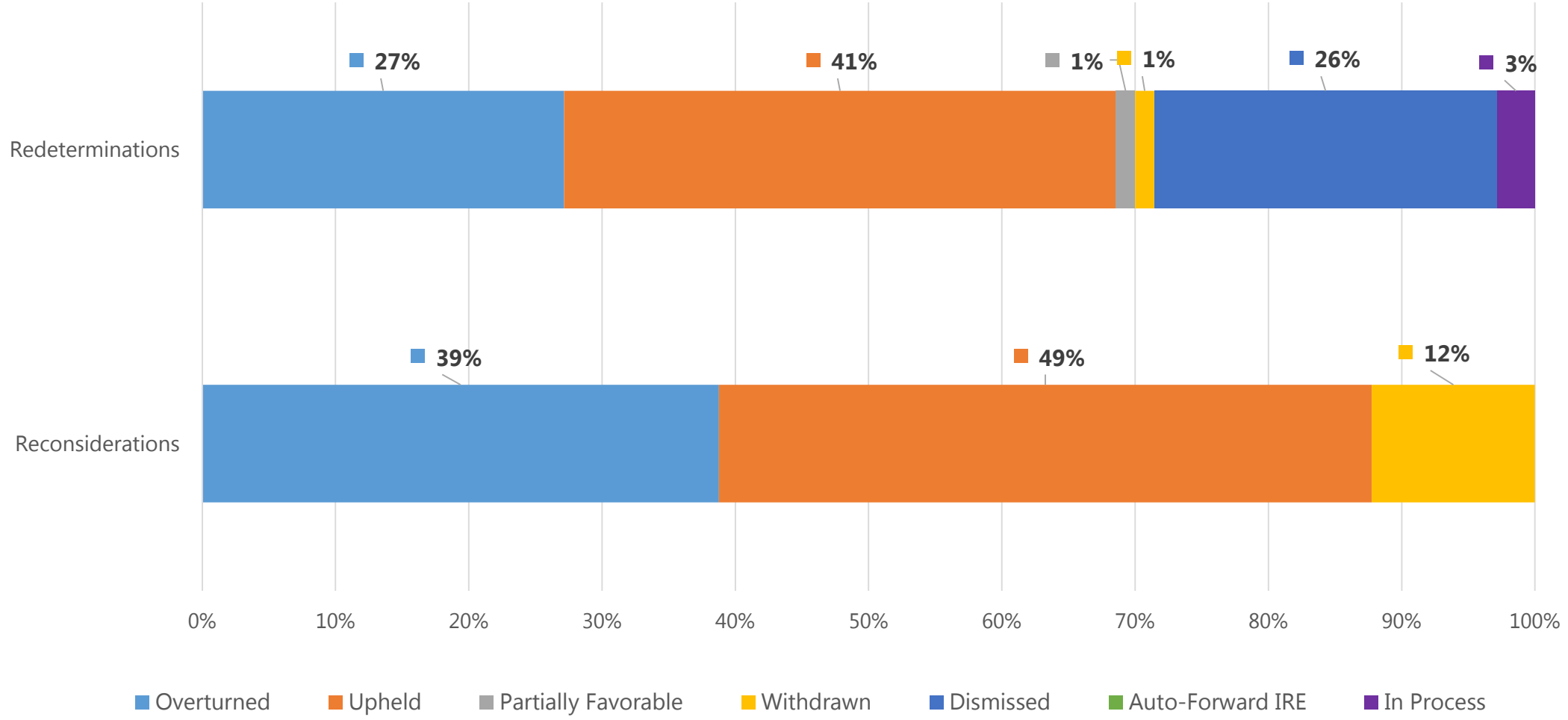


Q4 2017 – Q3 2018: CMC Rates per 1000

	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



State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: November 14, 2017

ALL PLAN LETTER 17-019
SUPERSEDES ALL PLAN LETTER 16-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVIDER CREDENTIALING / RECREDENTIALING AND SCREENING / ENROLLMENT

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their responsibilities related to the screening and enrollment of all network providers pursuant to the Centers for Medicare and Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule), CMS-2390-F,[1] dated May 6, 2016. Additionally, this APL clarifies MCPs' contractual obligations related to credentialing and recredentialing as required in Title 42 Code of Federal Regulations (CFR), Section 438.214.[2] This APL supersedes APL 16-012.[3] The screening and enrollment responsibilities are located in Part: 1 and the credentialing and recredentialing responsibilities are located in Part: 2 of this APL.

All MCP network providers must enroll in the Medi-Cal Program. MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through the Department of Health Care Services (DHCS). MCPs electing to establish their own enrollment process are expected to have their infrastructure in place by January 1, 2018.

BACKGROUND:
On February 2, 2011, CMS issued rulemaking CMS-6028-FC[4] to enhance fee-for-service (FFS) provider enrollment screening requirements pursuant to the Affordable Care Act. The intent of Title 42 CFR, Part 455, Subparts B and E[5] was to reduce the

[1] CMS-2390-F is available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[2] Title 42 CFR Section 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=755076fcbadfbe6a02197ec96e0f7e16&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_1214
[3] APL 16-012 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-012.pdf
[4] CMS-6028-FC is available at: https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf
[5] Title 42 CFR, Part 455, Subparts B and E are available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=3471319414e845a757a46ec42cde2b72&mc=true&node=pt42.4.455&rgn=div5

incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

In May 2016, CMS issued rulemaking CMS-2390-F, which extended the provider screening and enrollment requirements of 42 CFR, Part 455, Subparts B and E to MCP contracted providers (Title 42 CFR, Section 438.602(b)). These requirements are designed to reduce the number of providers who do not meet CMS provider enrollment requirements from participating in the MCPs' provider networks.

