Santa Clara
Family Health Plan
The Spirit of Care

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

Thursday, February 2, 2017
12:15 PM – 1:45 PM
210 E. Hacienda Avenue
Campbell, CA 95008

AGENDA

1.	**Roll Call**	Dr. Padua, Chair	12:15	5 min.
2.	**Meeting Minutes** Review minutes from October 6, 2016 - Regular Meeting. **Possible Action:** Approve minutes.	Dr. Padua, Chair	12:20	5 min.
3.	**Public Comment** Members of the public may speak to any item not on the agenda; 2 minutes per speaker. The Committee reserves the right to limit the duration of public comment period to 30 minutes.	Dr. Padua, Chair	12:25	5 min.
4.	**Committee Membership and Charter** a. Resignation of Dr. Stephen Ho, CMO, Excel b. Governing Board approval of charter c. Re-appointment of committee members	Dr. Padua, Chair Ms. Tomcala, CEO	12:30 12:40	10 min. 5 min.
5.	**Chief Executive Officer** Discussion on membership and current topics.	Ms. Tomcala, CEO	12:45	15 min.
6.	**Chief Medical Officer** Discussion on CME and current topics.	Dr. Robertson, CMO	1:00	10 min.
7.	**Case Management** Discussion on palliative care.	Ms. Peterson, Manager Case Management	1:10	20 min.

8.	**Quality and Pharmacy** a. Update from P&T Committee on Epi Pen recommendation from October meeting. b. Discussion on Drug Report.	Ms. Liu, Director of Quality and Pharmacy	1:30	10 min.
9.	**Confidentiality, Conflict of Interest and Non-Discrimination Statement** **Possible Action:** Sign statement for 2017	Dr. Padua, Chair	1:40	5 min
10.	**Adjournment**	Dr. Padua, Chair	1:45	

Notice to the Public—Meeting Procedures

- Persons wishing to address the PAC 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 PAC 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 Rita Zambrano 48 hours prior to the meeting at 408-874-1842.
- To obtain a copy of any supporting document that is available, contact Rita Zambrano at 408-874-1842. 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.
- This agenda and meeting documents are available at www.scfhp.com

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

Thursday, October 06, 2016
12:15 PM – 1:45 PM
210 E. Hacienda Avenue
Campbell, CA 95008

Minutes

Members present:
Thad Padua, M.D., Chair
Steve Church
Bridget Harrision, M.D.
Peter Nguyen 12:30
Sherri Sager
Dolly Goel, M.D.
Tuyen Ngo, M.D.
Melinda Golden (on behalf of Dave Mineta)

Members not present:
Jimmy Lin, M.D.
Stephen Ho, M.D.

Staff present:
Christine Tomcala, Chief Executive Officer
Jeff Robertson, M.D., Chief Medical Officer
Jennifer Clements, Director of PNM
Sherry Holm, Behavioral Health Program Manager
Johanna Liu, Director of QI & RX
Lori Andersen, Operations Director, LTSS
Art Shaffer, Sr. Provider Services Representative
Claudio Graciano, Sr. Provider Services Representative
Caroline Alexander, Administrative Assistant
Tanya Nguyen, Director of Member Services
Jamie Enke, Health Services Project Manager
Andre Aguirre, QI Manager

Staff not present:
Irene Walsh, MLTSS Provider Services Representative
Abby Baldovinos, Sr. Provider Services Representative
Robyn Esparza, Administrative Assistant

1. **Roll Call**

   Thad Padua, MD, Chairperson, called the meeting to order at 12:25 pm. Roll call was taken and a quorum was established.

2. **Minutes Review and Approval**
   a. Meeting minutes were reviewed. Dr. Padua asked the Committee if there were any additional questions or comments regarding the July 27, 2016, meeting minutes.
      ✓ It was moved, seconded, and the July 27, 2016 meeting minutes were approved as presented.
   b. Kingstom Lum was recommended for appointment to the Committee.
      ✓ It was moved, seconded, and the appointment of Kingston Lum to the Committee was approved.

3. **Public Comment**

   There were no public comments.

4. **Chief Executive Officer Update**

   Ms. Christine Tomcala, CEO, presented the September 2016 Membership Summary.
   Ms. Tomcala noted the current enrollment is 280,380, with the majority of our membership in Medi-Cal:
   - Healthy Kids: 2,962
   - Cal MediConnect: 7,909
   - Medi-Cal: 269,402

   Ms. Tomcala noted the following during Fiscal Year of July 2015 to June 2016:
   - There was an increase in membership from a little over 260,000 members.
   - Revenue increased by approximately 29.5%. Most of the growth was in the Seniors and Persons with Disabilities population (SPD), as well as the adult population.
   - The Plan is looking at more outreach in the community which will involve working with providers regarding topics such as what Cal MediConnect has to offer and what Cal MediConnect is.

   Committee encouraged providers to refer members for Consumer Advisory Committee.

   Also, encourage referring members that are reflective of Medi-Cal population in the county (Seniors, Disabled).

5. **Chief Medical Officer**

   Dr. Robertson presented an update on CME topics available to the group. The six different topics to choose from this year are as follows:
   - Autoimmune Encephalitis
   - Neurological Manifestations of Lyme Disease
   - Population Health Science: A New Way to Think About Child Health
   - Treatment and Prevention of Ischemic Stroke
   - Neurodegenerative Disease
   - Lower Extremity Injuries in the Child and Adolescent: Evaluation and Treatment
     ✓ The committee unanimously voted for Population Health Science as the topic of most interest for a CME session.

   Dr. Robertson presented an update on Medicare registration for providers. Committee advised that a notice was sent to providers in May regarding Medicare prescriber enrollment requirement. Starting February 1, 2017, claims for prescribers not enrolled in Medicare will temporarily be covered through the provisional fill policy. This will allow Cal MediConnect members to receive up to a 3 month fill for each of their medications. After this provisional fill, subsequent claims for the medication will be rejected at the point of sale if the prescriber is not actively enrolled in Medicare or opted-out.

