Santa Clara Family Health Plan
The Spirit of Care

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Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, July 18, 2018
6:00 PM - 7:30 PM
210 E. Hacienda Avenue
Campbell, CA 95008

AGENDA

1.	**Introduction**	Dr. Lin	6:00	5 min.
2.	**Meeting Minutes** Review minutes of the April 18, 2018 Utilization Management Committee meeting. **Possible Action:** Approve 04/18/18 minutes	Dr. Lin	6:05	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. Lin	6:10	5 min.
4.	**CEO Update** Discuss status of current topics and initiatives.	Ms. Tomcala	6:15	10 min.
5.	**Discussion Items/Follow up Items**			
	a. Future meetings in new location	Dr. Robertson	6:25	5 min.
6.	**Action Items**	Ms. Castillo	6:30	10 min.
	a. Care Coordinator Guidelines **Possible Action:** Approve Care Coordinator Guidelines			
	b. UM Program Evaluation 2017 **Possible Action:** Approve UM Program Evaluation 2017			
7.	**Reports (MediCal/SPD, Healthy Kids)**			
	a. Membership	Dr. Robertson	6:40	5 min.
	b. UM Reports 2018	Dr. Boris	6:45	10 min.
	i. Dashboard Metrics: Turn Around Time (Cal MediConnect/Medi-Cal)			
	ii. Standard Utilization: Metrics PowerPoint			
	c. HS 04.01 Reporting Quality Monitoring of Plan Auths, Denials, etc. (Q2 18)	Ms. Castillo	6:55	5 min.
	d. Referral Tracking	Ms. Castillo	7:00	5 min.

	e. Procedure for documentation requirements for Prior Authorization when no clinical notes attached	Ms. Castillo	7:05	5 min.
	f. Nurse Advice Line Stats	Ms. Carlson	7:10	5 min.
8.	Behavioral Health UM Reports i. Turn Around Time ii. Developmental Screening Summary	Ms. Holm	7:15	10 min.
9.	Adjournment Next meeting: Wednesday, October 17, 2018 6 p.m.	Dr. Lin	7:25	

Notice to the Public—Meeting Procedures

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

The Utilization Management 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 210 E. Hacienda Avenue, Campbell.

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MINUTES
UTILIZATION MANAGEMENT COMMITTEE
April 18, 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	N
Dung Van Cai, MD	OB/GYN	Y
Habib Tobaggi, MD	Nephrology	Y
Jeff Robertson, MD, CMO	Managed Care	N
Ali Alkoraishi, MD	Adult and Child Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	Y
Lily Boris, MD	Medical Director	Y
Jana Castillo	Utilization Management Manager	Y
Sandra Carlson	Health Services Director	Y
Caroline Alexander	Administrative Assistant	Y
Lori Andersen	MLTSS Operations Director	Y
Joan McKay	Nurse Consultant, CCS	Y
Andrea Smith	Utilization Review and Discharge Planning Nurse	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. /II. Introductions Review/Revision/Approval of Minutes	Meeting was started with a Quorum at 6:07 PM. There was a motion to approve the October 26, 2017 and January 18, 2018 minutes.	Minutes approved as presented.
III. Public Comment	No public comment.	
IV. CEO Update	Christine Tomcala , CEO discussed the following items: Membership as of April, down about 1,300 members, at 262,569 total. Slight increase in Cal MediConnect membership. Healthy Kids increased as well. Continue to see Medi-Cal drop in our	Poll committee members regarding changing meeting time to lunchtime when move to the new building.

ITEM	DISCUSSION	ACTION REQUIRED
	county overall. In the middle of second week of DHCS audit. Closing conference will take place on Friday, April 20th. Different set of auditors than last year. Areas of deficiency worked on to correct. Data Validation Audit is currently taking place April 19th. We are submitting universes and data for DMHC audit for June 2018 now as well. Health Plan will be moving to the new location in South San Jose late July.	
V. Discussion Items/Follow Up Items	a. CCS Summary Ms. McKay presented an overview of California Children's Services (CCS) to the committee. Originally known as California Crippled Children's Society in 1927 and evolved into California Children's Services in 1978. Provides services to children under 21 years of age including diagnostic and treatment services, case management, physical and occupational therapies. DHCS governs implementation of CCS services. Mandates California counties to seek out eligible children to be recipients of expert sources for diagnosis and treatment. Services are not limited to Medi-Cal beneficiaries. The value of Santa Clara Family Health Plan/CCS Relationship is: • CCS determines program eligibility • Authorizes care with any provider or facility that participates in the Medi-Cal program (facilitates billing process) • CCS is payment source for all care authorized by the CCS program Treat about 200,000 children annually, 80% are Medi-Cal. Becomes carve in under Whole Child in 2021. b. UM Program Description Update-Assessment of New Technology Ms. Castillo presented an update on the UM Program Description. UM Program Description was presented to the UM Committee for approval in January 2018. The new technology section is corrected to state that the health plan would be reviewing any new technology requests by using the up to date website.	
VI. Action Items	a. UM Program Evaluation CY 2017 Ms. Castillo presented the UM Program Evaluation CY 2017. Did not find any negative findings on the goals submitted for evaluation. After motion duly made, seconded, UM Program Evaluation CY 2017 was approved as presented. b. UM Workplan CY 2018 Ms. Castillo presented the UM Work plan CY 2018. SCFHP is adding the current positions as the responsible party for each area. New technology policy added and will monitor until next year on Program Evaluation. After motion duly made, seconded, UM Work plan CY 2018 was approved as presented.	

ITEM	DISCUSSION	ACTION REQUIRED
	c. HS.14 LTC Authorization Review Policy Ms. Andersen presented a new LTC Authorization Review policy for approval. New policy developed as a separate policy for long term care authorization. Policy covers bed holds and addresses re-authorization versus initial authorization for LTC. Describes documentation required to be submitted with prior authorization request. It was recommend that verbiage be added to item II. D. This is because LTC is not a benefit outside of Santa Clara County. After motion duly made, seconded, HS. 14 LTC Authorization Review policy was approved with recommended edits. d. Medi-Cal Prior Authorization Grid 2018 Ms. Castillo presented the Medi-Cal Prior Authorization Grid 2018. SCFHP is adding Palliative Care benefit to the PA Grid. Palliative care became a benefit recently and in order to follow patient use we are recommending an admin auth be created. Medi-Cal which will require prior authorization. Non-Emergency Medical Transportation (NEMT) will not require prior authorization. Ground transportation from facility to facility and from hospital to home will not require prior authorization. After motion duly made, seconded, proposed additions to Medi-Cal Prior Authorization Grid 2018 were approved as presented.	

ITEM	DISCUSSION	ACTION REQUIRED
VII. Reports	a. Membership Presented during CEO Update. b. UM Reports 2018 i. Dashboard Metrics Ms. Castillo presented the Dashboard Metrics report. Monitoring compliance based on turnaround time. Divided by lines of business. For CMC line of business, at 99% of compliance for routine requests, 90% compliant for expedited/urgent requests, 100% compliant for retro requests. Developed better reporting mechanisms and monitoring of requests coming to UM fax. For Medi-Cal line of business, 96.7% compliant for routine, urgent 96.7%, retro 95.4%. Abandonment rate has been low, at 4%. ii. Standard Utilization Metrics Data is for January 1 to December 31, 2017. For MediCal/non SPD, discharges per thousand have been stable at 3.66, with average length of stay 3.55. For Medi-Cal SPD discharges per thousand are at 14.46. Average length of stay 4.92. For CMC population 5.93 days average length of stay. Discharges per thousand 266.4. For NCQA Medicaid Benchmark Comparisons, Non SPD fall at less than 10%, SPD falls at greater than 90%. Combined total is 50th percentile ranking for average length of stay. Medi-Cal SPD's 173 discharges per thousand, CMC is at 266 per thousand. Average length of stay is 4.92 for Medi-Cal SPD and 5.93 for CMC. Inpatient Readmissions Medi-Cal Non SPD is at 14.06. Goal is around 11 to 12% for Non SPD population. SPD Inpatient Readmissions for Medi-Cal overall average of 22%. Readmissions on CMC lower at 14.44%. NCQA Benchmark comparison for CMC Readmissions: Ages 18 to 64 readmission rate of 14.08%; Ages 65+ readmission rate of 14.54%. For age 18 to 64, greater greater than 50th percentile ranking, age 65+, less than 50th percentile ranking. (Lower rate indicates better performance). Frequency of selected procedures: Back Surgery comparison to benchmark, lower. Mastectomy higher in females age 15 to 44, lower age 45-64. Bariatric surgery higher in females age 20 to 44. Medi-Cal Behavioral Health Metrics based on 3 areas: ADHD Medication, Antidepressant Medication Management, Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia. Initiation phase and continuation maintenance phase for ADHD Medication is at less than 25th percentile rank. Antidepressant Medication Management Acute Phase Treatment and Continuation Phase Treatment is at	Three child psychiatry facilities in the county. Consider working with them on the Medi-Cal Behavioral Health metrics (follow up for children with ADHD/Initiation and continuation of treatment) Consider a "CareMore" type of program for inpatient admits/readmits in Cal MediConnect