MCPs are required to maintain contracts with their network providers (Plan-Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. However, prior to the Final Rule, the MCPs' network providers were not required to enroll in the Medi-Cal Program. Title 42 CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, in accordance with the requirements of Title 42 CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers[6] as well as prospective network providers.

The Medi-Cal FFS delivery system currently enforces a statewide set of enrollment standards that the Medi-Cal managed care program and MCPs must now implement.[7] Although the implementation date for Title 42 CFR Section 438.602(b) is not scheduled until July 1, 2018, Section 5005(b)(2) of the 21st Century Cures Act (Cures Act),[8] requires managed care network provider enrollment to be implemented by January 1, 2018.

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. The credentialing and recredentialing process is one component of the comprehensive quality improvement system required in all MCP contracts.[9] Credentialing is defined as the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, and/or professional association membership. The credentialing process ensures that providers are properly licensed and certified as required by state and federal law.

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[6] Exhibit E, Attachment 1 Definitions. The MCP Boilerplate contracts can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

[7] State-specific Medi-Cal FFS provider enrollment requirements are contained in Title 22, CCR, Section 51000 through 51051, and Welfare & Institutions Code, Division 9, Part 3, Chapter 7 (commencing with Section 14043).

[8] 42 USC § 1396u-2 (d)(6)(A)

[9] Exhibit A, Attachment 4, Credentialing and Recredentialing.

POLICY:

Part 1: Medi-Cal Managed Care Screening and Enrollment Requirements

Available Enrollment Options

MCPs may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, MCPs may also rely on the enrollment and screening results conducted by DHCS or other MCPs. MCPs can access the California Health and Human Services' (CHHS) Open Data Portal[10] to obtain a list of currently enrolled Medi-Cal FFS providers. MCPs are required to issue network providers a "verification of enrollment" that MCPs can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results.

Providers who enroll through the DHCS enrollment process may participate in both the Medi-Cal FFS program as well as contract with an MCP (provided the MCP chooses to contract with the provider). However, providers who only enroll through an MCP may not also participate in the Medi-Cal FFS program. Although DHCS does not require that managed care providers enroll as FFS providers, if a provider wishes to participate in, or receive reimbursement from, the Medi-Cal FFS program, the provider must enroll as a Medi-Cal FFS provider through DHCS.

MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis.

MCP Enrollment Processes

If the MCP elects to enroll a provider, the MCP must comply with the following processes:

General Requirements:

A. MCP Provider Application and Application Fee

MCPs are not required to use DHCS' provider enrollment forms. However, MCPs must ensure that they collect all the appropriate information, data elements, and supporting documentation required for each provider type.[11] In addition, MCPs must ensure that every network provider application they process is reviewed for both accuracy and

[10] The CHHS Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017

[11] Applications packages by provider type can be found at the following: http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. For associated definitions and provider types see Title 22 CCR 51000 – 51000.26 and 51051.

completeness. MCPs must ensure that all information specified in Title 22, California Code of Regulations (CCR), including but not limited to, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments to the application package have been received. The MCP must obtain the provider's consent in order for DHCS and the MCP to share information relating to the provider's application and eligibility, including but not limited to issues related to program integrity.

MCPs may collect an application fee, established by CMS from unenrolled prospective network providers, to cover the administrative costs of processing a provider's screening and enrollment application. The MCP's application fee policy must be comparable to, and must not exceed, the state's application fee.[12] The application fee for calendar year 2017 is $560. Before collecting this fee, the MCP should be certain that the network provider is not already enrolled.

B. DHCS Provider Enrollment Agreement and Plan Provider Agreement

All Medi-Cal providers are required to enter into a provider enrollment agreement with the state (DHCS Provider Enrollment Agreement) as a condition of participating in the Medi-Cal Program pursuant to Section 1902(a)(27) of the Social Security Act and Section 14043.1 of the Welfare & Institutions Code. As part of the enrollment process, MCPs are responsible for ensuring that all successfully enrolled providers execute and sign the DHCS Provider Enrollment Agreement. This provider agreement is separate and distinct from the Plan Provider Agreement (see below). MCPs must maintain the original signed DHCS Provider Enrollment Agreement for each provider and must submit a copy to DHCS, CMS, and other appropriate agencies upon request. MCPs are responsible for maintaining all provider enrollment documentation in a secure manner and place that ensures the confidentiality of each provider's personal information. These enrollment records must be made available upon request to DHCS, CMS, or other authorized governmental agencies.

The agreement between the MCP and a provider (Plan Provider Agreement) is separate and distinct from the DHCS Provider Enrollment Agreement. Both the DHCS Provider Enrollment Agreement and the Plan Provider Agreement are required for MCP network providers. The DHCS Provider Enrollment Agreement does not expand or alter the MCP's existing rights or obligations relating to its Plan Provider Agreement.

C. Review of Ownership and Control Disclosure Information

As a requirement of enrollment, providers must disclose the information required by Title 42, CFR, Sections 455.104, 455.105, and 455.106, and Title 22, CCR, Section 51000.35. Providers who are unincorporated sole-proprietors are not required to

[12] Application Fee information is available at: http://www.dhcs.ca.gov/provgovpart/Pages/AppFeeChange2017.aspx

disclose the ownership or control information described in Title 42, CFR, Section 455.104. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42, CFR, Section 455.104.

Full disclosure throughout the enrollment process is required for participation in the Medi-Cal Program. These disclosures must be provided when:

- A prospective provider submits the provider enrollment application.
- A provider executes the DHCS Provider Enrollment Agreement.
- A provider responds to an MCP's request during the enrollment re-validation process.
- Within 35 days of any change in ownership of the network provider.

Upon MCP request, a network provider must submit within 35 days:

- Full and complete information about the ownership of any subcontractor with whom the network provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,
- Any significant business transactions between the network provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.[13]

Additionally, MCPs must comply with the requirements contained in Title 22, CCR, Section 51000.35, Disclosure Requirements. MCPs are not required to utilize the DHCS disclosure forms (DHCS 6207 and 6216[14]); however, MCPs must collect all information and documentation required by Title 22, CCR, Section 51000.35.