6. **SCFHP Strategic Plan 2016-2017**

Ms. Tomcala presented the Strategic Plan for Fiscal Year July 2016 - June 2017, noting a lot of carryover from previous fiscal year.

Ms. Tomcala noted the following key points:

- Plan is working on building infrastructure.
- The top priority is compliance. Working on strengthening Fraud, Waste and Abuse program as part of increased compliance.
- Implementing new claims system for Medi-Cal population.
- Implementing QNXT for both Cal MediConnect and Medi-Cal products.
- Developing a reporting and analytics structure.
- Working on fostering membership growth and retention by developing and implementing Cal MediConnect and Medi-Cal retention activities.
- Initiating marketing and outreach program for Cal MediConnect by January 2017. Implement Model of Care for Cal MediConnect and SPD population by January 2017 as part of establishing complex care delivery expertise.
- As part of union contract, the Plan to convene a Compensation Committee, which will re-write all job descriptions and benchmark pay ranges by fourth Quarter of 2016.
- Achieve budgeted financial performance by achieving Fiscal Year 2016-2017 Net Surplus of $11.7 million.

7. **Provider Incentive Program**

Dr. Robertson presented an overview of the Provider Incentive Program. Incentive is paid out to capitated Primary Care Physician groups as applicable. Provider groups receive incentive check based on performance measures, such as emergency admits, generic prescription rates etc. Program based on HEDIS scores, increase in access, and Quality of Care.

Medi-Cal Program to include the following five measures:

- All Cause Readmission
- Cervical Cancer Screening
- IHA (Initial Health Assessment)
- Access to Primary Care,
- Encounter Data

The Plan to expand to six or seven measures next year.

8. **Quality and Pharmacy Update**

Ms. Liu presented the third quarter drug report, noting the top drugs requested for prior authorization for Medi-Cal and Healthy Kids are epi-pens and insulin and the lidocaine patch for Cal MediConnect. Ms. Liu noted the top drug by cost for Medi-Cal and Healthy Kids was Hep C agents, followed by Humira and diabetes medications. For Cal MediConnec, the top drug by cost was Hep C agents, followed by diabetes and antipsychotic medications. No new trends to report from last quarter.

Ms. Sager recommended splitting out pharmacy costs by age on future reports.

9. **Member Enrollment**

Ms. Nguyen presented an overview of member enrollment and provider assignment process to the Committee.

10. **Access and Availability**

Ms. Clements presented an update on contracts with Acupuncturists and an update on providers for End of Life Benefit. Plan is working on contracts with Acupuncturists, a few are working on credentialing. Redirecting to Medi-Cal Fee for Service providers as far as End of Life providers.

11. **Meeting Calendar for 2017**

Dr. Padua presented the 2017 meeting calendar to the committee.

- ✓ Committee approved continuing to meet on Thursday's.

12. **Adjournment**

It was moved, seconded, and approved to adjourn the meeting at 1:50pm.

- ✓ Next Meeting is scheduled for February 02, 2017.

_____ _____

Dr. Thad Padua, PAC Committee Chair **Date**

Santa Clara
Family Health Plan

Santa Clara County Health Authority

Provider Advisory Council Charter

Purpose

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

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

Members

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

All Provider Advisory Council (PAC) members, including the Chairperson, shall be appointed by the SCFHP's Chief Executive Officer.

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

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

Meetings

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

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

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

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

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

Responsibilities

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

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

Santa Clara
Family Health Plan

Medi-Cal Membership by Age Group and Network

January 2017

Age	SCFHP Direct	Valley Health Plan	Kaiser	Palo Alto Medical Foundation	Physician's Medical Group	Premier Care	Total	Percentage
< 6 Years	1,668	16,287	4,106	725	8,423	1,339	32,548	12.14%
6 to 17	4,435	33,602	9,497	1,757	18,516	4,523	72,330	26.98%
18 to 34	3,958	35,468	5,668	1,254	8,701	3,417	58,466	21.81%
35 to 44	1,703	12,327	2,058	476	3,413	1,628	21,605	8.06%
45 to 54	1,622	13,815	1,909	647	4,102	2,532	24,627	9.19%
55 to 64	1,813	16,198	1,796	664	4,095	2,777	27,343	10.20%
65 to 74	5,310	7,941	789	521	1,023	319	15,903	5.93%
75 to 84	4,076	4,574	805	905	469	129	10,958	4.09%
>= 85 Years	1,971	1,421	410	426	76	30	4,334	1.62%
Total	26,556	141,633	27,038	7,375	48,818	16,694	268,114	100.00%
Percentage	9.90%	52.83%	10.08%	2.75%	18.21%	6.23%	100.00%	

Santa Clara
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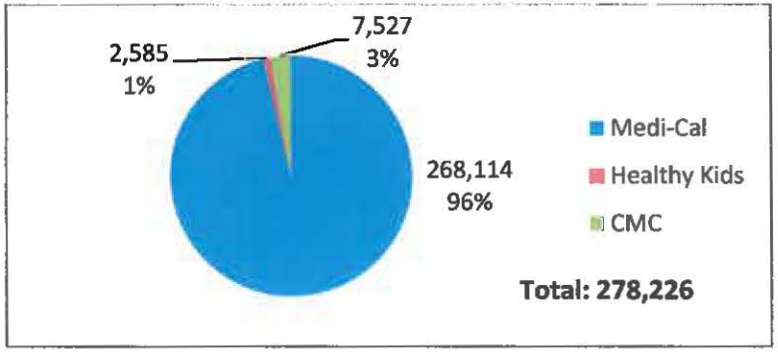
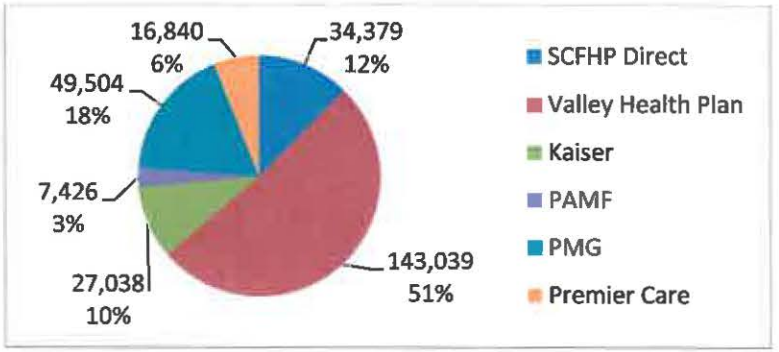
Enrollment Summary as of January 2017