ITEM	DISCUSSION	ACTION REQUIRED
	greater than 75th percentile rank. Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia is at greater than 90th percentile. c. Interrater Reliability: Medical and Behavioral Health Dr. Boris presented the Interrater Reliability report for Behavioral Health. In accordance with Policy HS.09, Santa Clara Family Health Plan (SCFHP) UM staff scheduled and completed the first of two required Bi-Annual IRR testing sessions. The second IRR testing session is expected to be completed within the second half of calendar year 2018. A total of 10 random UM authorizations are selected for testing purposes for all of the Utilization Management staff, including non-licensed Care Coordinators, licensed professional staff, and Medical Directors (MD). In the first testing in 2018, 95% or 20/21 of the staff were found to be proficient while the remaining 5% or 1/21 were not proficient and will require remediation. 100% of Utilization Management staff completed the IRR testing including CMO, Medical Director, Licensed staff and Coordinators. Identified common findings were as follows: • Improper identification of required turnaround time for inpatient concurrent review • Lack of understanding for specific Care Coordinator Guidelines Corrective action plan after identifying the coming findings are: • Remedial training was planned for staff that failed IRR but was incomplete due to voluntary transfer to another department • Continue regular staff training with emphasis on care coordinator guidelines and regulatory turnaround times • Change of staff assignments for more experience with different lines of business and regulatory requirements For the Behavioral Health team, 100% or 3/3 of staff were found to be proficient during this review. 100% of Behavioral Health staff who complete authorizations completed the IRR testing. Identified common findings were as follows: • Staff who are authorized to review/approve BH services through SCFHP express comfort in knowing the process/where to go to for clarification Corrective action plan after identifying the common findings would be: • Mandatory remedial training with post testing for all non-proficient staff (should this be required-not needed at this time) • Mandatory bi-annual review of guidelines and criteria, as well as biannual testing, will continue to be scheduled.	

ITEM	DISCUSSION	ACTION REQUIRED
	d. HS 04.01 Reporting Quality Monitoring of Plan Auths, Denials, etc. (Q1 18) Ms. Castillo presented the Q1 2018 Quality Monitoring Report. Santa Clara Family Health Plan (SCFHP) completed the 1st quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations. For the 1st Quarter review of 2018, the findings are as follows: A. For the dates of services and denials for January, February and March of CY 2018 were pulled in the 1st quarter sampling year. a. 30 unique authorizations were pulled with a random sampling. i. 83% or 25/30 Medi-Cal LOB and 17% or 5/30 CMC LOB ii. Of the sample 100% or 30/30 were denials iii. Of the sample 27% or 8/30 were expedited request; 67% or 20/30 were standard request, 6% or 2/30 were retroactive request. 1. 100% or 8/8 of the expedited authorizations met regulatory turnaround time of 72 calendar hours 2. 95% or 2/2 retroactive request met regulatory turnaround time of 30 Calendar days. iv. 67% or 20/30 are medical denials, 33% or 10/30 are administrative denials v. 100% or 30/30 of cases were denied by MD or pharmacist. vi. 100% were provided member and provider notification. vii. 90% or 28/30 of the member letters are of member's preferred language. 2 letters that were not in member's language were outside of 5 regulatory language threshold and were written in English instead. viii. 100% of the letters were readable and rationale for denial was provided, although 7% or 2/30 letters were found to be too clinical and not written in a member specific language. ix. 83% or 25/30 letters included criteria or EOB in the letter. x. 100% of the letters included IMR information, interpreter rights and instructions on how to contact CMO or Medical Director.	

ITEM	DISCUSSION	ACTION REQUIRED
	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: • Continue to improve on denial verbiage matrix including member specific language • Provide staff education to re-read denial letters for letter quality • Continue QA report monitoring process e. Referral Tracking Ms. Castillo presented the Annual Specialty Referral Tracking report. New system for reporting. Required to have a twelve month rolling report for any authorizations that does not have a claim attached. Need to follow up on why service was not rendered if no claim attached. Number of authorizations without a claim is 4,321. Three month lag for claims. Exclude the last three months of authorized services and focus on services before those three months. Pull 10% of authorizations that do not have claim attached. Up to 50%, will do outbound calls to members and providers to find out more detail. Will be presenting this data quarterly but new system will allow to look at data monthly. 60 to 70% of authorizations have services rendered, drops off in February due to claims lag. Will also present an annual report. f. Nurse Advice Line Stats Ms. Carlson presented the Nurse Advice Line Stats. In November 2017, switched to vendor Care Net to handle Nurse Advice Line calls. Medi-Cal received 1645 calls, Healthy Kids 75 calls, Cal MediConnect calls 116 during the first quarter of 2018. For Medi-Cal the highest number of dispositions rendered was to see provider within 24 hours. Second highest was referral to home care. For Cal MediConnect, told to see provider within 24 hours or go to Emergency. For Medi-Cal, general information, for pediatrics, cold and cough.	Consider adding to the procedure for "referral tracking" auth tracking
VIII. Adjournment	Meeting adjourned at ____7:15 PM__	
NEXT MEETING	The next meeting is scheduled for Wednesday, July 18, 2018, 6:00 PM	

Prepared by:

_____ Date _____
Caroline Alexander
Administrative Assistant

Reviewed and approved by:

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

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Outpatient Physical, Occupational and Speech Therapy

1. Member must be CMC or Medi-Cal/HK assigned to:
   b. Independent Physician's
   c. Palo Alto Medical Foundation- Medi-Cal only
   d. All networks Out of Area and Non Contracted Provider - must be reviewed by nurse to determine emergent/ urgent necessity
   e. Any other network (VHP, Kaiser, PMG, Premier Care) redirect to delegated network for authorization.

2. Covered benefit for all LOB's when medically indicated. Must include:
   a. MD order
   b. Documentation must include that "MD order received"

3. Approve initial request ordered by contracted hospital or physician up to total of 12 visits (Combination of services: PT, OT, ST,)

4. Initial request exceeding 12 visits must be forwarded to nurse for review.

5. All continued ongoing Outpatient therapies must be sent to nurse for review.
   a. Treatment plan and most recent progress notes required

6. All Outpatient therapies that were approved for members that are less than 21 years old must be forwarded to the Medical Review Nurse for CCS referral via email including member's ID, name, and Auth number.

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Wheelchair repair

1. Member must be CMC or Medi-Cal/HK assigned to:
    a. Independent Physician's
    b. Palo Alto Medical Foundation- Medi-Cal only
    c. All networks Out of Area and Non Contracted Provider - must be reviewed by nurse to determine emergent/ urgent necessity
    d. Any other network (VHP, Kaiser, PMG, Premier Care) redirect to delegated network for authorization.

2. Wheelchair must be 3 year old or less.

3. Covered benefit for all LOB's when medically indicated. Must include:
    a. Wheelchair information (manual or powered)
    b. List of items for repair

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SCFHP UTILIZATION MANAGEMENT WORK PLAN AND PROGRAM EVALUATION 2017
Medi-Cal and Healthy Kids

	WORK PLAN								EVALUATION	
	Scope	**Objective**	**Type**	**Activity /Tasks**	**Goal/Baseline**	**Responsible Position**	**Frequency**	**Target Completion**	**Completion**	**Assessments, Findings, Monitoring of Previous Issues**
1	Quality of Clinical Care	Expand on Current reporting and present findings to UMC	Report UM Statistics/ Trends	Review MediCal Inpatient Admissions/1000	MCG and CA benchmarks	Med. Dir.	Annually	4th Qtr.	UM reports presented to UMC Quarterly	Dr. Boris presents quarterly UM reports (on agenda as PowerPoint). Comparisons to national / regional benchmarks are completed. TOC and CM were expanded in 2017 to assist with UM goals. There were no findings. Please see UMC minutes and PowerPoint
2	Quality of Clinical Care	Monitor appropriate inpatient admissions	Report UM Statistics/Trends	Review MediCal Inpatient Admissions/1000	MCG and CA benchmarks	Med. Dir.	Annually	4th Qtr.	UM reports presented to UMC Quarterly	Dr. Boris presents quarterly UM reports (on agenda as PowerPoint). Comparisons to national / regional benchmarks are completed. TOC and CM were expanded in 2017 to assist with UM goals. There were no findings. Please see UMC minutes and PowerPoint
3	Quality of Clinical Care	Monitor appropriateness of inpatient stays to assess proper level of care	Report UM Statistics/Trends	Review MediCal Inpatient ALOS	MCG and CA benchmarks	Med. Dir.	Annually	4th Qtr.	UM reports presented to UMC Quarterly	Dr. Boris presents quarterly UM reports (on agenda as PowerPoint). Comparisons to national / regional benchmarks are completed. TOC and CM were expanded in 2017 to assist with UM goals. There were no findings Please see UMC minutes and PowerPoint