D. "Limited," "Moderate," "High" Risk Assignment

MCPs must screen initial provider applications, including applications for a new practice location, and any applications received in response to a network provider's reenrollment or revalidation request to determine the provider's categorical risk level as "limited," "moderate," or "high." If a provider fits within more than one risk level, the MCP must screen the provider at the highest risk level.

The federal requirements for screening requirements and for MCPs to stratify their network providers by risk level are set forth in Attachment 1 to this APL. These federal requirements list provider types considered as limited risk, moderate risk, and high risk, and define the screening requirements for each level of risk. A provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated provider lists, and criminal background checks. MCPs are

[13] 42 CFR 455.105(b)
[14] DHCS Forms 6207 and 6216 are available at: http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

not able to enroll a provider who fails to comply with the screening criteria for that provider's assigned level of risk.

Providers are subject to screening based on verification of the following requirements:

Limited-Risk Providers:

- Meet state and federal requirements.
- Hold a license certified for practice in the state and has no limitations from other states.
- Have no suspensions or terminations on state and federal databases.

Medium-Risk Providers:

- Screening requirements of limited-risk providers.
- Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to the MCP and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

High-Risk Providers:

- Screening requirements of medium-risk providers.
- Criminal background checks based in part on a set of fingerprints.

The MCP and DHCS will adjust the categorical risk level when any of the following circumstances occur:

- The state imposes a payment suspension on a provider based on a credible allegation(s) of fraud, waste, or abuse.
- The provider has an existing Medicaid overpayment based on fraud, waste, or abuse.
- The provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten years, or when a state or federal moratorium on a provider type has been lifted.

DHCS will provide the information necessary to determine provider risk level to MCPs on a regular basis. MCPs may also obtain this information upon request from their DHCS Managed Care Operations Division (MCOD) contract manager.

E. Additional Criteria for High Risk Providers - Fingerprinting and Criminal Background Check

High-risk providers are subject to criminal background checks, including fingerprinting and the screening requirements for medium-risk providers. Regardless of whether a high-risk provider has undergone fingerprinting in the past, the requirement to submit to a criminal background check and fingerprinting remains the same. Any person with a

5% or more direct or indirect ownership in a high-risk applicant must submit to a criminal background check.[15] In addition, information discovered in the process of onsite reviews or data analysis may lead to a request for fingerprinting and criminal background checks for applicants.

DHCS will coordinate all criminal background checks. DHCS will make a pre-filled Live Scan form available to all MCPs to distribute to providers. When fingerprinting is required, MCPs must furnish the provider with the Live Scan form and instructions on where to deliver the completed form. It is critical that MCPs distribute the designated Live Scan form as this ensures the criminal history check results are forwarded directly to DHCS. The provider is responsible for paying for any Live Scan processing fees. MCPs must notify DHCS upon initiation of each criminal background check for a provider that has been designated as high risk. DHCS will provide notification of the Live Scan results directly to the MCP. The MCP must maintain the security and confidentiality of all of the information it receives from DHCS relating to the provider's high-risk designation and the results of criminal background checks.

F. Site Visits

MCPs must conduct pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the MCP and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements, including but not limited to, Title 22, CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. In addition, all providers enrolled in the Medi-Cal Program, including providers enrolled through MCPs,[16] are subject to unannounced onsite inspections at all provider locations.

Onsite visits may be conducted for many reasons including, but not limited to, the following:

- The provider was temporarily suspended from the Medi-Cal Program.
- The provider's license was previously suspended.
- There is conflicting information in the provider's enrollment application.
- There is conflicting information in the provider's supporting enrollment documentation.
- As part of the provider enrollment process, the MCP receives information that raises a suspicion of fraud.

[15] Welfare and Institutions Code 14043.38(c)(2)
[16] 42 CFR 455.432

G. Federal and State Database Checks

During the provider enrollment process, MCPs are required to check the following databases to verify the identity and determine the exclusion status of all providers:

- Social Security Administration's Death Master File.[17]
- National Plan and Provider Enumeration System (NPPES).[18]
- List of Excluded Individuals/Entities (LEIE).[19]
- System for Award Management (SAM).[20]
- CMS' Medicare Exclusion Database (MED).[21]
- DHCS' Suspended and Ineligible Provider List.[22]

H. Denial or Termination of Enrollment/Appeal Process

MCPs may enroll providers to participate in the Medi-Cal Managed Care Program. However, if the MCP declines to enroll a provider, it must refer the provider to DHCS for further enrollment options. If the MCP acquires information, either before or after enrollment, that may impact the provider's eligibility to participate in the Medi-Cal Program, or a provider refuses to submit to the required screening activities,[23] the MCP may decline to accept that provider's application. However, only DHCS can deny or terminate a provider's enrollment in the Medi-Cal Program.

If at any time the MCP determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, the MCP must immediately suspend the enrollment process. The MCP must inform the prospective provider that he/she may seek enrollment through DHCS.[24]

MCPs are not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.[25]

I. Provider Enrollment Disclosure

At the time of application, MCPs must inform their network providers, as well as any providers seeking to enroll with an MCP, of the differences between the MCP's and

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[17] Social Security Administration's Death Master File is available at: https://www.ssdmf.com/
[18] NPPES is available at: https://nppes.cms.hhs.gov
[19] LEIE is available at: https://oig.hhs.gov/exclusions/exclusions_list.asp
[20] SAM is available at: https://www.sam.gov
[21] MED is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html
[22] Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
[23] 42 CFR 455.416
[24] Provider Enrollment information can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx.
[25] 42 CFR 455.422

DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

DHCS has provided a disclosure statement (Attachment 2), which MCPs may use to advise providers. MCPs are not required to use this exact form, but any disclosure used must contain, at a minimum, the same information contained in Attachment 2. DHCS may periodically require MCPs to provide additional disclosures to providers relating to differences in the enrollment processes.