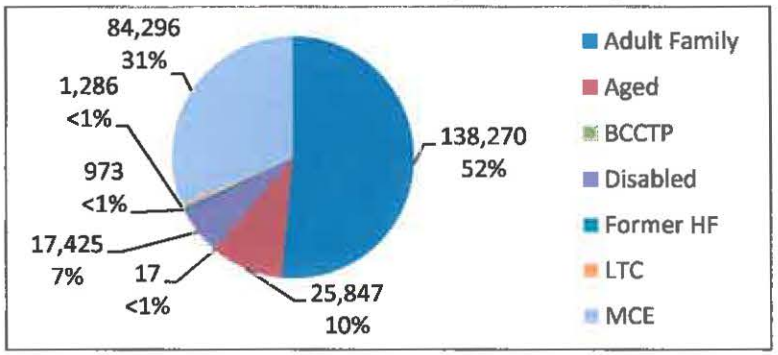
Membership by Line of Business



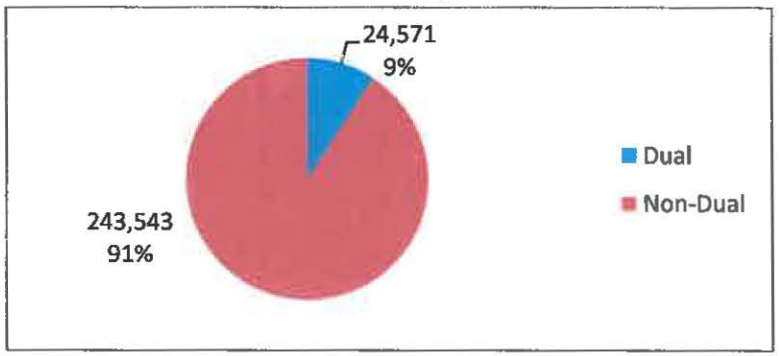
Membership by Network



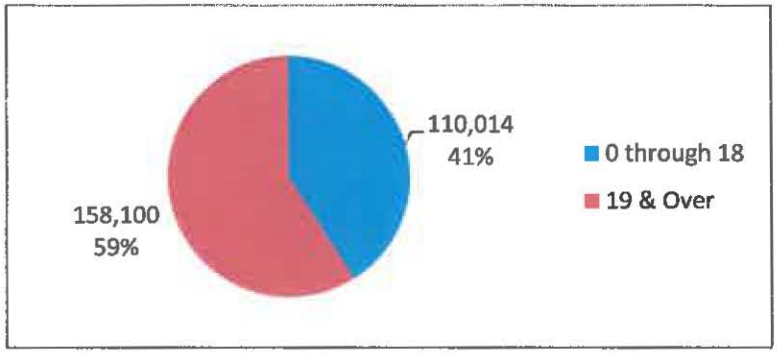
Medi-Cal Membership by Aid Category



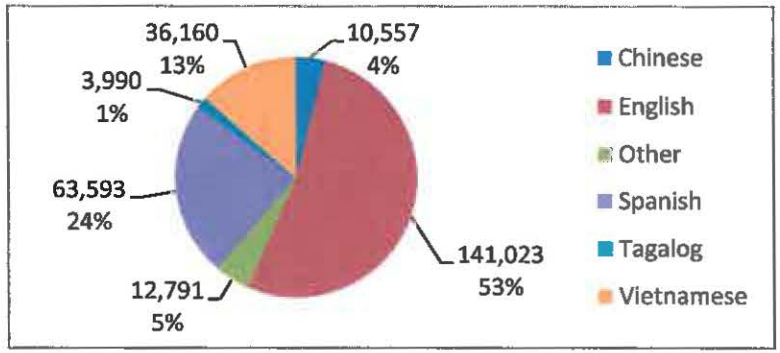
Medi-Cal Membership by Dual Status



Medi-Cal Membership by Age Group



Medi-Cal Membership by Language



Santa Clara
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The Spirit of Care

CME Event

Date: **03/23/17**

Time: **6-8pm**

Location: **Fiorillo's Restaurant in Santa Clara**
638 El Camino Real, Santa Clara, CA 95050

Topic: **Lower Extremity Injuries in the Child and Adolescent: Evaluation and Treatment**

Presenter: **Meghan N. Imrie, MD**
Clinical Assistant Professor of Orthopaedic Surgery Stanford

Learning Objectives:

1. Learn how to recognize and refer patients with slipped capital femoral epiphysis for prompt orthopedic treatment
2. Understand how common lower extremity in children and adolescents may defer than similar injuries in adults

Meghan N. Imrie, MD
Rady Children's Hospital San Diego
3030 Children's Way, MC 5062
San Diego, CA 92123-4282
(858) 966-4073

Home address:
390 Stratford Court #1
Del Mar, CA 92014
(650) 996-1985
mnimrie@yahoo.com

Education

9/99 – 6/03	University of California San Diego, California	Medical Doctorate
9/94 – 6/98	Yale University New Haven, Connecticut	Bachelor of Science Chemistry