4	Quality of Clinical Care	Monitor appropriateness of inpatient stays to assess proper level of care	Report UM Statistics/Trends	Review CMC Inpatient ALOS	MCG and CA benchmarks	Med. Dir.	Annually	4th Qtr.	UM reports presented to UMC Quarterly	Dr. Boris presents quarterly UM reports (on agenda as PowerPoint). Comparisons to national / regional benchmarks are completed. TOC and CM were expanded in 2017 to assist with UM goals. There were no findings. Please see UMC minutes and PowerPoint
5	Quality of Clinical Care	Monitor Readmissions, all cause to minimize unnecessary premature discharge and applicable post discharge follow up and care.	Report UM Statistics/Trends	MediCal Inpatient Readmissions	HEDIS goal	Med. Dir.	Annually	4th Qtr.	UM reports presented to UMC Quarterly	Dr. Boris presents quarterly UM reports (on agenda as PowerPoint). Comparisons to national / regional benchmarks are completed. TOC and CM were expanded in 2017 to assist with UM goals. There were no findings. Please see UMC minutes and PowerPoint
6	Quality of Clinical Care	Monitor Readmissions, all cause to minimize unnecessary premature discharge and applicable post discharge follow up and care.	Report UM Statistics/Trends	CMC Inpatient Readmissions	HEDIS goal	Med. Dir.	Annually	4th Qtr.	UM reports presented to UMC Quarterly	Dr. Boris presents quarterly UM reports (on agenda as PowerPoint). Comparisons to national / regional benchmarks are completed. TOC and CM were expanded in 2017 to assist with UM goals. There were no findings. Please see UMC minutes and PowerPoint
7	Quality of Service	Assess denial rates on PARs; provide benchmarks and compare to CA specific plans	Report UM Statistics/Trends	Measure and act on denial rates on Outpatient PARs	MCG and CA benchmarks	Med. Dir.	Annually	4th Qtr.	UM reports presented to UMC Quarterly	Dr. Boris presents quarterly UM reports (on agenda as PowerPoint). Comparisons to national / regional benchmarks are completed. TOC and CM were expanded in 2017 to assist with UM goals. There were no findings. Please see UMC minutes and PowerPoint

8	Quality of Service	Assess denial rates on PARs; provide benchmarks and compare to CA specific plans	Report UM Statistics/Trends	Measure and act on denial rates on Inpatient PARs	MCG and CA benchmarks	Med. Dir.	Annually	4th Qtr.	UM reports presented to UMC Quarterly	Dr. Boris presents quarterly UM reports (on agenda as PowerPoint). Comparisons to national / regional benchmarks are completed. TOC and CM were expanded in 2017 to assist with UM goals. There were no findings. Please see UMC minutes and PowerPoint
9	Quality of Service	Track and monitor denial rates on PARs; provide benchmarks and compare to CA specific plans	Report UM Statistics/Trends	Track and monitor BH IP Stays for CMC	MCG and CA benchmarks	BH Dir.	Annually	4th Qtr.	UM reports presented to UMC Quarterly	Dr. Boris presents quarterly UM reports (on agenda as PowerPoint). Comparisons to national / regional benchmarks are completed. TOC and CM were expanded in 2017 to assist with UM goals. There were no findings. Please see UMC minutes and PowerPoint
10	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	Report UM Statistics/Trends	MediCal ADD Follow-up Care for Children with ADD	HEDIS Benchmarks	BH Dir.	Annually	4th Qtr.	UM reports presented to UMC Quarterly	Dr. Boris presents quarterly UM reports (on agenda as PowerPoint). Comparisons to national / regional benchmarks are completed. TOC and CM were expanded in 2017 to assist with UM goals. There were no findings. Please see UMC minutes and PowerPoint
11	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	Report UM Statistics/Trends	MediCal AMM Antidepressant Medication Management	HEDIS Benchmarks	BH Dir.	Annually		UM reports presented to UMC Quarterly	Dr. Boris presents quarterly UM reports (on agenda as PowerPoint). Comparisons to national / regional benchmarks are completed. TOC and CM were expanded in 2017 to assist with UM goals. There were no findings. Please see UMC minutes and PowerPoint

12	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	Report UM Statistics/Trends	CMC SMC Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	HEDIS Benchmarks	BH Dir.	Annually	4th Qtr.	UM reports presented to UMC Quarterly	Dr. Boris presents quarterly UM reports (on agenda as PowerPoint). Comparisons to national / regional benchmarks are completed. TOC and CM were expanded in 2017 to assist with UM goals. There were no findings. Please see UMC minutes and PowerPoint
13	Quality of Service	Internal audit process and corrective action as necessary	Report UM Activities	Report Turn Around Times(TAT) for Prior Auth.	Routine Medi-Cal 5 calendar day	Med. Dir.	Bi-annually	1st Qtr.	UM reports presented to UMC Quarterly	Dashboard reporting on a monthly basis. 96% compliant for routine Medi-Cal PA request 2017 YTD.
14	Quality of Service	Internal audit process and corrective action as necessary	Report UM Activities	Report TAT based on Priority	Plan P&P requirements	Med. Dir.	Bi-annually	1st Qtr.	UM reports presented to UMC Quarterly	Dashboard reporting on a monthly basis. UM is within regulatory threshold (95%) of meeting TAT based on disposition.
15	Quality of Service	Annual IRR will be presented to the UMC	Report UM Activities	Assess and measure consistency of applying medical necessity criteria	85% Pass rate	UM manager	Annually	3rd Qtr.	Reported Biannually to UMC	UM and BH IRR are completed separately. UM's IRR result on 1st testing was: 100% prefeciency UM's IRR result findings on 2nd testing was: 63% preficiency. Re-training was completed. BH's IRR result finding on 1st testing: was 100% profeciency.
20	Quality of Clinical Care	UM Program Description	Report UM Activities	UM Program Description will be adopted on an annual basis	Adoption	CMO	Annually	2nd Qtr.	Presented to UMC 1/18/2017	UM Program description was adopted

21	Quality of Clinical Care	Annual Evaluation of Utilization Management Program will be reviewed and updated	Report UM Activities	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis	Revisions/Adoption	CMO	Annually	2nd Qtr.	Presented to UMC 4/19/2017	No Findings
22	Medical Necessity Criteria to be adopted	Implement a UM program which utilizes medical necessity decisions consistently, are objective and based upon evidence based criteria	Report UM Activities	Annually approve Medical Necessity Criteria	Review and Adoption	CMO	Annually	1st Qtr.	Policy Reported to UMC 1/18/2017	Dr. Boris presents quarterly UM quality measures to the committee for Prior Auth volume and use of medical necessity criteria. There were no findings.
23	Quality of Clinical Care	Annual Adoption of Clinical Practice Guidelines and Preventive Guidelines (Medical and Behavioral)	Report UM Activities	Annually review, revise as needed as developed by the UMC	Review and Adoption	CMO	Annually	4th Qtr.	Policy Reported to UMC 1/18/2017	No Findings

24	Safety of Clinical Care, Quality of Service and Quality of Clinical Care - Review of notification to members	Continuity and Coordination of Care reviewed and assessed		Assessment of communication to members when a primary care provider is terminated from the network. Standard is 30 days' notice. Exception: Plan is notified in less than 30 days of termination, then notification would be within three business days	85%	Director of Member Services	Annually		Policy Reported to UMC 1/18/2017	No Findings
25	UM Committees and Resources	Evlaute the Current UM Program Resources, and the overall effecivness of the UM program.								UM Program goals are being met for all inititives. The timeliness and notification of UM decisions was not consistenly met for CMC based on staffing. This was corrected. The CM and TOC teams were staffed more fully and as such, this postively affected our UM Inpatient statistics. The UM Committee is meeting the orgnaization needs and will continue to meet quarterly in 2018.

Santa Clara Family Health Plan Membership Report

	2018-01	2018-02	2018-03	2018-04	2018-05	2018-06
AM	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Santa Clara Family Health Plan	N/A	N/A	N/A	N/A	N/A	N/A
HK	**3,209**	**3,250**	**3,415**	**3,454**	**3,220**	**3,196**
Palo Alto Medical Foundation	76	90	89	93	111	93
Physicians Medical Group	1,063	1,080	1,120	1,142	1,076	1,089
Premier Care	228	228	233	248	240	237
Santa Clara Family Health Plan	369	358	381	386	355	349
Valley Health Plan	1,473	1,494	1,592	1,585	1,438	1,428
MC	**253,257**	**254,141**	**253,025**	**251,680**	**249,188**	**248,776**
Kaiser	26,047	26,139	26,166	26,048	26,072	26,056
Network 00	13,584	13,620	13,673	13,582	13,695	13,735
Palo Alto Medical Foundation	7,292	7,334	7,290	7,310	7,300	7,228
Physicians Medical Group	46,721	47,003	46,748	46,377	46,113	45,881
Premier Care	15,893	15,906	15,762	15,687	15,643	15,628
Santa Clara Family Health Plan	14,844	15,168	15,208	15,394	15,641	15,829
Valley Health Plan	128,876	128,971	128,178	127,282	124,724	124,419
CMC	**7,389**	**7,417**	**7,409**	**7,435**	**7,440**	**7,503**
Santa Clara Family Health Plan	7,389	7,417	7,409	7,435	7,440	7,503
Grand Total	**263,855**	**264,808**	**263,849**	**262,569**	**259,848**	**259,475**