The provider enrollment disclosure must include, but is not limited to, the following elements:

- A statement that certain enrollment functions will not be performed by the MCP, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.
- Notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a provider chooses to enroll through an MCP, including provisional provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal an MCP's decision to suspend the enrollment process.
- A provision informing the provider that if the MCP receives any information that impacts the provider's eligibility for enrollment, the MCP will suspend processing of the provider's enrollment application and make the provider aware of the option to apply through the DHCS' Medi-Cal FFS provider enrollment process.
- A statement clarifying that in order for the provider to participate in the Medi-Cal FFS Program, the provider must enroll through DHCS, and that enrolling through DHCS will also make the provider eligible to contract with the MCP.

J. Post Enrollment Activities

Revalidation of Enrollment

To ensure that all enrollment information is accurate and up-to-date, all providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process. MCPs may align revalidation efforts with their recredentialing efforts to reduce duplication of activities. MCPs must revalidate the enrollment of each of their limited-risk and medium-risk network providers at least every five years,[26] and their high-risk network providers every three years. MCPs are not required to revalidate providers that were enrolled through DHCS or revalidated by another MCP.

[26] 42 CFR 455.414

Data Base Checks
MCPs must review the SAM and LEIE databases on a monthly basis. All other databases must be reviewed upon a provider's reenrollment to ensure that the provider continues to meet enrollment criteria. Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal Programs; any provider terminated from the Medicare or Medicaid/Medi-Cal Program may not participate in the MCP's provider network.

Retention of Documents
MCPs are required to retain all provider screening and enrollment materials and documents for ten years.[27] Additionally, MCPs must make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

K. Miscellaneous Requirements

Timeframes
Within 120 days of receipt of a provider application, the MCP must complete the enrollment process and provide the applicant with a written determination. MCPs may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process, in accordance with Title 42, CFR, Section 438.602(b)(2).

Delegation of Screening and Enrollment
MCPs may delegate their authority to perform screening and enrollment activities to a subcontractor. When doing so, the MCP remains contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor's ability to perform these activities, including an initial review to ensure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the delegated functions.

Part 2: Medi-Cal Managed Care Credentialing and Recredentialing Requirements

MCPs must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, certified, or registered. MCPs must implement the provider credentialing and recredentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of their network providers. Each MCP must ensure that its governing

[27] 42 CFR 438.3(u)

body, or the designee of its governing body, reviews and approves these policies and procedures, and must ensure that the responsibility for recommendations regarding credentialing decisions rest with a credentialing committee or other peer-review body.

Some screening and enrollment requirements overlap with credentialing and recredentialing requirements. Any such overlap does not require an MCP to duplicate any of the activities described in this APL. However, if an MCP relies on the screening and enrollment activities conducted by another MCP, or by DHCS, the MCP must comply with all credentialing and recredentialing requirements described in this APL.

Provider Credentialing

MCPs are required to verify the credentials of their contracted medical providers, and to verify the following items, as required for the particular provider type, through a primary source,[28] as applicable:[29]

- The appropriate license and/or board certification or registration.
- Evidence of graduation or completion of any required education.
- Proof of completion of any relevant medical residency and/or specialty training.
- Satisfaction of any applicable continuing education requirements.

MCPs must also receive the following information from every network provider, but do not need to verify this information through a primary source:

- Work history.
- Hospital and clinic privileges in good standing.
- History of any suspension or curtailment of hospital and clinic privileges.
- Current Drug Enforcement Administration identification number.
- National Provider Identifier number.
- Current malpractice insurance in an adequate amount, as required for the particular provider type.
- History of liability claims against the provider.
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable.[30]

[28] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.
[29] The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.
[30] National Practitioner Data Bank is available at: https://www.ncsbn.org/418.htm.

- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List may not participate in the MCP's provider network.[31]
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards.

Attestations

For all medical service provider types who deliver Medi-Cal-covered medical services, the provider's application to contract with the MCP must include a signed and dated statement attesting to all the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.[32]

Provider Recredentialing

DHCS requires each MCP to verify every three years that each network provider delivering medical services continues to possess valid credentials. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of this APL, in the same manner, as applicable. Recredentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews. The recredentialing application must include the same attestation as contained in the provider's initial application.

MCPs must maintain a system for reporting to the appropriate oversight entities serious quality deficiencies that result in suspension or termination of a network provider. MCPs must maintain policies and procedures for disciplinary actions, including reduction, suspension, or termination of a provider's privileges, and must implement and maintain a provider appeal process.

MCPs must also conduct onsite reviews of their network provider sites. For detailed guidance, see Policy Letter (PL) 14-004, Site Reviews, Facility Site Review and Medical

[31] The Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

[32] These limited statements comply with requirements of the Americans with Disabilities Act (ADA), as discussed in the attached PL 02-03. The ADA Attachment is available at (pg. 7): http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2002/MMCDPL02003.pdf.

Record Review,[33] and any subsequent revisions to this PL. MCPs must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the MCP's provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

Delegation of Provider Credentialing and Recredentialing

MCPs may delegate their authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the MCP remains contractually responsible for the completeness and accuracy of these activities. If an MCP delegates credential verification activities, it should establish a formal and detailed agreement with the entity performing those activities. These agreements must be revised when the parties change the agreement's terms and conditions. To ensure accountability for these activities, the MCP must establish a system that:

- Evaluates the subcontractor's ability to perform delegated activities that includes an initial review to assure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.
- Ensures that the subcontractor meets MCP and DHCS standards.
- Continuously monitors, evaluates, and approves the delegated functions.