Post-degree Honors, Awards, and Professional Memberships

Passed ABOS Part I – Board Eligible
Stanford Orthopaedic Surgery Department Resident Research Award, 2008
Candidate Member, *Pediatric Orthopaedic Society of North America*
Team Member, *Operation Rainbow* 2007 – orthopaedic volunteer, Nicaragua
Recipient, Lena Sefton Clark Fellowship Award, *Rady Children's Hospital,* 2009

Work Experience

Stanford University *Lucille Packard Children's Hospital* *Stanford, CA*	Assistant Clinical Professor, Pediatric Orthopaedics (9/09 – present)
Children's Specialists of San Diego *San Diego, CA*	Pediatric Orthopaedic Fellow (8/08 – 7/09)
Stanford University Hospital *Palo Alto, CA*	Orthopaedic Surgery Resident (6/03 – 7/08)
Structural Genomix *San Diego, CA*	Summer Intern - Chemist (6/00 – 8/00) Member of protein purification team in start-up biotech company. Using variety of methods, worked with insoluble proteins as part of biotechnology "assembly line."
UCSF Stanford Health Care Orthopaedic Clinic *Palo Alto, CA*	Medical Assistant (7/98 – 8/99) Managed paperwork for the clinic. Roomed patients and assisted doctors with injections, cast and suture removal.
Stanley H. Kaplan Education Center *San Jose, CA*	Instructor (1/99 – 4/99) Taught Medical College Admissions Test preparation course.
Stanford Hospital *Palo Alto, CA*	Operating Room Orderly (6/95 – 9/95, 6/96 – 9/96) Assisted in daily operation of main operating rooms.

Research and Publications

Children's Specialist's of San Diego *San Diego, CA*	Principal Contributor (8/08 – present) With Dr. Scott Mubarak, evaluating the incidence of late dysplasia in children born breech with normal screening ultrasound. Presented 2009 *POSNA* meeting; nominated for Best Clinical Paper. Accepted for presentation, 2010 AAOS meeting.
	Principal Contributor (8/08 – present) With Dr Peter Newton and Dr Burt Yaszay, evaluating the role of percent correction of idiopathic scoliosis with outcome. Accepted for presentation, 2009 NASS meeting, 2010 AAOS meeting.
	Principal Contributor (8/08 – present) With Dr. Henry Chambers, prospective study of outcomes in ACL reconstruction with and without postoperative CPM use. Ongoing project.
Stanford Hospitals and Clinics Stanford, CA	Imrie M, Yao J. "The History of Distal Radius Fractures," Distal Radius Fractures. Slutsky DJ, Osterman AL, eds, Elsevier, Philadelphia, PA. 2008.
Lucille Packard Children's Hospital Stanford, CA	Principal Contributor (3/05 – present) With Dr. Lawrence Rinsky, evaluating the clinical results of the Marchesi technique of pelvic fixation in neuromuscular scoliosis. Submitted for presentation.
University of California *San Diego, CA*	Principal Contributor (4/02 – 6/03) With guidance of Dr. Jeffrey Smith of the Orthopaedic Trauma Department, created an educational CD-ROM on acute compartment syndrome.
Yale University *New Haven, CT*	Research Assistant (9/98 – 6/98) Assisted Dr. Ron Breaker in studying the enzymatic capabilities of nucleic acids using standard biochemical techniques. Developed new materials and methods to facilitate search for DNA and RNA sequences of interest.
University of California *Berkeley, CA*	Research Assistant (6/97 – 9/97) Volunteered in the lab of Dr. Jack Kirsch studying the genetics and activities of several bacterial aminotransferase enzymes. Various techniques, such as transformation and ligation were used to construct a knockout bacterial strain to be used in future enzyme investigation.

Extracurricular Activities/Interests

Yoga, ballet, modern dance
Gymnastics – 15 years competitive experience, including Division I collegiate gymnastics

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: XX, 2016

ALL PLAN LETTER 16-XXX

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PALLIATIVE CARE AND MEDI-CAL MANAGED CARE

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their obligation to provide palliative care to their beneficiaries pursuant to Senate Bill (SB) 1004 (Hernandez, chapter 574, Statues of 2014).[1] The requirements discussed in this APL specifically apply to Medi-Cal managed care beneficiaries who are not Medicare – Medi-Cal dually-eligible beneficiaries.

BACKGROUND:
SB 1004 requires the Department of Health Care Services (DHCS) to establish standards and provide technical assistance to MCPs for the delivery of palliative care as codified in the Welfare and Institute Code (WIC) Section 14132.75.[2] Palliative care consists of patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The provision of palliative care shall not result in the elimination or reduction of any covered benefits or services under the MCP contracts and shall not affect a beneficiary's eligibility to receive any services, including home health services, for which the beneficiary would have been eligible in the absence of receiving palliative care.

Hospice care is a Medi-Cal benefit that serves seriously ill beneficiaries consisting of interventions that focus primarily on pain and symptom management rather than cure or prolongation of life. To qualify for hospice care, a Medi-Cal beneficiary must have a life expectancy of six months or less. Further information regarding Medi-Cal hospice care can be found in APL 13-014.[3]

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[1] SB 1004 (Hernandez, chapter 574, statues of 2014) is available at:
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB1004
[2] WIC section 14132.75 is available at:
http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=14001-15000&file=14131-14138
[3] APL 13-014 can be found at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-014.pdf

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4400
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

Palliative care may be provided concurrently with curative care and does not require the beneficiary to have a life expectancy of six months or less. A beneficiary with a serious illness who is receiving palliative care may choose to transition to hospice care if he/she meets the hospice eligibility criteria. A beneficiary may not be concurrently enrolled in hospice care and palliative care.