Santa Clara Family Health Plan
Medi-Cal

		2016	2017	2018						
	Goal	YTD	YTD	Jan	Feb	Mar	April	May	Jun	YTD
HEALTH SERVICES										
Medical Authorizations - HS Combined										
Routine Authorizations										
% of Timely Decisions made within 5 Business Days of request	95%	95.6%	96.4%	70.6%	93.0%	91.7%	83.8%	91.3%	97.4%	87.9%
Expedited Authorizations										
% of Timely Decisions made within 72 Hours of request	95%	92.7%	95.4%	96.0%	98.0%	94.5%	92.9%	92.8%	97.0%	95.1%
Retrospective Review										
% of Retrospective Reviews completed within 30 Calendar Days of request	95%	91.5%	98.3%	94.9%	92.1%	80%	99.1%	98.9%	100%	93.6%

Santa Clara Family Health Plan

Cal MediConnect

		2016	2017	2018						
	Goal	YTD	YTD	Jan	Feb	Mar	Apr	May	Jun	YTD
UTILIZATION MANAGEMENT										
Pre-Service Organization Determinations - HS Combined										
Standard Part C										
% of Timely Decisions made within 14 days	100%	**80.6%**	**98.2%**	96.7%	98.7%	93.0%	89.5%	95.0%	99.1%	**95.1%**
Expedited Part C										
% of Timely Decisions made within 72 Hours	100%	**74.2%**	**96.2%**	97.0%	97.4%	97.2%	89.9%	85.7%	97.2%	**94.0%**
Post Service Organization Determinations										
% of Timely Decisions made within 30 days	100%	**90.6%**	**98.9%**	94%	100.0%	89%	100.0%	100.0%	100.0%	**94.7%**

Santa Clara
Family Health Plan
The Spirit of Care

Utilization Management Committee (UMC)

July 2018

UMC Goals and Objectives

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

Inpatient Utilization: Medi-Cal – Non-SPD
4/1/2017 – 3/31/2018

Source: HEDIS Inpatient Utilization (IPU) data for measurement year ending 3/31/18

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2017 Q2	2,549	3.97	9,068	3.56
2017 Q3	2,425	3.77	8,314	3.43
2017 Q4	2,334	3.63	8,442	3.62
2018 Q1	2,346	3.65	8,461	3.61
Total	9,654	3.76	34,285	3.55

Inpatient Utilization: Medi-Cal – SPD
4/1/2017 – 3/31/2018

Source: HEDIS Inpatient Utilization (IPU) data for measurement year ending 3/31/18

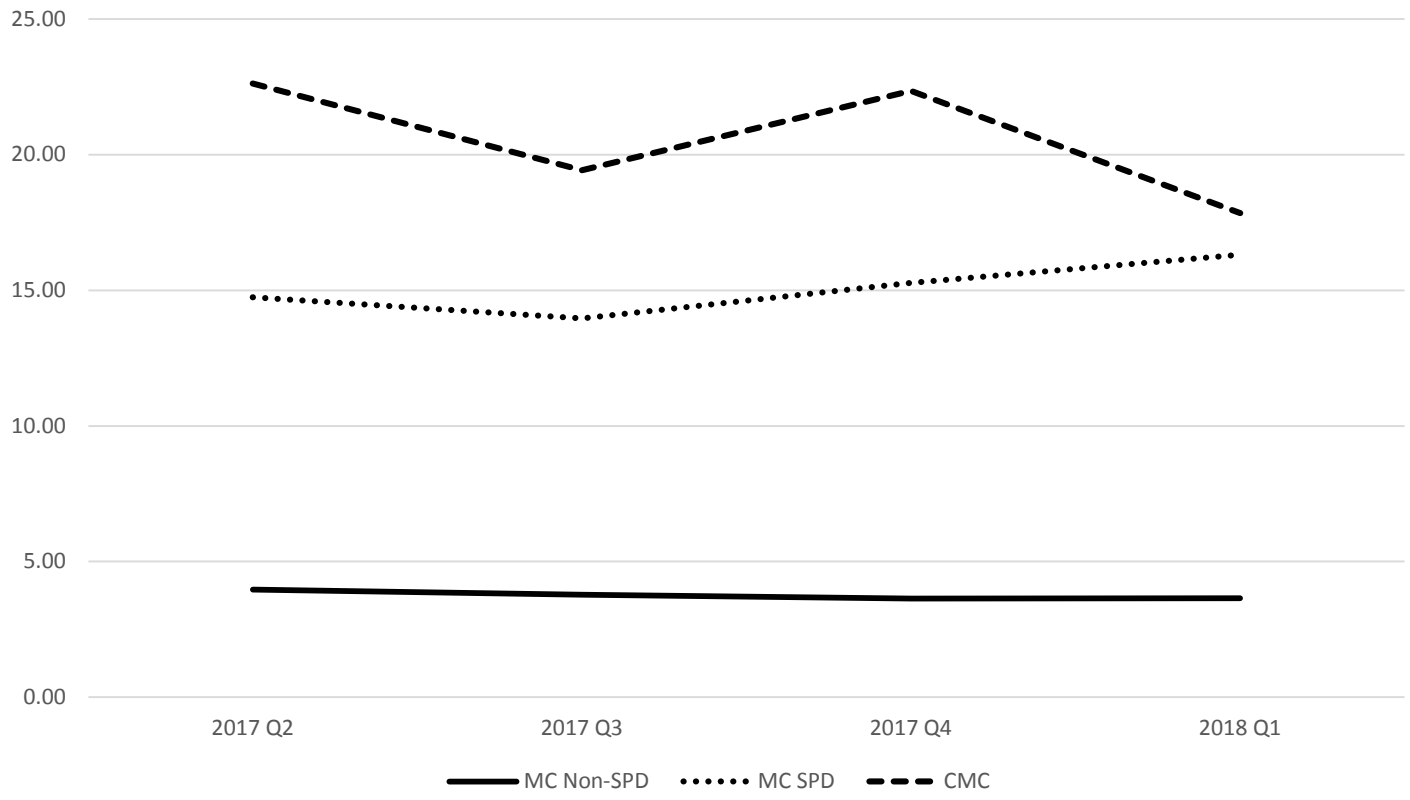
Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2017 Q2	778	14.74	3,517	4.52
2017 Q3	737	13.96	3,624	4.92
2017 Q4	806	15.27	4,083	5.07
2018 Q1	861	16.31	4,135	4.80
Total	3,182	15.07	15,359	4.83

Inpatient Utilization: Cal MediConnect (CMC)
4/1/2017 – 3/31/2018

Source: CMC Enrollment & QNXT Claims Data

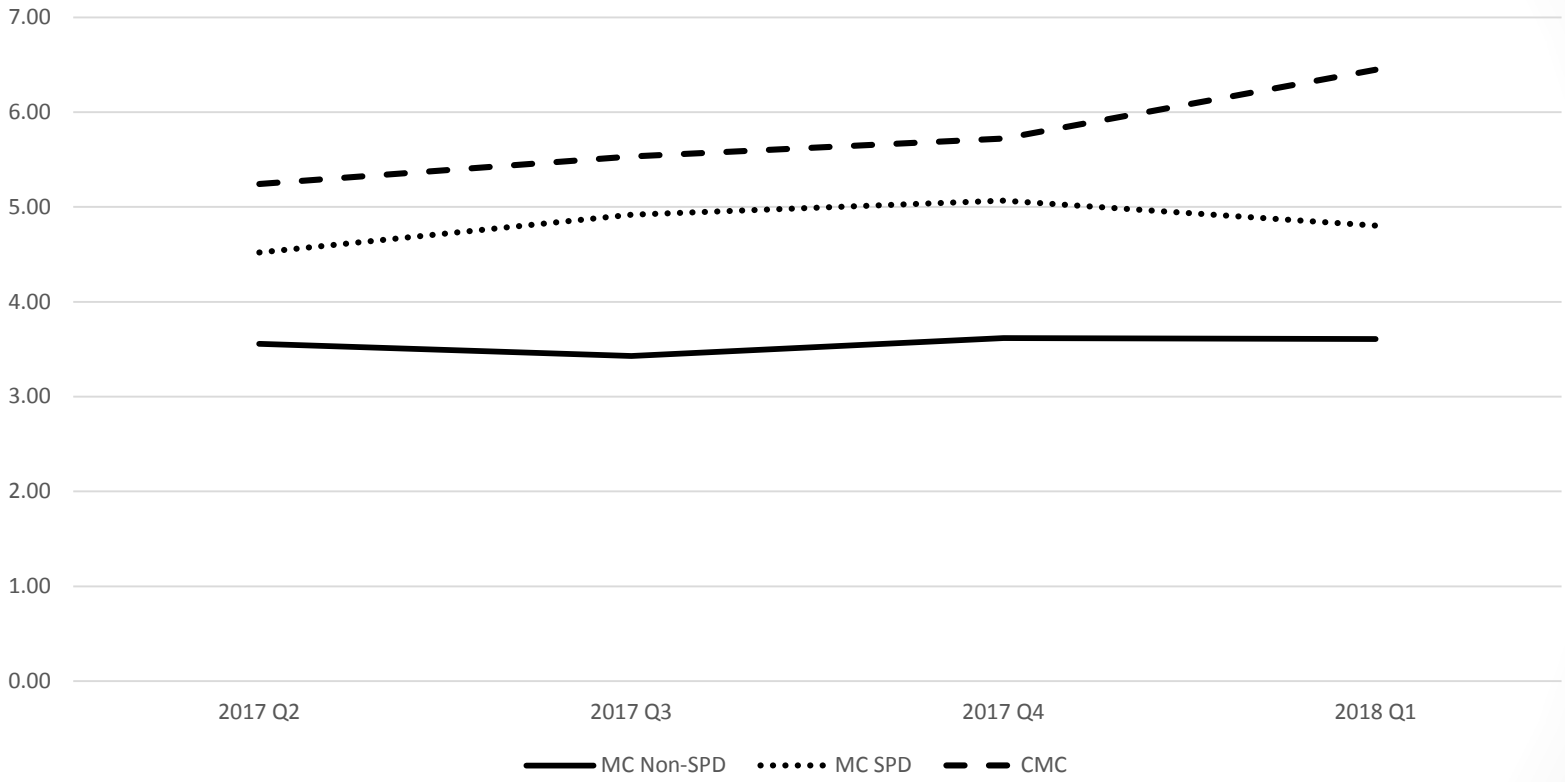
Quarter	Discharges	Discharges / 1,000 Members per Year	Days	Average Length of Stay
2017 Q2	494	271.5	2,589	5.24
2017 Q3	413	233.1	2,285	5.53
2017 Q4	478	268.2	2,735	5.72
2018 Q1	381	214.1	2,457	6.45
Total	1,766	246.9	10,066	5.70

