Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, October 16, 2019, 6:30-8:00 PM
Santa Clara Family Health Plan, Redwood
6201 San Ignacio Ave., San Jose, CA 95119

AGENDA

1.	**Introduction**	Dr. Lin	6:30	5 min
2.	**Meeting Minutes** Review minutes of the July 17, 2019 Q3 2019 Utilization Management Committee (UMC) Meeting **Possible Action:** Approve Q3 2019 UMC Meeting minutes	Dr. Lin	6:35	5 min
3.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The committee reserves the right to limit the duration of public comment to 30 minutes.	Dr. Lin	6:40	5 min
4.	**CEO Update** Discuss status of current topics and initiatives	Ms. Tomcala	6:45	10 min
5.	**CMO Update** a. General Update b. Update – Completion of CMS IVA Audit	Dr. Nakahira	6:55	10 min
6.	**Old Business/Follow Up Items** a. General Old Business b. Post Bariatric Surgery Update c. Bariatric CME Request d. MCG S-516: Gastric Restrictive Procedures, Sleeve Gastrectomy, by Laparoscopy e. How to Access Health Education Handout f. Health Education Materials and Classes for Members g. Language Assistance Contact Information	Dr. Boris Ms. Shah	7:05 7:13	8 min 5 min

7.	**Action Items** a. Policy Update: HS.01 Prior Authorization **Possible Action:** Approve Revised Policy HS.01 b. Medical Covered Services Prior Authorization (PA) Grid and Medical Benefit PA Grid **Possible Action:** Approve PA Grids	Dr. Boris	7:18	5 min
8.	**Reports**			
	a. Membership Report	Dr. Nakahira	7:23	2 min
	b. Standard Utilization Metrics	Dr. Boris	7:25	20 min
	c. Hospital Specific Metrics: Readmission			
	d. Referral Tracking Quarterly Report – Q3 2019			
	e. Turn Around Time Report – Q3 2019			
	f. UM Call Center Metrics – Q2 & Q3 2019			
	g. HS.04.01 Quality Monitoring – Q3 2019			
	h. Inter-Rater Reliability (IRR) Report – 2019 2/2			
9.	**Behavioral Health UM Reports** a. Early and Periodic Screening, Diagnostic & Treatment (EPSDT) b. Metrics Reports	Ms. McKelvey	7:50	10 min
10.	**Adjournment** Next meeting: Wednesday, January 15, 2020 at 6:30 p.m.	Dr. Lin	8:00	

Notice to the Public—Meeting Procedures

- Persons wishing to address the Committee on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Amy O'Brien 48 hours prior to the meeting at 408-874-1997.
- To obtain a copy of any supporting document that is available, contact Amy O'Brien at 408-874-1997. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave., San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com

Santa Clara Family Health Plan™

Meeting Minutes

Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, July 17, 2019, 6:30 PM - 8:00 PM
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MINUTES

Members Present
Jimmy Lin, MD, Chairperson, Internal Medicine
Indira Vemuri, Pediatric Specialist
Dung Van Cai, MD, OB/GYN Specialist
Ali Alkoraishi, MD, Adult & Child Psychiatry
Habib Tobbagi, Psychiatry Specialist MD
Laurie Nakahira, DO, SCFHP Chief Medical Officer

Members Absent
Ngon Hoang Dinh, DO, Head & Neck Surgery
Dung Van Cai, MD, OB/GYN Specialist
Jeff Robertson, MD, SCFHP Medical Director

Staff Present
Christine Tomcala, Chief Executive Officer
Lily Boris, MD, Medical Director
Lori Andersen, Director of Long Term Services & Support
Sandra Carlson, Director of Medical Management
Natalie McKelvey, Manager of Behavioral Health
Luis Perez, Utilization Management Supervisor
Nancy Aguirre, Administrative Assistant
Amy O'Brien, Administrative Assistant

1. Introduction

Jimmy Lin, Chair, called the meeting to order at 6:30 pm. Roll call was taken and a quorum was established.

2. Meeting Minutes

The April 17th, 2019 Utilization Management Committee (UMC) meeting minutes were reviewed.

It was **moved by Dr. Alkoraishi** and **seconded by Dr. Vemuri**, **and** the minutes of the April 17, 2019 Utilization Management Committee meeting were **unanimously approved.**

3. Public Comment

There were no public comments.

4. CEO Update

Ms. Tomcala presented the following updates:
Santa Clara Family Health Plan (SCFHP) recently ended the fiscal year. SCFHP is now on to the new fiscal year with the primary focus being quality, followed by compliance.

SCFHP is developing a satellite office. The satellite office would be used as a community service center, offering various classes and resources for members. Location is pending.

Ms. Tomcala reported one of the State's new requirements is that the minimum quality performance level of health plans will be the HEDIS 50th percentile, retroactive to January 2019. The State will also implement immediate sanctions prior to corrective action plans.

5. CMO Health Plan Updates

Dr. Nakahira presented the following Health Plan updates:
The CMS Independent Validation Audit has begun as of May 1st, 2019 and will end on July 31st, 2019.

DHCS Exit Conference took place on June 13th, 2019. SCFHP received a draft audit report and the Plan is currently responding to their findings.

SCFHP is working closely with the Quality department to improve gaps in care for HEDIS measures.

6. Old Business/Follow Up Items

Presented by Dr. Boris.
There was one (1) staff member with an Inter Rater Reliability (IRR) follow up.

Ms. McKelvey presented Behavioral Health Treatment (BHT) and Mild to Moderate (MTM) Services as well as their utilization, excluding Kaiser and VHP.