A beneficiary under age 21 years may be eligible for palliative care concurrently with curative care through other existing programs such as Section 1915(c) Home and Community Based Services waiver known as Partners for Children (PFC) or Section 2302 of the Patient Protection and Affordable Care Act (ACA). Information regarding the concurrent care policy is available in APL 13-014[4], California Children's Services Numbered Letter 06-1011[5], and Managed Care Policy Letter 11-004[6].[7]

POLICY:

DHCS' SB 1004 Palliative Care Policy[8] specifies the types of palliative care MCPs must at a minimum authorize when medically necessary for a beneficiary who meets the minimum eligibility criteria. MCPs may either adopt DHCS' minimum eligibility criteria for palliative care, or submit a more liberal eligibility criteria to DHCS for approval.

I. Eligibility Criteria

DHCS' minimum eligibility criteria requires a beneficiary to meet all requirements for the general eligibility criteria and at least one of the four disease-specific eligibility requirements.

A. General Eligibility Criteria:

1. The beneficiary is likely to or has started to use the hospital or emergency department as a means to manage his/her late stage disease. This refers to unanticipated decompensation and does not include elective procedures.
2. The beneficiary is in a late stage of illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.

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[4] APL 13-014 can be found at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-014.pdf

[5] California Children's Services Numbered Letter 06-1011 can be found at
http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl061011.pdf

[6] Managed Care Policy Letter 11-004 can be found at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-004.pdf

[7] As concurrent care under Section 2302 of the ACA and the PFC waiver provide additional services and broader eligibility criteria for children than SB 1004, enrollment in SB 1004 and either Section 2302 concurrent care or the PFC waiver would result in redundant services. Children enrolled in either of those programs cannot enroll in SB 1004 palliative care.

[8] DHCS' SB 1004 Medi-Cal Palliative Care Policy, dated September 1, 2016, can be found at:
http://www.dhcs.ca.gov/provgovpart/Documents/SB1004PallCarePolicyDoc090116.pdf

3. The beneficiary's death within a year would not be unexpected based on clinical status.
4. The beneficiary has received appropriate patient-desired medical therapy, or for whom patient-desired medical therapy is no longer effective. Patient is not in reversible acute decompensation.
5. The beneficiary and, if applicable, the family/patient-designated support person, agrees to:
    a. Attempt in-home, residential-based or outpatient disease management instead of first going to the emergency department; and
    b. Participate in Advance Care Planning discussions.

B. Disease-Specific Eligibility Criteria:

1. Congestive Heart Failure (CHF): Must meet (a) and (b)
    a. The beneficiary is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned OR meets criteria for New York Heart Association (NYHA) heart failure classification III or higher,[9] AND
    b. The beneficiary has an Ejection Fraction <30% for systolic failure OR significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease (COPD): Must meet (a) or (b)
    a. The beneficiary has a Forced Expiratory Volume (FEV)1 less than 35 % predicted AND 24-hour oxygen requirement of less than 3 liters (L) per minute OR
    b. The beneficiary has a 24-hour oxygen requirement of greater than or equal to 3L per minute.

3. Advanced Cancer: Must meet (a) and (b)
    a. The beneficiary has a stage III or IV solid organ cancer, lymphoma, or leukemia, AND
    b. The beneficiary has a Karnofsky Performance Scale (KPS) score less than or equal to 70[10] OR has failure of two lines of standard chemotherapy.

4. Liver Disease: Must meet (a) and (b) combined or (c) alone
    a. The beneficiary has evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, AND

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[9] NYHA classifications are available at: http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure_UCM_306328_Article.jsp#.V-MZu9LH--o

[10] "Performance Scales: Karnofsky and ECOG Scores," http://oncologypro.esmo.org/Guidelines-Practice/Practice-Tools/Performance-Scales

b. The beneficiary has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices OR
c. The beneficiary has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.[11]

If a beneficiary continues to meet the above minimum eligibility criteria, he or she may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death. MCPs should periodically assess the beneficiary for changes in his/her condition or palliative care needs. MCPs may discontinue palliative care that is no longer medically necessary or reasonable.

II. Palliative Care

Effective April 1, 2017, when a beneficiary meets the minimum eligibility criteria for palliative care, MCPs must authorize palliative care without regard to age. Palliative care must include, at a minimum, the following eight services when medically necessary or reasonable for the palliation or management of a qualified serious illness and related conditions:

1. Advance Care Planning: Advance care planning for beneficiaries enrolled in Medi-Cal palliative care under SB 1004 includes discussions between a physician or other qualified healthcare professional and a patient, family member, or surrogate in counseling and discussing advance directives, including Physicians Authorization for Life Sustaining Treatment (POLST) forms. Please refer to the section on Advanced Care Planning in the Provider Manual for further details.[12]

2. Palliative Care Assessment and Consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning, or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:
    - Treatment plans, including palliative care and curative care
    - Pain and medicine side effects
    - Emotional and social challenges

[11] MELD score calculator is available at: https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld-calculator

[12] Medi-Cal Provider Manual "Evaluation and Management (E&M)." Available at https://www.google.com/url?q=https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/eval_m00o03.doc&sa=U&ved=0ahUKEwi1w7-e2KPPAhVV7GMKHclmCkUQFggEMAA&client=internal-uds-cse&usg=AFQjCNH1-XcVgZ-oocK-OzJhLYgZ1sMslA. Accessed September 22, 2016.

- Spiritual concerns
- Patient goals
- Advance directives, including POLST forms

3. Plan of Care: A plan of care should be developed with the engagement the beneficiary and/or his or her representative(s) in its design. If a beneficiary already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A beneficiary's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care.

4. Palliative Care Team: The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional and spiritual needs of beneficiaries and their families and are able to assist in identifying sources of pain and discomfort of the beneficiary. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members must provide all authorized palliative care. DHCS recommends that the palliative care team include, but is not limited to, a doctor of medicine or osteopathy (Primary Care Provider if MD or DO), a registered nurse and/or nurse practitioner (Primary Care Provider if NP), a social worker, and a chaplain.