SCFHP Medi-Cal & Cal MediConnect
Acute Inpatient Discharges per 1,000 Member Months (MM)
4/1/2017 – 3/31/2018



Statewide inpatient admissions per 1,000 MM as of March 2017:
SPD – 44.4
Dual – 56.3
ACA – 9.9
OLTIC – 3.3
Other – 7.0

SCFHP Medi-Cal & Cal MediConnect
Acute Inpatient Average Length of Stay (ALOS)
4/1/2017 – 3/31/2018



Santa Clara Family Health Plan
The Spirit of Care

7/3/2018

Medi-Cal Inpatient Utilization
NCQA Medicaid Benchmark Comparisons
4/1/2017 – 3/31/2018

	Medi-Cal Population		
Measure	**Non-SPD**	**SPD**	**Total**
Discharges / 1,000 Member Months	3.76	15.07	4.62
NCQA Medicaid Percentile Rank[1]	<10th	>90th	<10th
ALOS	3.55	4.83	3.87
NCQA Medicaid Percentile Rank[2]	<25th	>75th	<50th

[1] NCQA Medicaid 50th percentile = 6.54
[2] NCQA Medicaid 50th percentile = 4.18

Medi-Cal SPD & CMC Inpatient Utilization
MCG & NCQA Medicare Benchmark Comparisons
4/1/2017 – 3/31/2018

	Discharges / 1,000 Members per Year	Days / 1,000 Members per Year	ALOS
SCFHP Population			
Medi-Cal SPD	180.9	853.5	4.83
CMC	246.9	1,580.5[1]	5.70
MCG Medicare Plans			
Loosely Managed	258.7	1,406.9	5.44
Moderately Managed	214.8	1,078.7	5.02
Well Managed	171.0	750.6	4.39
NCQA Medicare Mean	214.6	1,208.9	5.41

[1] CMC inpatient days / 1,000 = 1,289.1 for 6 CCI counties through 9/30/16; in comparison, a 5% sample of 2015 Medicare FFS data for the same counties showed inpatient days / 1,000 = 2,502.6

Inpatient Readmissions: Medi-Cal – Non-SPD

Source: All Cause Readmissions (ACR) data for 4/1/2017 – 3/31/2018 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1, 2]
2017 Q2	1,304	191	14.6%
2017 Q3	1,240	174	14.0%
2017 Q4	1,235	185	15.0%
2018 Q1	784	114	14.5%
Total	4,563	664	14.6%

[1] A lower rate indicates better performance.

[2] The 30-day readmission rate for the ACR measure is Medi-Cal specific and only includes non-dual members ages 21 years and older.

Inpatient Readmissions: Medi-Cal – SPD

Source: All Cause Readmissions (ACR) data for 4/1/2017 – 3/31/2018 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1,2]
2017 Q2	629	158	25.1%
2017 Q3	605	108	17.9%
2017 Q4	647	145	22.4%
2018 Q1	487	106	21.8%
Total	2,368	517	21.8%

[1] A lower rate indicates better performance.

[2] The 30-day readmission rate for the ACR measure is Medi-Cal specific and only includes non-dual members ages 21 years and older.

Inpatient Readmissions: Cal MediConnect (CMC)

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 4/1/2017– 3/31/2018 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1, 2]
2017 Q2	362	54	14.9%
2017 Q3	281	40	14.2%
2017 Q4	356	64	18.0%
2018 Q1	258	38	14.7%
Total	1,257	196	15.6%

[1] A lower rate indicates better performance.

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

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

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 4/1/2017 – 3/31/2018 measurement period

Rate Description	Ages 18 – 64 (PCR-A)	Ages 65+ (PCR-B)
Count of Index Hospital Stays	301	956
Count of 30-Day Readmissions	60	136
Actual Readmission Rate	19.93%	14.23%
NCQA Medicare 50th Percentile	16.34%	12.68%
SCFHP Percentile Ranking	>75th	>50th

[1] A lower rate indicates better performance.

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

Frequency of Selected Procedures: Medi-Cal

Source: HEDIS data for 4/1/2017 – 3/31/2018 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Tonsillectomy				
Male & Female, Age 0-9	208	0.32	0.63	↓
Male & Female, Age 10-19	85	0.12	0.29	↓
Hysterectomy, abdominal				
Female, Age 15-44	23	0.04	0.10	↓
Female, Age 45-64	51	0.17	0.24	↓
Hysterectomy, vaginal				
Female, Age 15-44	24	0.04	0.10	↓
Female, Age 45-64	35	0.11	0.17	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 4/1/2017 – 3/31/2018 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Cholecystectomy, open				
Male, Age 30-64	10	0.02	0.03	↓
Female, Age 15-44	5	0.01	0.01	↔
Female, Age 45-64	3	0.01	0.03	↓
Cholecystectomy, closed (laparoscopic)				
Male, Age 30-64	63	0.15	0.26	↓
Female, Age 15-44	226	0.38	0.61	↓
Female, Age 45-64	101	0.33	0.58	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 4/1/2017 – 3/31/2018 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Back Surgery				
Male, Age 20-44	28	0.08	0.19	↓
Female, Age 20-44	18	0.04	0.14	↓
Male, Age 45-64	38	0.15	0.52	↓
Female, Age 45-64	52	0.17	0.51	↓
Mastectomy				
Female, Age 15-44	23	0.04	0.02	↑
Female, Age 45-64	29	0.09	0.12	↓
Lumpectomy				
Female, Age 15-44	55	0.09	0.11	↓
Female, Age 45-64	70	0.23	0.34	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 4/1/2017 – 3/31/2018 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Bariatric Weight Loss Surgery				
Male, Age 0-19	0	0.00	0.00	↔
Female, Age 0-19	0	0.00	0.00	↔
Male, Age 20-44	1	0.00	0.01	↓
Female, Age 20-44	27	0.06	0.05	↑
Male, Age 45-64	1	0.00	0.01	↓
Female, Age 45-64	19	0.06	0.06	↔

Medi-Cal Behavioral Health Metrics

Source: HEDIS data for 4/1/2017–3/31/2018 measurement period

Measure	Rate	NCQA Medicaid 50th Percentile	SCFHP Percentile Rank
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	27.81%	44.80%	<10th
Continuation & Maintenance Phase	27.38%	55.90%	<10th
Antidepressant Medication Management			
Acute Phase Treatment	59.96%	51.90%	>75th
Continuation Phase Treatment	42.50%	36.21%	>75th
Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia	100.0%	77.94%	>90th

Santa Clara
Family Health Plan
The Spirit of Care

Questions?

Santa Clara
Family Health Plan

I. Purpose of the Quality Assurance (QA)

In order to present the results to Utilization Management Committee (UMC), Santa Clara Family Health Plan (SCFHP) completed the 2nd quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations.

II. Procedure

Santa Clara Family Health Plan reviewed in accordance to this procedure, 30 authorizations for the 2nd quarter of 2018 in order to assess for the following elements.