Entities such as medical groups or independent physician organizations may conduct delegated credentialing activities and may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their discretion. The POC focuses on the entity's role as the agent performing the credentialing functions on behalf of an MCP. The MCP may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated physician organizations. If an MCP delegates credential verification activities, it should establish a formal and detailed written agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

Health Plan Accreditation

MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to have met DHCS' requirements for credentialing. Such MCPs will be exempt from DHCS' medical review audit of credentialing practices. MCPs; however, retain overall responsibility for ensuring that credentialing requirements are met. Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

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[33] Policy Letter 14-004 is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including applicable APLs, PLs and Dual Plan Letters. For questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

Attachment 1: Provider Types and Categories of Risk[34]/Screening Requirements

(1) Limited Risk Provider Types. Physician or non-physician practitioners and medical groups or clinics:

- Ambulatory Surgical Centers (ASCs)
- End-Stage Renal Disease (ESRD) facilities
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Hospitals, including Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) facilities
- Mammography screening centers
- Mass immunization roster billers
- Organ Procurement Organizations (OPOs)
- Portable x-ray suppliers
- Providers or suppliers that are publicly traded on the New York Stock Exchange (NYSE) or NASDAQ
- Public or Government-Owned Ambulance Services Suppliers
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Rural Health Clinics (RHCs)
- Radiation therapy centers
- Skilled Nursing Facilities (SNFs)

(2) Moderate Risk Provider Types. Provider and supplier categories:

- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Currently enrolled (re-validating) home health agencies
  - Exception: Any such provider that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Currently enrolled (re-validating) suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)
  - Exception: Any such supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities

[34] CMS-6028-FC Tables 1–3. Federal Register / Vol. 76, No. 22 / February 2, 2011 / Rules and Regulations

- Non-public, non-government owned or affiliated ambulance services suppliers
    - Exception: Any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered ‘‘limited’’ risk.

(3) High Risk Provider Types. Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS.

Attachment 2: Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that all managed care network providers must enroll in the Medi-Cal Program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal Program. Providers may enroll through (1) DHCS; or (2) an MCP. If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (FFS) providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements - the "Plan Provider Agreement" and the "DHCS Provider Enrollment Agreement." The Plan Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The DHCS Provider Enrollment Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. Enrollment through an MCP. The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment

application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.

- Providers will not have the right to appeal an MCP's decision to cease the enrollment process.
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' FFS Provider Enrollment Division (PED) for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS.

- The provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program. (See http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)
- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.

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

Emergency Prescription Access Report
4th Quarter 2017
Santa Clara Family Health Plan

Analysis Goal: Evaluate access to medications prescribed pursuant to an emergency room (ER) visit and determine whether any barriers to care exist.

Methodology: Claim and encounter records for an emergency room visit during a calendar quarter will be evaluated and analyzed by network, primary diagnosis, and claims status. Prescription claim history will be evaluated to assess if any prescriptions were filled by the member within 72 hours of the ER visit date. Key diagnosis used will be urinary tract infection (UTI) due to clinical determination that such a diagnosis will require a prescription, particularly for antibiotic. Analysis includes: 1. Approved antibiotic claims: sampling of cases to evaluate for sufficient quantity based on diagnosis and medication per nationally recognized drug compendia and the Infectious Disease Society of America (IDSA) guidelines; 2. Denied antibiotic claims: sampling of cases to evaluate sufficient quantity based on diagnosis and medication as well as denial reasons; 3. No antibiotic claims history: sampling of cases through claims history review as well as chart review of no related prescription claims history following an emergency room visit to identify non-pharmacy point-of-sale in-hospital dispensing or completion of in-house drug regimen.

Summary of Findings:

Section 1 – ER Visits

In 2017Q4, SCFHP had total 24,333 ER visits from claim and encounter data.

Table 1: Members by Provider Network

Network	Unique Members	ER Visit Rx	ER Visit w/o Rx	Total ER Visits
No Network	604	159	608	767
Non-Delegated	1,736	1,223	1,152	2,375
Valley Health Plan	10,906	7,379	7,486	14,865
Palo Alto Medical Foundation	327	168	239	407
Physician Medical Group	3,807	2,595	2,423	5,018
Premier Care	713	539	362	901
Grand Total	18,093	12,063	12,270	24,333

Section 2 – Diagnosis

Table 2: Key Diagnosis

		4Q2017		
Code	Diagnosis	Rx	No Rx	% Rx
N390	UTI, SITE NOT SPEC	440	144	75.3%

Section 3 – Claims Analysis

Approved Claims

Treatment guidelines for urinary tract infection/uncomplicated cystitis treatment are typically for at least 3 days with the exception of fluconazole, fosfomycin, and ofloxacin that are administered as a single dose. Of prescriptions processed, we evaluated quantity per day supply and total day supply. There were no prescriptions filled inappropriately for less than a quantity of 1 per day. In this section we will focus on approved prescriptions with 2 day supply or less to evaluate if sufficient quantity and day supplies were written.

Table 3: Approved Antibiotics Prescribed for UTI 3-Day Supply or Less

DRUG	Day Supply	Svc Prov Name	Approved
CEPHALEXIN	**2**	Regional Medical Center of SJ	1
FLUCONAZOLE	**1**	Regional Medical Center of SJ	4
		St Louise Regional Med Center	1
		O'connor Hospital	2
		Mercy San Juan Hospital	2
		Good Samaritan Hospital	2
		Kaiser Hospital San Jose	2
Grand Total			**13**

Fluconazole is appropriately written for 1 day supply. We identified one possible prescription that may not be sufficiently written. A prescription for Cephalexin 500mg capsule was filled for a quantity and day supply of 10/2 on 11/14/2017. Upon chart note review, patient was given Ceftriaxone 1gram x1 in the ER on 11/14 for "uncomplicated UTI without evidenced of pyelonephritis." The final culture result on 11/16/17 stated no growth.