5. Care Coordination: A member of the palliative care team should provide coordination of care, ensure continuous assessment of the beneficiary's needs, and implement the plan of care.

6. Pain and Symptom Management: Adequate pain and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address beneficiary pain and other symptoms. The beneficiary's plan of care must include all services authorized for pain and symptom management.

7. Mental Health and Medical Social Services: Counseling services must be available to the beneficiary to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services must include, but are not limited to: psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate. Provision of mental health and medical social services shall not duplicate specialty mental health services (SMHS) provided by county Mental Health Plans (MHPs) and does not change the

MCP's responsibilities for referring to, and coordinating with, county MHPs as delineated in APL 13-021.[13]

8. Chaplain Services: MCPs must provide access to chaplain services, when reasonable, as part of the palliative care team. Chaplain services provided as palliative care are not reimbursable through the Medi-Cal program.

MCPs must have a process to determine the type of palliative care medically necessary or reasonable for eligible beneficiaries. MCPs must have an adequate network of palliative care providers to meet the need of their beneficiaries.

Additionally, MCPs may authorize additional palliative care that is not described above, at the MCP's discretion and cost. An example of an additional service that is offered by many community-based palliative care programs is a telephonic palliative care support line, separate from a routine advice line that is available twenty-four hours a day, seven days a week.

III. Providers

MCPs may authorize palliative care to be provided in a variety of settings, including but not limited to: inpatient, outpatient, or community-based settings. MCPs must utilize qualified providers for palliative care based on the setting and needs of a beneficiary so long as the MCP ensures that its providers comply with existing Medi-Cal contracts and/or APLs. DHCS recommends that MCPs use providers with current palliative care training and/or certification to conduct palliative care consultations or assessments.

MCPs may contract with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff. MCPs may contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. Palliative care provided in a beneficiary's home must comply with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans.

IV. MCP Policies and Procedures

MCPs must update their written Policy and Procedures (P&Ps) for palliative care and Evidence of Coverage (EOC) documents as outlined in this APL. MCPs shall submit their updated P&Ps and revised EOC to the DHCS contract manager on or before March 1, 2017.

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[13] APL "Medi-Cal Managed Care Plan Responsibilities For OUtpatinet Mental Health Services" available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-021.pdf

The MCPs' P&Ps for palliative care must describe:

1. The process the MCP will utilize to inform and educate providers regarding the availability of palliative care;

2. The eligibility criteria for providers to identify beneficiaries eligible for palliative care and include a provider referral process;

3. The process the MCP will utilize to address disputes related to the provision of palliative care consistent with current grievance and appeals requirements;

4. The method the MCP will utilize to monitor and collect palliative care enrollment and utilization data. The MCP must report palliative care data to DHCS on a quarterly basis and upon request.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal law and regulations and other contract requirements as well as DHCS's guidance, including APLs and Dual Plan Letters. DHCS's readiness review process includes a review of each MCP's delegation oversight. MCPs must receive prior approval from DHCS for each delegate.

If you have any questions regarding this APL, please contact your Contract Manager.

Sincerely,

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

Attachment A: Palliative Care Resources

DHCS SB 1004 Palliative Care Website: Materials available related to SB 1004. Please send questions to: SB1004@dhcs.ca.gov

California HealthCare Foundation (CHCF): Wide range of online materials and resources, as well as in-person technical assistance events.

Coalition for Compassionate Care of California: Consumer and provider resources on advance care planning and palliative care. Also frequent webinars and training programs.

California State University Institute for Palliative Care: Instructor-led and self-paced online training for health care professionals as well as for patients and families.

Santa Clara Family Health Plan
Top 10 Drugs by Total Cost
Fill date: 10/1/2016 – 12/31/2016

SAC01 – Medi-Cal

	Label Name	Total Cost	Patient Paid	Plan Paid	% of Total Plan Paid	Generic % of Plan Paid	Total Claims	% of Total Claims	Generic % of Total Claims	Plan Paid / Day	Plan Paid / Claim
1	EPCLUSA 400 MG-100 MG TABLET	$2,421,191	$0.00	$2,421,191	8.1%	0.0%	194	0.0%	0.0%	$891.45	$12,480.37
2	ZEPATIER 50-100 MG TABLET	$1,251,969	$0.00	$1,251,969	4.2%	0.0%	138	0.0%	0.0%	$648.02	$9,072.24
3	HUMIRA 40 MG/0.8 ML PEN	$995,025	$0.00	$995,025	3.3%	0.0%	221	0.0%	0.0%	$160.85	$4,502.37
4	FREESTYLE LITE TEST STRIP	$940,150	$0.00	$940,150	3.1%	0.0%	5,771	1.7%	0.0%	$3.92	$107.19
5	LANTUS SOLOSTAR 100 UNITS/ML	$663,865	$0.00	$663,865	2.2%	0.0%	1,693	0.3%	0.0%	$9.85	$392.12
6	HUMALOG 100 UNITS/ML VIAL	$608,185	$0.00	$608,185	2.0%	0.0%	1,476	0.3%	0.0%	$15.71	$412.05
7	RENAGEL 800 MG TABLET	$575,021	$0.00	$575,021	1.9%	0.0%	314	0.1%	0.0%	$63.57	$1,831.22
8	LANTUS 100 UNITS/ML VIAL	$566,063	$0.00	$566,063	1.9%	0.0%	1,861	0.4%	0.0%	$11.57	$304.17
9	VENTOLIN HFA 90 MCG INHALER	$501,441	$0.00	$501,441	1.7%	0.0%	9,139	1.8%	0.0%	$2.58	$54.87
10	QVAR 80 MCG ORAL INHALER	$443,402	$0.00	$443,402	1.5%	0.0%	2,127	0.4%	0.0%	$7.07	$208.46
Totals for Top 10		$8,966,316	$0.00	$8,966,316	30.0%	0.0%	25,934	5.0%	0.0%	$13.35	$345.74
Totals for SAC		$29,917,484	$0.00	$29,917,482	100.0%	28.6%	515,805	100.0%	88.8%	$1.91	$58.00