A. Quality Monitoring

1. The UM Manager is responsible for facilitating a random review of denial letters to assess the integrity of member and provider notification.
    a. At least 30 denial letters per quarter
    b. Is overseen by the Utilization Management Committee on a quarterly basis
    c. Assessment of denial notices includes the following:
        1. Turn-around time for decision making
        2. Turn-around time for member notification
        3. Turn-around time for provider notification
        4. Assessment of the reason for the denial, in clear and concise language
        5. Includes criteria or Evidence of Benefit (EOB) applied to make the denial decision and instructions on how to request a copy of this from UM department.
        6. Type of denial: medical or administrative
        7. Addresses the clinical reasons for the denial
        8. Specific to the Cal Mediconnect membership, the denial notification includes what conditions would need to exist to have the request be approved.
        9. Appeal and Grievance rights
        10. Member's letter is written in member's preferred language within plan's language threshold.
        11. Member's letter includes Independent Medical Review (IMR) information or state fair hearing rights
        12. Member's letter includes interpretation services availability
        13. Member's letter includes nondiscriminatory notice.
        14. Provider notification includes the name and direct phone number of the appropriately licensed professional making the denial decision

Quarterly Quality Report in Accordance with Procedure HS.04.01
For 2nd Quarter 2018

III. Findings

For the 1st quarter review of 2018, the findings are as follows:

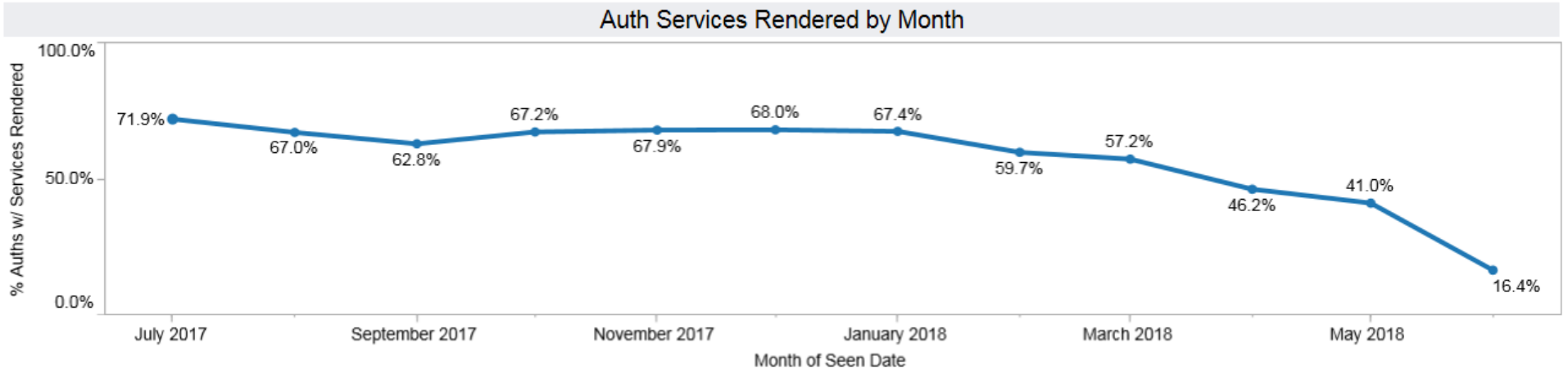
A. For the dates of services and denials for January, February, March of CY 2018 were pulled in the 1st quarter sampling year.
    a. 30 unique authorizations were pulled with a random sampling.
        i. 57% (17/30) Medi-Cal LOB and 43% or (13/30) CMC LOB
        ii. Of the sample 100% or 30/30 were denials
        iii. Of the sample 27% or 8/30 were expedited request; 73%or 22/30 were standard request.
            1. 100% or 8/8 of the expedited authorizations met regulatory turnaround time of 72 calendar hours
            2. 65% or 15/20 of the standard authorizations met regulatory turnaround time (5 business days for Medi-Cal LOB and 14 calendar days for CMC LOB)
        iv. 63% or 19/30 are medical denials, 37% or 11/30 are administrative denials
        v. 100% or 30/30 of cases were denied by MD or pharmacist.
        vi. 100% were provided member and provider notification.
        vii. 90% or 28/30 of the member letters are of member's preferred language.
        viii. 100% of the letters were readable and rationale for denial was provided.
        ix. 100% of the letters included IMR information, interpreter rights and instructions on how to contact CMO or Medical Director.

IV. Follow-Up

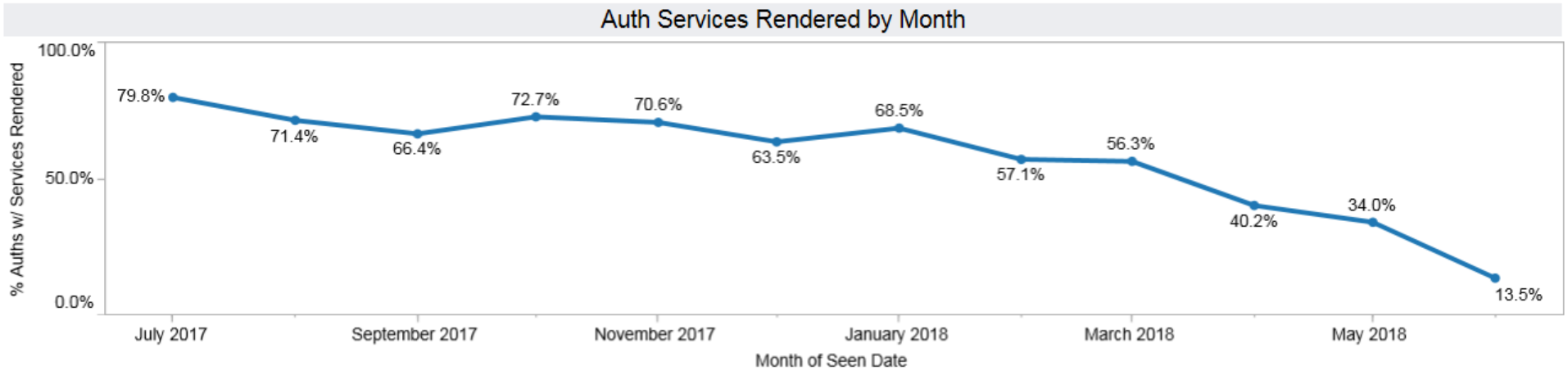
The Manager of Utilization Management and Director of Health Services reviewed the findings of this audit and recommendations from that finding presented to UMC are as follows:

1. Continue QA report monitoring process.
2. Manage reviews to meet turn around time requirements.

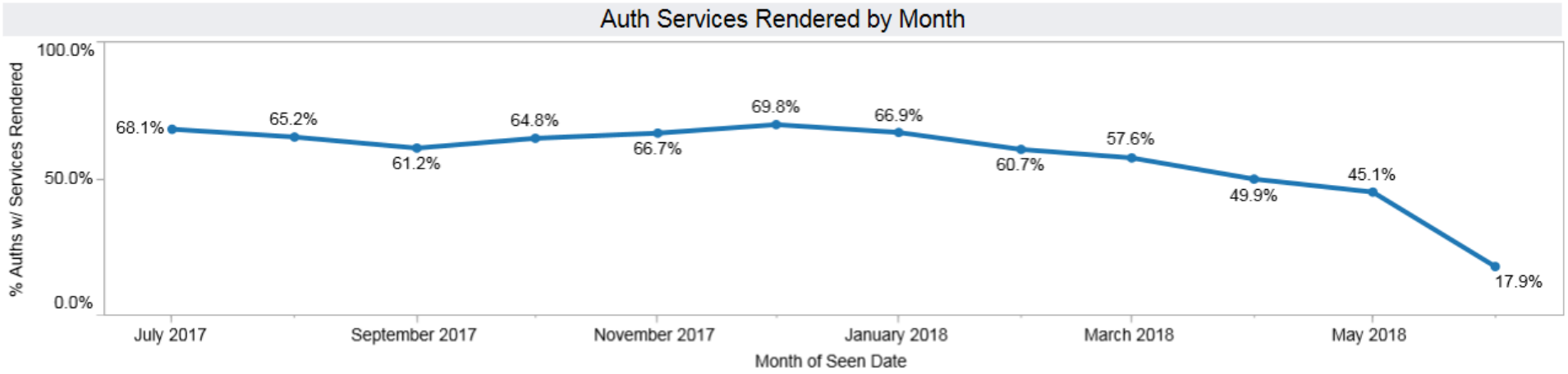
COMBINATION OF ALL LINES OF BUSINESS:



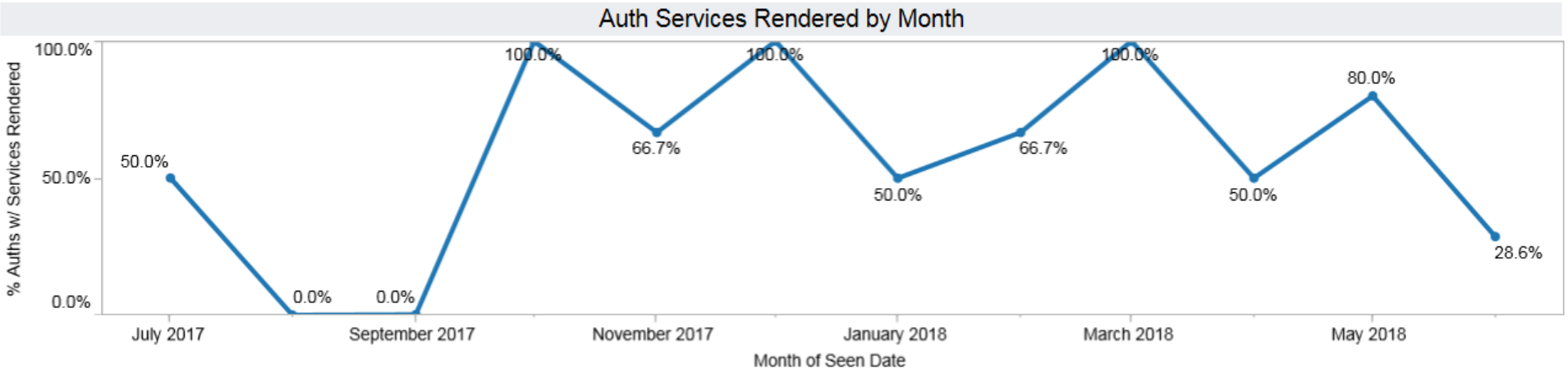
CAL MEDICONNECT:



MEDI-CAL:



HEALTHY KIDS:



Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Cal MediConnect	CBAS	Dental - Routine	1	1	0	0	0.0%
		Retro Request	24	23	0	1	4.2%
		Routine - Extended Service	7	4	0	3	42.9%
		Routine - Initial Request	39	34	0	5	12.8%
	CONT OF CARE	Non Contracted Provider - Ro..	2	2	0	0	0.0%
	DME	Non Contracted Provider - Ret..	6	6	0	0	0.0%
		Non Contracted Provider - Ro..	16	11	1	4	25.0%
		Non Contracted Provider - Urg..	8	3	0	5	62.5%
		Retro Request	38	17	1	20	52.6%
		Routine - Extended Service	6	4	0	2	33.3%
		Routine - Initial Request	543	386	11	146	26.9%
		Urgent - Initial Request	174	143	0	31	17.8%
	HomeHealth	Non Contracted Provider - Ret..	2	2	0	0	0.0%
		Non Contracted Provider - Ro..	4	1	0	3	75.0%
		Non Contracted Provider - Urg..	44	22	0	22	50.0%
		Retro Request	14	6	0	8	57.1%
		Routine - Extended Service	28	6	0	22	78.6%
		Routine - Initial Request	48	25	0	23	47.9%
		Urgent - Extended Service	39	17	0	22	56.4%
		Urgent - Initial Request	405	275	0	130	32.1%
		Urgent – RN review; Expedite..	1	1	0	0	0.0%
	HOSPICE	Non Contracted Provider - Ro..	2	1	0	1	50.0%
		Non Contracted Provider - Urg..	5	4	0	1	20.0%
		Retro Request	1	1	0	0	0.0%
		Routine - Initial Request	4	3	0	1	25.0%
		Urgent - Initial Request	2	2	0	0	0.0%
	OP-BehavioralGr	Non Contracted Provider - Ret..	18	18	0	0	0.0%
		Non Contracted Provider - Ro..	10	7	0	3	30.0%
		Retro Request	5	5	0	0	0.0%
		Routine - Initial Request	14	9	0	5	35.7%
		Urgent - Initial Request	1	1	0	0	0.0%
	OP-Behavorial	Non Contracted Provider - Ret..	5	5	0	0	0.0%
		Non Contracted Provider - Ro..	7	2	0	5	71.4%
		Retro Request	14	14	0	0	0.0%
		Routine - Initial Request	6	4	0	2	33.3%
	OPHospital	Non Contracted Provider - Ret..	39	25	0	14	35.9%
		Non Contracted Provider - Ro..	88	43	0	45	51.1%
		Non Contracted Provider - Urg..	54	22	0	32	59.3%
		Prospective Inpatient Admit	1	1	0	0	0.0%
		Retro Request	137	53	0	84	61.3%
		Routine - Extended Service	24	2	0	22	91.7%
		Routine - Initial Request	1,329	496	26	807	60.7%
		Urgent - Extended Service	6	1	0	5	83.3%
		Urgent - Initial Request	643	333	7	303	47.1%
	OPHospitalGr	Non Contracted Provider - Ret..	3	3	0	0	0.0%
		Non Contracted Provider - Ro..	6	5	0	1	16.7%
		Non Contracted Provider - Urg..	3	2	0	1	33.3%
		Retro Request	18	9	0	9	50.0%
		Routine - Extended Service	3	0	0	3	100.0%

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Cal MediConnect	OPHospitalGr	Routine - Initial Request	77	37	1	39	50.6%
		Urgent - Initial Request	65	42	0	23	35.4%
	Transportation	Non Contracted Provider - Ret..	2	1	0	1	50.0%
		Retro Request	29	8	0	21	72.4%
		Routine - Initial Request	135	26	4	105	77.8%
		Urgent - Initial Request	2	0	0	2	100.0%
Healthy Kids	DME	Routine - Initial Request	1	1	0	0	0.0%
		Urgent - Initial Request	1	1	0	0	0.0%
	OP-BehavioralGr	Non Contracted Provider - Ro..	1	1	0	0	0.0%
		Routine - Extended Service	1	1	0	0	0.0%
		Routine - Initial Request	3	3	0	0	0.0%
	OP-Behavorial	Non Contracted Provider - Ret..	1	1	0	0	0.0%
		Non Contracted Provider - Ro..	1	1	0	0	0.0%
		Retro Request	1	1	0	0	0.0%
		Routine - Initial Request	1	1	0	0	0.0%
	OPHospital	Non Contracted Provider - Ro..	1	0	0	1	100.0%
		Retro Request	2	2	0	0	0.0%
		Routine - Extended Service	1	0	0	1	100.0%
		Routine - Initial Request	11	5	0	6	54.5%
		Urgent - Initial Request	5	1	0	4	80.0%
	OPHospitalGr	Routine - Extended Service	1	0	0	1	100.0%
		Routine - Initial Request	1	0	0	1	100.0%
Medi-Cal	CBAS	Retro Request	212	199	1	12	5.7%
		Routine - Extended Service	98	76	0	22	22.4%
		Routine - Initial Request	246	222	0	24	9.8%
	CONT OF CARE GR	Non Contracted Provider - Urg..	1	1	0	0	0.0%
		Routine - Initial Request	1	0	0	1	100.0%
	Dental	Routine - Initial Request	34	10	0	24	70.6%
		Urgent - Initial Request	10	2	0	8	80.0%
	DME	Non Contracted Provider - Ret..	8	7	0	1	12.5%
		Non Contracted Provider - Ro..	16	9	1	6	37.5%
		Non Contracted Provider - Urg..	4	2	0	2	50.0%
		Retro Request	26	9	1	16	61.5%
		Routine - Extended Service	3	1	0	2	66.7%
		Routine - Initial Request	608	378	17	213	35.0%
		Urgent - Initial Request	42	24	0	18	42.9%
	HomeHealth	Non Contracted Provider - Ret..	1	0	0	1	100.0%
		Non Contracted Provider - Urg..	4	2	0	2	50.0%
		Retro Request	3	2	0	1	33.3%
		Routine - Initial Request	15	11	0	4	26.7%
		Urgent - Extended Service	5	2	0	3	60.0%
		Urgent - Initial Request	75	41	0	34	45.3%
	HOSPICE	Non Contracted Provider - Ret..	18	16	0	2	11.1%
		Non Contracted Provider - Ro..	9	8	0	1	11.1%
		Non Contracted Provider - Urg..	15	11	0	4	26.7%
		Retro Request	1	1	0	0	0.0%
		Urgent - Initial Request	2	2	0	0	0.0%
	OP-BehavioralGr	Non Contracted Provider - Ret..	38	35	1	2	5.3%
		Non Contracted Provider - Ro..	132	115	0	17	12.9%

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Medi-Cal	OP-BehavioralGr	Non Contracted Provider - Urg..	5	5	0	0	0.0%
		Retro Request	66	63	0	3	4.5%
		Routine - Extended Service	14	12	0	2	14.3%
		Routine - Initial Request	246	181	3	62	25.2%
		Urgent - Extended Service	1	1	0	0	0.0%
		Urgent - Initial Request	9	6	0	3	33.3%
	OP-Behavorial	Non Contracted Provider - Ret..	7	5	0	2	28.6%
		Non Contracted Provider - Ro..	26	6	0	20	76.9%
		Non Contracted Provider - Urg..	2	0	0	2	100.0%
		Retro Request	8	5	0	3	37.5%
		Routine - Extended Service	18	5	0	13	72.2%
		Routine - Initial Request	74	24	0	50	67.6%
		Urgent - Initial Request	6	2	0	4	66.7%
	OPHospital	Dental - Routine	55	44	0	11	20.0%
		Dental - Urgent	13	10	0	3	23.1%
		Non Contracted Provider - Ret..	30	15	0	15	50.0%
		Non Contracted Provider - Ro..	87	29	0	58	66.7%
		Non Contracted Provider - Urg..	70	31	0	39	55.7%
		Retro Request	149	60	2	87	58.4%
		Routine - Extended Service	48	8	0	40	83.3%
		Routine - Initial Request	2,307	1,298	23	986	42.7%
		Urgent - Extended Service	7	0	0	7	100.0%
		Urgent - Initial Request	887	526	9	352	39.7%
		Urgent – RN review; Expedite..	1	0	0	1	100.0%
	OPHospitalGr	Non Contracted Provider - Ret..	2	1	0	1	50.0%
		Non Contracted Provider - Ro..	12	1	0	11	91.7%
		Non Contracted Provider - Urg..	4	2	0	2	50.0%
		Retro Request	94	66	0	28	29.8%
		Routine - Extended Service	21	1	0	20	95.2%
		Routine - Initial Request	938	417	11	510	54.4%
		Urgent - Extended Service	3	0	0	3	100.0%
		Urgent - Initial Request	398	253	2	143	35.9%
	Transportation	Non Contracted Provider - Ret..	2	0	0	2	100.0%
		Retro Request	221	45	0	176	79.6%
		Routine - Extended Service	4	1	0	3	75.0%
		Routine - Initial Request	927	286	12	629	67.9%
		Urgent - Extended Service	1	0	0	1	100.0%
		Urgent - Initial Request	28	9	0	19	67.9%
Grand Total			**12,658**	**6,797**	**134**	**5,727**	**45.2%**