Denied Claims

6 members total had denied prescription claims. 5 members had denied claims due to primary insurance coverage outside of SCFHP. 1 member had a denied claim for non-antibiotic drug.

No Claims

144 unique members diagnosed with UTI ER claims did not result in a prescription processed following 72 hours. We excluded 33 members with primary insurance coverage outside of SCFHP from this analysis. We subsequently randomly chose a sample of 15 by using Excel. We were able to obtain 13 chart notes from the 15 requested. From the 13 samples, we found 1 member had prescription filled 3 days prior to hospital ER claim. 1 member eloped from the ER. 1 member was transferred to another hospital. The rest 10 members were given prescriptions, however, weren't filled. None of these 13 members were readmitted to the emergency room for the same diagnoses of UTI in the same quarter.

Mbr	Hospital	DOS	Findings
1	Good Samaritan	11/2/2017	Discharged on 11/13/2017. Filled Sulfamethoxazole/TMP DS #10/5 on 11/10/2017
2	Regional Medical Center of SJ	12/29/2017	Member eloped from ER. Provider attempted to call member, but couldn't reach her and unable to leave a voicemail.
3	Regional Medical Center of SJ	11/27/2017	Received Ceftriaxone 1000mg IV x1 in ER, then Rx for Cephalexin. No QS/DS mentioned in chart note. Didn't fill.
4	St. Louise Regional Medical Ctr	11/17/2017	Rx for Cephalexin 500mg, #28/7. Didn't fill.

5	Santa Clara Valley Medical Ctr	12/26/2017	Rx for Cephalexin 500mg, #20/5. Didn't fill.
6	El Camino Hospital - Los Gatos	10/28/2017	Rx for Ciprofloxacin 500mg, #14/7. Didn't fill.
7	O'connor Hospital	11/16/2017	Rx for Nitrofurantoin (Macrobid) 100mg, #14/7. Didn't fill.
8	O'connor Hospital	10/27/2017	Received Ceftriaxone 1000mg IM x1 and Zithromax 1000mg PO x1 in ER. Rx for Cephalexin 500mg, #14/7. Didn't fill.
9	Regional Medical Center of SJ	12/05/2017	Received Cefoxitin 2000mg IV x1 in ER, Azithromycin 1000mg x1 in ER, Ceftriaxone 250mg x1 ER. Rx for Cephalexin, DS/QS not stated. Didn't fill.
10	St. Louise Regional Med Ctr	12/01/2017	Ceftriaxone 1000mg x1 in ER. Rx for Cephalexin 500mg, #20/5. Didn't fill.
11	Regional Medical Center of SJ	10/16/2017	Ceftriaxone 2000mg x1 ER. Transferred to Santa Clara Valley Medical Ctr.
12	Regional Medical Center of SJ	11/14/2017	Ceftriaxone 1000mg x1 in ER. Rx for Cephalexin 500mg, #10/2. Didn't fill.
13	ValleyCare Health System	12/23/2017	Received Fluconazole 150mg x1 and Nitrofurantoin 100mg x1 in ER. Rx for Nitrofurantoin 100mg, #6/3. Didn't fill.

Section 4 – Pharmacies

Pharmacy Locations

SCFHP has six 24 hour in-network pharmacies within Santa Clara County for members to access. In addition, the majority of retail chain pharmacies are opened until 9 P.M.

Table 4: 24 Hour In-Network Pharmacies in Santa Clara County

NABP	NPI	Pharmacy Name	Address	City	Zip
501507	1962417238	WALGREENS	121 E. EL CAMINO REAL	MT. VIEW	94040
514667	1730194002	WALGREENS	350 NORTH CAPITOL AVE.	SAN JOSE	95133
533011	1255346532	WALGREENS	440 BLOSSOM HILL ROAD	SAN JOSE	95123
552287	1710921549	CVS PHARMACY	2514 BERRYESSA RD	SAN JOSE	95132
580591	1730194069	WALGREENS	423 N SANTA CRUZ AVE	LOS GATOS	95030
5660015	1285081596	SANTA CLARA VALLEY MEDICAL CENTER	751 S BASCOM AVE MAIN HOSPITAL BUILDING	SAN JOSE	95128

Summary: Members with diagnoses of UTI who do not have access to medications after an ER visit are at high risk for complications or readmissions. For this quarter, all approved claims were appropriate in terms of quantity and day supply. All denied claims were also appropriate. They were mainly denied for other primary insurance coverage. For no claims, we continue to find members who were given prescriptions but weren't filled. No readmissions for the same diagnosis were found. Members who didn't fill or didn't pick up prescriptions from quarter 3 of 2017 also did not appear on this quarter's report for the same diagnosis.

Next Steps: Continue quarterly assessment of emergency prescription access with medical and pharmacy data. Follow up members who didn't have claims for trends and readmissions. For future quarters, members with no claims who also appear on the subsequent quarter report for similar diagnoses such as pyelonephritis or cystitis will also be assessed. Members will be contacted via telephone if needed in order to identify if there are any barriers to care.

This report will be shared with delegates at quarterly JOC.

Emergency Prescription Access Report
1st Quarter 2018
Santa Clara Family Health Plan

Analysis Goal: Evaluate access to medications prescribed pursuant to an emergency room (ER) visit and determine whether any barriers to care exist.