SAC02 – Healthy Kids

	Label Name	Total Cost	Patient Paid	Plan Paid	% of Total Plan Paid	Generic % of Plan Paid	Total Claims	% of Total Claims	Generic % of Total Claims	Plan Paid / Day	Plan Paid / Claim
1	HUMALOG 100 UNITS/ML VIAL	$3,101	$80	$3,021	10.1%	0.0%	8	1.0%	0.0%	$20.01	$377.65
2	EPIPEN JR 2-PAK 0.15 MG INJCTR	$2,466	$40	$2,426	8.1%	0.0%	4	0.5%	0.0%	$69.85	$606.35
3	VENTOLIN HFA 90 MCG INHALER	$2,440	$405	$2,035	6.8%	0.0%	45	5.9%	0.0%	$2.17	$45.21
4	EPIPEN 2-PAK 0.3 MG AUTO-INJCT	$1,915	$25	$1,890	6.3%	0.0%	3	0.4%	0.0%	$29.08	$630.02
5	QVAR 80 MCG ORAL INHALER	$1,813	$80	$1,733	5.8%	0.0%	9	1.2%	0.0%	$6.42	$192.33
6	TRUVADA 200 MG-300 MG TABLET	$1,484	$5	$1,479	4.9%	0.0%	1	0.1%	0.0%	$49.29	$1,478.92
7	CLINDAMYCIN PH 1% GEL	$1,114	$80	$1,034	3.4%	100.0%	8	1.0%	100.0%	$4.92	$129.20
8	QVAR 40 MCG ORAL INHALER	$1,072	$60	$1,012	3.4%	0.0%	7	0.9%	0.0%	$4.82	$144.60
9	BUDESONIDE 0.5 MG/2 ML SUSP	$769	$20	$749	2.5%	100.0%	2	0.3%	100.0%	$16.64	$374.40
10	CLINDAMYCIN PH 1% SOLUTION	$747	$110	$637	2.1%	100.0%	12	1.6%	100.0%	$2.12	$53.06
Totals for Top 10		$16,920	$905	$16,019	53.4%	15.1%	99	13.0%	22.2%	$7.09	$161.77
Totals for SAC		$36,278	$6,283	$29,995	100.0%	51.7%	762	100.0%	85.4%	$2.04	$39.36

SAC06 – Cal MediConnect

	Label Name	Total Cost	Patient Paid	Plan Paid	% of Total Plan Paid	Generic % of Plan Paid	Total Claims	% of Total Claims	Generic % of Total Claims	Plan Paid / Day	Plan Paid / Claim
1	HARVONI 90-400 MG TABLET	$535,622	$0.00	$535,622	6.4%	0.0%	17	0.0%	0.0%	$1,125.26	$31,507.20
2	EPCLUSA 400 MG-100 MG TABLET	$200,588	$0.00	$200,588	2.4%	0.0%	8	0.0%	0.0%	$896.82	$25,111.04
3	FREESTYLE LITE TEST STRIP	$173,220	$0.00	$173,220	2.1%	0.0%	1,582	2.0%	0.0%	$3.26	$109.56
4	LANTUS 100 UNITS/ML VIAL	$142,346	$75	$142,171	1.7%	0.0%	369	0.5%	0.0%	$11.90	$385.30
5	INVEGA SUSTENNA 234 MG/1.5 ML	$135,766	$0.00	$135,766	1.6%	0.0%	61	0.1%	0.0%	$80.86	$2,225.66
6	LANTUS SOLOSTAR 100 UNITS/ML	$124,154	$13	$124,141	1.5%	0.0%	335	0.5%	0.0%	$9.29	$349.69
7	SPIRIVA 18 MCG CP-HANDIHALER	$121,432	$143	$121,289	1.4%	0.0%	278	0.4%	0.0%	$11.42	$436.29
8	JANUVIA 100 MG TABLET	$113,717	$110	$113,608	1.4%	0.0%	206	0.3%	0.0%	$11.84	$551.49
9	ENBREL 50 MG/ML SYRINGE	$106,027	$0.00	$106,027	1.3%	0.0%	22	0.0%	0.0%	$145.64	$4,819.43
10	NOVOLOG 100 UNITS/ML FLEXPEN	$103,970	$0.00	$103,970	1.2%	0.0%	175	0.2%	0.0%	$19.50	$594.11
Totals for Top 10		$1,758,154	$342	$1,757,812	20.9%	0.0%	3,073	4.0%	0.0%	$16.40	$572.02
Totals for SAC		$8,413,211	$1,239	$8,411,978	100.0%	24.2%	77,326	100.0%	83.0%	$2.54	$108.79

Santa Clara Family Health Plan
Top 10 Drugs Requested for Prior Authorization
PA Finalized Date Range: 10/1/2016 – 12/31/2016