Procedure

Santa Clara
Family Health Plan

Policy Title:	**Prior-authorization and Organization Decisions**	**Procedure No.:**	HS01.01
Replaces Policy Title (if applicable):	Prior Auth for Non-Delegated SCFHP and VHP ReRMC Contra ct TERM FINAL Prior Auth Process REDLINE Prior Authorization Process Continuity of Care Policy Out of Network Out of Area Referrals	**Replaces Policy No. (if applicable):**	UM002_07 UM002_09 UM002_08 UM031_04 UM033_04
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Procedure

A. Submissions

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

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

B. Provider Education

Practitioners and providers are educated on the prior authorization requirements through

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

C. Timeliness

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

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

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

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

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

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

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

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

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

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

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

H. Member initiated organization determination

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

I. Denial to Expedite an Organization Determination Request

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

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

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

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

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

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

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

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

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

O. Continuity of Care
1. The plan shall allow new members to continue services with out of network providers for a defined period of time in order to facilitate a smooth transition of care into the plan's contracted network. Continuity of care will apply to the following circumstances
    a. Acute episode of care
    b. Active treatment for chronic condition
    c. Pregnancy
    d. Terminal illness
    e. Newborn care ages birth to 36 months
    f. Surgeries
    g. Other courses of treatment

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

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

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

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

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

Q. Reporting/Monitoring

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

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

R. Denials

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

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

III. Responsibilities

Health Services collaborates with internal and external stakeholders to ensure optimal utilization management of services for plan members. This includes working with of Quality, Benefits, IT, Provider and

Member Services, outside community resources and providers.

IV. Policy References

HS.01 Prior Authorization

V. Approval/Revision History

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

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**			
v1	**Revised**			

07/2018

- Objective:

  - To increase developmental screenings for children:

    Birth to 30 months for all providers of Santa Clara Family Health Plan (SCFHP)

    To address the DMHC deficiency on tracking and monitoring of developmental screenings for our membership.

Santa Clara
Family Health Plan

Objective

- Review the Developmental Screening recommendations for children Birth -16 years of age
- Review the developmental screening code: 96110 as an additional fee-for-service payment if it billed with a well child diagnosis for Independent Network (10), Palo Alto Medical Foundation (40), Physicians Medical Group (50), and Premiere Care (60)
- Discuss VHP Network 20 and Kaiser Network 30

Santa Clara
Family Health Plan

Pediatric Population SCFHP Oct 2017

Approximately 37% of children <3 years of age: receive services in Networks 10, PAMF, PMG, PCNC (combined)

Count of MbrHealthPlanID	Column Labels						
	10 Directly Contracted	20	30	40	50	60	Grand Total
Row Labels	SCFHP	VHP	Kaiser	PAMF	PMG	PCNC	
HK	247	1,032		74	757	174	2,284
Age 0-2	10	81		8	63	4	166
Age 3-5	25	125		8	83	25	266
Age 6-12	93	365		28	309	67	862
Age 13-18	119	461		30	302	78	990
MC	6,896	49,747	13,967	2,574	27,154	6,025	106,363
Age 0-2	861	7,303	1,912	284	3,680	517	14,557
Age 3-5	849	7,918	2,123	394	4,193	732	16,209
Age 6-12	2,709	19,572	5,333	993	10,678	2,298	41,583
Age 13-18	2,477	14,954	4,599	903	8,603	2,478	34,014
Grand Total	7,143	50,779	13,967	2,648	27,911	6,199	108,647

Santa Clara
Family Health Plan

Current American Academy of Pediatric Recommendations

- The American Academy of Pediatrics (AAP) recommends that all children receive autism-specific screening at 18 and 24 months of age, in addition to the broad developmental screening **(Ages and Stages Questionnaire)** at 9, 18, and 24 months.
- Pediatric offices complete this in two stages:

  - ✓ The Ages and Stages Questionnaires (ASQ) are a series of parent-completed child development screening tools, endorsed by the American Academy of Pediatrics. They are administered to the parents at (Child Health and Disability Prevention) CHDP visits ages (9-12)-(18-24)-30 months. The family completes the questionnaire and the pediatrician review/grade the questionnaire. If abnormal, they then refer family to local resources.

  - ✓ Pediatricians also use the **M-CHAT (Modified Checklist for Autism in Toddlers)** in ages 16-30 months. Again parent completed. Scored with the provider and referrals made.

Developmental Screening Additional Info

- Additional screening might be needed if a child is at high risk for developmental problems due to pre-term birth, low birth weight, or other reasons.
  - Referral for further evaluation if developmental screening results are positive:
  - STARTS Form initiates a referral to County assessment and services such as Kids Scope/Kids Connection. Attach developmental screening results and any additional information and FAX to 408-938-4536. See STARTS Form in packet.
- Autism Spectrum Disorder (ASD), refer after confirmed diagnosis to SCFHP for services
- Early Periodic Screening, Diagnostic, and Treatment (EPSDT) allows for services for children as a health benefit, such as Speech Therapy which are beyond the services offered in the educational systems. Services which are non-ASD related are the responsibility of the health plans, but do not require a prior authorization.
- California Children's Services if child has a concurrent medical condition
- San Andreas Regional Center is a resource and can be reached at 408 374-9960.
  - Refer to Early Start Program (ESP) if under 2.9 years old (408) 392-3805

    http://www.sanandreasregional.org/early-start/

2017 Q1-2 Developmental Screening Code Analysis by Network

Analysis by network for measurement years 2016 and 2017.

Denominator = Children who had their 1st, 2nd or 3rd birthday during the measurement year, were continuously enrolled for the 12 months prior to their birthday and had no more than a one-month gap in coverage during the measurement year

Numerator = Children who had a claim with CPT code 96110 in the 12 months preceding their 1st, 2nd or 3rd birthday

Please note that there were not any claims billed or encounters submitted with the local code (B1) that corresponds to 96110. And, just to confirm, the numerator and denominator represent the unique counts of children.

Measurement Year 2016			
Network	Denominator	Numerator	Rate
Independent Providers (10)	477	9	1.9%
Valley Health Plan (20)	5,067	21	0.4%
Kaiser (30)	1,307	5	0.4%
PAMF (40)	208	61	29.3%
Physicians Medical Group (50)	2,674	35	1.3%
Premier Care (60)	463	3	0.6%
Grand Total	10,196	134	1.3%

Measurement Year 2017			
Network	Denominator	Numerator	Rate
Independent Providers (10)	446	4	0.9%
Valley Health Plan (20)	4,598	49	1.1%
Kaiser (30)	1,130	1	0.1%
PAMF (40)	156	74	47.4%
Physicians Medical Group (50)	2,250	154	6.8%
Premier Care (60)	332	2	0.6%
Grand Total	8,912	284	3.2%

Update on the payment of the screening code:

- Starting July 2017, SCFHP pays the developmental screening code: 96110 as an additional fee-for-service payment if it billed with a (Child Health and Disability Prevention) CHDP visit.
  This is for Independent Network (10), PAMF (40), PMG (50), and PCNC (60).

Santa Clara
Family Health Plan

Next Steps

- Provider Education (directly contracted)
- Analytics on each network expanded
- Engagement of Delegated Provider Networks: Physicians Medical Group (PMG) and Premier Care (PCNC)
- Group Discussion

Santa Clara
Family Health Plan
The Spirit of Care

To: SCFHP Providers

From: Eric Tatum, Director, Provider Network Management

Date: June 15, 2018

Subject: **Developmental Screening Recommended by the AAP**

Dear Providers:

As a healthcare provider, you play a critical role in monitoring children's growth and development and identifying problems as early as possible. According to the American Academy of Pediatrics (AAP), one in four children are at risk for developmental delay. Preventive childhood screening provides an opportunity to identify delays early and intervene during the most critical period of development.

The AAP recommends the following for all children:

- Conducting developmental surveillance at every health supervision visit and conducting developmental screening using formal, validated tools at 9, 18, 24 and 30 months, or whenever surveillance reveals a concern.
- Screening for autism spectrum disorder at 18 and 24 months.
- Screening conducted with formal, validated tools at regular intervals beginning in the first year of life for behavioral and emotional problems.

SCFHP wants to ensure all members receive their recommended preventive care. Please use the following code when submitting claims for reimbursement for developmental screenings:

- 96110 – Developmental screening (e.g. developmental milestone survey, speech and language delay screen) with scoring and documentation per standardized instrument. When used with a well-child diagnosis code, this code will generate an additional fee-for-service payment.

If you have questions regarding the above information, please contact Rosa Perez, SCFHP Provider Network Management Representative at (408) 874-1755 or perezros@scfhp.com.

Thank you!