Methodology: Claim and encounter records for an emergency room visit during a calendar quarter will be evaluated and analyzed by network, primary diagnosis, and claims status. Prescription claim history will be evaluated to assess if any prescriptions were filled by the member within 72 hours of the ER visit date. Key diagnosis used will be urinary tract infection (UTI) due to clinical determination that such a diagnosis will require a prescription, particularly for antibiotic. Analysis includes: 1. Approved antibiotic claims: sampling of cases to evaluate for sufficient quantity based on diagnosis and medication per nationally recognized drug compendia and the Infectious Disease Society of America (IDSA) guidelines; 2. Denied antibiotic claims: sampling of cases to evaluate sufficient quantity based on diagnosis and medication as well as denial reasons; 3. No claims history: sampling of cases through claims history review as well as chart review of no related prescription claims history following an emergency room visit to identify non-pharmacy point-of-sale in-hospital dispensing or completion of in-house antibiotics regimen.

Summary of Findings:

Section 1 – ER Visits

In 2018Q1, SCFHP had total 26,349 ER visits from claim and encounter data.

Table 1: Members by Provider Network

Network	Unique Members	ER Visit Rx	ER Visit w/o Rx	Total ER Visits
No Network	881	247	859	1,106
Non-Delegated	1,924	1,534	1,088	2,622
Valley Health Plan	11,737	8,211	7,637	15,848
Palo Alto Medical Foundation	431	257	300	557
Physician Medical Group	4,084	2,944	2,309	5,253
Premier Care	791	581	382	963
Grand Total	19,848	13,774	12,575	24,333

Section 2 – Diagnosis

Table 2: Key Diagnosis

		4Q2017		
Code	Diagnosis	Rx	No Rx	% Rx
N390	UTI, SITE NOT SPEC	415	119	77.7%

Section 3 – Claims Analysis

Approved Claims

Treatment guidelines for urinary tract infection/uncomplicated cystitis treatment are typically for at least 3 days with the exception of fluconazole, fosfomycin, and ofloxacin that are administered as a single dose. Of prescriptions processed, we evaluated quantity per day supply and total day supply. There were no prescriptions filled inappropriately for less than a quantity of 1 per day. In this section we will focus on approved prescriptions with 2 day supply or less to evaluate if sufficient quantity and day supplies were written.

Table 3: Approved Antibiotics Prescribed for UTI 3-Day Supply or Less

DRUG	Day Supply	Svc Prov Name	Approved
CIPROFLOXACIN	**2**	El Camino Hospital	1
FLUCONAZOLE	**1**	Woodland Memorial Hospital	4
		St Louise Regional Med Center	1
		O'connor Hospital	1
		Good Samaritan Hospital	1
Grand Total			**13**

Fluconazole is appropriately written for 1 day supply. We identified one possible prescription that may not be sufficiently written. A prescription for Ciprofloxacin 500mg tablet was filled for a quantity and day supply of 4/2 on 01/22/2018. Upon chart review, member was admitted to inpatient. Duration of stay from 01/19/18 to 01/22/18. Member received Ceftriaxone and Ciprofloxacin in house, then prescription upon discharge for Ciprofloxacin 500mg for quantity and day supply of 4/2. This is appropriate since the total days of treatment with Ciprofloxacin was 6 days.

Denied Claims

5 members total had denied prescription claims for antibiotics. 2 members had denied claim due no longer eligible for coverage. 1 member to primary insurance coverage outside of SCFHP. 1 member (NET20 Valley Health Plan) had a denied claim non-formulary antibiotic Invanz, which is usually administered intravenously. This member subsequently had approved claim for Cephalexin 250mg, #24 capsules/3 days, four days later. 1 member had denied claim for quantity limit for Fluconazole 150mg. The Plan allows for #1 tablet per day, claim was for #4 tablets/4 days. Upon chart note review, patient was given Fluconazole 150mg orally x1 in the ER, then was given a prescription for Fluconazole #4 tablets/4 days that was not filled. Per chart note, patient had confirmed for yeast in urine culture, no bacteria. Usually one dose of fluconazole is sufficient to treat yeast in the urine, therefore, no follow up required.

No Claims

119 unique members diagnosed with UTI ER claims did not result in a prescription processed following 72 hours. We excluded 55 members with primary insurance coverage outside of SCFHP from this analysis. We subsequently randomly chose a sample of 18 by using Excel. We requested 16 chart notes from different hospitals. We were able to obtain 9 chart notes and 2 medication lists. The 5 remaining requested chart notes were either not received, chart not available, or inappropriate charts received due to wrong dates of service. From the 13 samples below, we found 2 members had prescriptions filled 3 and 4 days prior to hospital ER claim, 1 member eloped from the ER, 2 members received first dose of antibiotic in the ER, however, since we were unable to obtain ER chart notes the prescription statuses are unknown. 6 members were given prescriptions, however, weren't filled. 1 member didn't

receive an antibiotic in the ER and a prescription upon discharge. 1 member received 1 dose of Ceftriaxone in the ER but also didn't receive a prescription upon discharge. These two members will be referred to the Quality Department to assess further for any potential barriers of care.

Mbr	Hospital	DOS	Findings
1	Regional Medical Center of SJ	01/02/2018	Ceftriaxone 1gram x1 ER, Rx for Cephalexin, no QS/DS stated, not filled
2	Regional Medical Center of SJ	02/05/2018	Ceftriaxone 1gram x1 ER, Rx for Cephalexin, no QS/DS stated, not filled
3	Regional Medical Center of SJ	02/05/2018	No abx in ER, no Rx. Approved fill for Ciprofloxacin 500mg #10/5 on 3/6/18 (forward to Quality Department)
4	St. Louise Regional Medical Ctr	01/03/2018	Nitrofurantoin 100mg x1 ER, Rx for Nitrofurantoin #10/5, not filled
5	St. Louise Regional Medical Ctr	02/01/2018	Ceftriaxone 1gram x1 ER, Rx for Bactrim DS 800mg-160mg #20/10, not filled
6	Good Samaritan Hospital	03/10/2018	Medication list only, no ER chart note: Ceftriaxone 1gram x1 ER
7	Mills-Peninsula Med Center	03/29/2018	Cefoxitin 2gram x1 ER, then Rx for Cephalexin 125mg/5mL oral suspension, #140mL/7 days
8	Good Samaritan Hospital	03/18/2018	Medication list only, no ER chart note: Ceftriaxone 1gram x1 ER
9	Regional Medical Center of SJ	03/07/2018	Pt eloped prior to receiving Rx for Nitrofurantoin
10	O'connor Hospital	03/16/2018	Approved Rx for Cephalexin 500mg #28/7, not filled
11	Regional Medical Center of SJ	03/13/2018	Ceftriaxone 1gram x1 ER, but no Rx? (forward to Quality)
12	Regional Medical Center of SJ	02/05/2018	Approved Rx Cephalexin 500mg #27/7 on 2/1/2018
13	Stanford Hospital	01/04/2018	Approved Rx Cephalexin250mg/5mL #100mL/7 on 1/1/2018