SAC01 – Medi-Cal

Rank	Drug Category	PA Count Finalized	PA Count Approved	PA Count Denied / Partial Approved	PA Count Other	PA Approved %	Rx Count	Total Amt Paid	Amt Paid/Rx
1	HUMALOG 100 UNITS/ML KWIKPEN	202	149	20	33	73.76%	545	$334,671.52	$614.08
2	FREESTYLE LITE TEST STRIP	126	123	1	2	97.62%	229	$53,454.50	$233.43
3	ASPIRIN EC 81 MG TABLET	100	100	0	0	100.00%	101	$376.16	$3.72
4	XARELTO 20 MG TABLET	95	59	22	14	62.11%	169	$62,883.89	$374.31
5	DICLOFENAC SODIUM 1% GEL	90	36	50	4	40.00%	72	$4,422.62	$61.43
6	LANTUS 100 UNITS/ML VIAL	83	79	0	4	95.18%	448	$190,262.50	$426.03
7	RESTASIS 0.05% EYE EMULSION	52	29	39	14	35.37%	126	$52,574.71	$417.26
8	HUMIRA 40 MG/0.8 ML PEN	73	51	13	9	69.86%	221	$995,024.69	$4,502.37
9	TRETINOIN 0.025% CREAM	66	27	23	16	40.91%	38	$5,930.68	$156.07
10	AMLODIPINE BESYLATE 5 MG TAB	60	55	5	0	91.67%	71	$442.20	$6.23
Totals for Top 10		977	708	173	96	72.47%	2,019	$1,700,643.77	$842.32
Totals for SAC		6,203	5,494	1,814	895	66.98%	14,379	$15,796,093.33	$1,098.55

SAC02 – Healthy Kids

Rank	Drug Category	PA Count Finalized	PA Count Approved	PA Count Denied / Partial Approved	PA Count Other	PA Approved %	Rx Count	Total Amt Paid	Amt Paid/Rx
1	FLUARIX QUAD 2016-2017 SYRINGE	2	2	0	0	100.00%	0	$0.00	$0.00
2	METHYLPHENIDATE ER 27 MG TAB	2	0	2	0	0.00%	0	$0.00	$0.00
3	TRETINOIN 0.025% CREAM	2	0	0	2	0.00%	0	$0.00	$0.00
4	VESICARE 10 MG TABLET	2	1	0	1	50.00%	1	$283.21	$283.21
5	DEXTROAMPHETAMINE 10 MG TAB	1	1	0	0	100.00%	2	$269.04	$134.52
6	ELIDEL 1% CREAM	1	0	1	0	0.00%	0	$0.00	$0.00
7	EPIPEN 2-PAK 0.3 MG AUTO-INJCT	1	1	0	0	100.00%	0	$0.00	$0.00
8	METHYLPHENIDATE 10 MG/5 ML SOL	1	1	0	0	100.00%	1	$158.32	$158.32
9	MONTELUKAST SOD 4 MG GRANULES	1	0	1	0	0.00%	0	$0.00	$0.00
10	TACROLIMUS 0.1% OINTMENT	1	0	1	0	0.00%	0	$0.00	$0.00
Totals for Top 10		14	6	5	3	42.86%	4	$710.57	$177.64
Totals for SAC		14	6	5	3	42.86%	8	$1,750.67	$219.58

SAC06 – Cal MediConnect

Rank	Drug Category	PA Count Finalized	PA Count Approved	PA Count Denied / Partial Approved	PA Count Other	PA Approved %	Rx Count	Total Amt Paid	Amt Paid/Rx
1	LIDOCAINE 5% PATCH	36	19	9	8	52.78%	30	$6,599.45	$219.98
2	ZOLPIDEM TARTRATE 5 MG TABLET	16	10	3	3	62.50%	61	$379.81	$6.23
3	ZOLPIDEM TARTRATE 10 MG TABLET	14	9	3	2	64.29%	37	$209.85	$5.66
4	BENZTROPINE MES 1 MG TABLET	8	3	3	2	37.50%	18	$193.40	$10.74
5	HYDROCHLOROTHIAZIDE 25 MG TAB	8	8	0	0	100.00%	7	$27.46	$3.92
6	OMEPRAZOLE DR 20 MG CAPSULE	7	7	0	0	100.00%	6	$67.64	$11.27
7	AMLODIPINE BESYLATE 5 MG TAB	6	6	0	0	100.00%	6	$33.76	$5.63
8	GLIPIZIDE 5 MG TABLET	6	6	0	0	100.00%	19	$140.52	$7.41
9	HYDROXYZINE HCL 10 MG TABLET	6	4	1	1	66.67%	8	$106.24	$13.29
10	LOSARTAN POTASSIUM 50 MG TAB	6	6	0	0	100.00%	5	$43.76	$8.75
Totals for Top 10		113	78	19	16	69.03%	197	$7,801.99	$39.60
Totals for SAC		641	515	72	54	80.34%	1,701	$9,275,515.59	$1,337.75

Sant.a Clara
Family Health Plan

The Spirit of Care

CONFIDENTIALITY, CONFLICT OF INTEREST & NON-DISCRIMINATION AGREEMENT 2017

CONFIDENTIALITY STATEMENT

I understand that Santa Clara Family Health Plan (SCFHP) has a legal and ethical responsibility to comply with all applicable federal and state laws established under the Health Insurance Portability and Accountability Act (HIPAA) and Privacy Rule adopted thereunder (45 CFR Parts 160 and 164) and all related SCFHP Policies and Procedures.

In addition, I understand that during the course of my affiliation with the Provider Advisory Council (PAC), I agree to respect and maintain the confidentiality of all confidential information, especially Protected Health Information (PHI). I also agree that my obligations under this agreement regarding PHI will continue after the termination of my affiliation with the PAC.

CONFLICT OF INTEREST STATEMENT

I understand and agree that I will report to the Committee Chairperson if I have a financial or non-financial conflict of interest which would impair my objectivity in performing my responsibilities as a member of the PAC. Furthermore, I will refrain from any proceeding or cast a vote on any issue related to conflict of interest.

NON-DISCRIMINATION

Santa Clara Family Health Plan (SCFHP) and all PAC Committee Members comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, religion, citizenship status, genetic information, marital status, sexual orientation and identity, medical condition, AIDS/HIV, military or veteran status, political affiliations or activities, or status as a victim of domestic violence, assault or stalking.

AGREEMENT

I, the undersigned, have read and understand the above Confidentiality and Conflict of Interest Statements and agree to abide by these standards and requirements in the conduct of my responsibilities related to matters of the PAC.

_____ _____

Signature Date

_____

Print Name