Section 4 – Pharmacies

Pharmacy Locations

SCFHP has six 24 hour in-network pharmacies within Santa Clara County for members to access. In addition, the majority of retail chain pharmacies are opened until 9 P.M.

Table 4: 24 Hour In-Network Pharmacies in Santa Clara County

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5660015	1285081596	SANTA CLARA VALLEY MEDICAL CENTER	751 S BASCOM AVE MAIN HOSPITAL BUILDING	SAN JOSE	95128

Summary: Members with diagnoses of UTI who do not have access to medications after an ER visit are at high risk for complications or readmissions. For this quarter, one approved claim for Ciprofloxacin was for 2 days, which is considered potentially insufficient. Upon chart review, this case was appropriate. All denied claims were appropriate except for one member, however, we felt it was not a potential risk due to Fluconazole is usually sufficient for one dose for UTI with yeast. The rest of denied

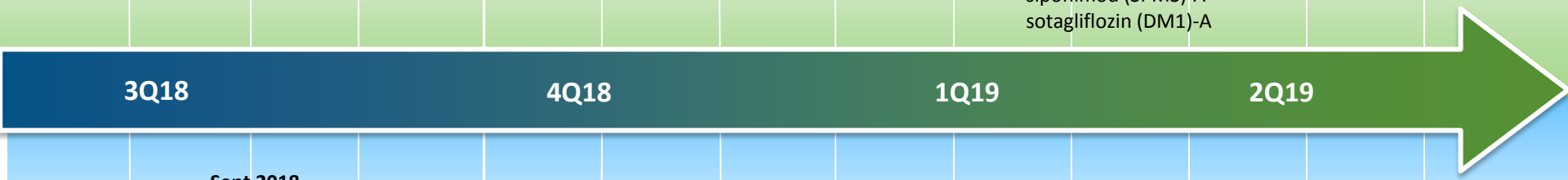
claims were mainly denied for other primary insurance coverage. For no claims, we continue to find members who were given prescriptions but weren't filled. 2 members who didn't receive a prescription upon discharge based on pharmacy claims data and chart notes review will be referred to Quality Department for further investigation to see if there were any potential barriers of care. No readmissions for the same diagnosis were found for these members and members from the previous quarter 4Q2017.

Next Steps: Continue quarterly assessment of emergency prescription access with medical and pharmacy data. Follow up members who didn't have claims for trends and readmissions. For future quarters, members with no claims who also appear on the subsequent quarter report for similar diagnoses such as pyelonephritis or cystitis will also be assessed. Cases with potential barriers of care will be forward to Quality Department.

This report will be shared with delegates at quarterly JOC.

Discussion Items

High Impact-Interest Agent Pipeline



Aug 2018
Onpattro† (hATTR amyloidosis)-BT
Takhzyro (HAE)-C

Oct 2018
Talzenna (BRCA+ MBC)-C
Xofluza (influenza)-C

December 2018
solriamfetol (OSA/narcolepsy)-C

March 2019
bremelanotide (HSDD)-C
netarsudil/ latanoprost (glaucoma)-C
siponimod (SPMS)-A
sotagliflozin (DM1)-A

May 2019
cladribine (MS)-C
esketamine† (treatment-resistant depression)-A
AVXS-101† (SMA)-BT

Sept 2018
dasotraline* (ADHD)-C
Ajovy (migraine)-C
Emgality (migraine)-C

Nov 2018
lorlatinib (ALK+ NSCLC)-C

February 2019
caplacizumab (aTTP)-BT

April 2019
risankizumab (plaque psoriasis)-C
selinexor (myeloma)-BT

Not Yet Filed
alpelisib (breast cancer)-C
eflapegrastim (neutropenia)-C
fedratinib (myelofibrosis)-C
lasmiditan (migraine)-C
leronlimab (HIV)-C
pitolisant (narcolepsy)-C
roxadustat (anemia of CKD)-C
upadacitinib (RA)-C

KEY
C = Pipeline agent will **compete** with current standard of care
A = Pipeline agent will be used in **addition** to current therapy or expands the patient population treated
BT = Pipeline agent is a **breakthrough**/novel treatment in an area where no drug therapy previously existed
† = Medical Cost
** = Complete Response Letter*

Generic Pipeline

HIGH IMPACT

4Q2018
Byetta
Nuvaring

Oct 2018
Onfi

Dec 2018
Remodulin

Jan 2019
Epclusaŧ
Harvoniŧ

2019
Tracleer*
Restasis
Sensipar

Oct 2018
Levitra

Nov 2018
Finacea Gel*

4Q 2018
Rapaflo*
Flector
Astagraf XL
Androgel 1.62%
Kaletra

Dec 2018
Canasa

Feb 2019
Ranexa
Solodyn 55mg
& 105mg

March 2019
Faslodex*
Tekturna
Emend Inj.

1H 2019
Omnaris
Rozerem

MEDIUM /LOW IMPACT

**NO exclusivity*
ŧ Authorized Generic