BHT is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. Treatment can be Applied Behavioral Analysis (ABA) or Social Skills in either individual or group settings.

Ms. McKelvey reported a total of 586 children with autism receiving BHT services, and 7 children with other primary diagnoses receiving BHT services for the 2018 calendar year.

Managed Care Plans (MCP) must inform members that EPSDT services are available for members under 21 years of age. Provide access to comprehensive screening and prevention services, at designated intervals or at other intervals indicated as medically necessary, including but not limited to:

- A health and developmental history
- A comprehensive unclothed physical examination
- Appropriate immunizations
- Lab tests and lead toxicity screening
- Screening services to identify developmental issues as early as possible

MCPs must also provide access to medically necessary diagnostic and treatment services, including but not limited to, BHT services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist.

Ms. McKelvey explained for Mild to Moderate (MTM) services, MCPs are responsible for outpatient mental health services for MTM conditions such as psychiatry and talk therapy.

7. Action Items

There were no action items to present.

8. Reports (MediCal/SPD, Healthy Kids)

a. Membership Reports
Dr. Nakahira presented the membership reports.
From July 2018 to July 2019, Cal MediConnect (CMC) membership increased by over 500 members. As a result, SCFHP met its' organizational goals. For MediCal, there is a slow decline. Healthy Kids has remained close to the same as last month. Overall membership has slightly decreased due to the reduced MediCal membership.

b. UM Reports 2019
Ms. Carlson presented the Utilization Management (UM) Reports for January through May 2019.

For UM expedited authorizations for Med-Cal, 100% of timely decisions were made within 72 hours of request. For Cal MediConnect, SCFHP was between 98-100% compliant. For UM standard authorizations for both MediCal (5 business days) and Cal MediConnect (14 business days), SCFHP was 97.8-100% compliant.

Ms. Carlson will bring UM provider phone call metrics to present to next UMC meeting in October.

Dr. Vemuri shared her experience in language barriers with patients as well as barriers in certifying office staff as bilingual. Dr. Boris will reach out to help access SCFHP's language line services as it is a provided interpretation service for members. Dr. Nakahira offered help from Ms. Shah, SCFHP Health Educator, to reach out to Dr. Vemuri for assistance with this barrier.

Dr. Boris presented the Standard Utilization Metrics Powerpoint. The goal is to compare SCFHP utilization levels against relevant industry benchmarks and monitor utilization trends among SCFHP membership over time. In addition, SCFHP is to analyze key drivers and potential barriers, prioritize opportunities for improvement, and develop interventions that promote high-quality and cost-effective use of medical services.

The metrics report reflects four (4) full quarters through May 30th, 2019. The MediCal inpatient utilization (IPU) for non-seniors or persons with disabilities (SPD) has been relatively stable. Average length of stay (ALOS) has maintained less than four (4).

For MediCal for SPD, the ALOS is 4.7 days. For CMC, the population is about eight (8) thousand, the average LOS is significantly longer at 5-6 days. SCFHP ranks less than 10% in The National Medicaid NCQA benchmark.

For the non-SPD population, readmission rates have been about 10-12%. For SPD population, rates are higher, reflecting 23%. The CMC population has been stable with less readmissions, reflecting 10-14%.

Comparatively to NCQA Medicare Benchmark for readmission rates, SCFHP ranked greater than 90th percentile for CMC members ages 18-64. For CMC members ages 64+, SCFHP ranked greater than the 50th percentile. The CMC members ages 18-64 are receiving Medicare based on a disability. The CMC members ages 64+ include MediCal, which adds social economic factors.

Dr. Boris noted the requests for bariatric surgery has increased, in both men and women, ages 20-64. This reflects general obesity within the population.

Ms. Tomcala asked for post-surgery outcomes and data, to reflect the success of the surgery. Dr. Boris will present a comprehensive study for bariatric surgery to one of the next two (2) UMC meetings. Dr. Boris will ask SCFHP's Health Education department for materials on bariatric surgery and bring a guideline of bariatric to the UMC meeting in October, 2019.

c. HS.04.01 Reporting Quality Monitoring of Plan Authorizations, Denials etc. (Q2 19)
Presented by Ms. Carlson.
SCFHP completed the 2nd quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations.

30 unique denial letters were randomly selected. 16 out of 30 were for MediCal and the remaining 14 were for CMC. 100%, or 13/13, of the expedited authorizations met regulatory turnaround time of 72 calendar hours. 100%, or 17/17, of the standard authorizations met regulatory turnaround time. 100% were provided member and provider notification. 100% of the letters were readable and rationale for denial provided. 100% of the letters included IMR information, interpreter rights and instructions on how to contact CMO or Medical Director for Peer to Peer review.

Ms. Carlson shared SCFHP will continue the quarterly quality assurance report monitoring process and manage reviews to meet turn-around time requirements.

d. Referral Tracking Quarterly Report (Q2 19)
Presented by Ms. Carlson.
This report gives a breakdown of CBAS, and monitors how many services were approved and how many were rendered. The data shows approximately 68%, which has been our highest, and has remained stable since.

9. Behavioral Health UM Reports

a. Criteria for ABA Services
Presented by Ms. McKelvey.
For MediCal Q2 2019, there have been 191 members receiving BHT, 1 receiving SCFHP Case Management, and 7 receiving MTM referrals. For MediCal year to date, there have been 418 members receiving BHT, 4 receiving SCFHP Case Management, and 17 MTM referrals.

The county has not provided data for number of members in Q2 2019 receiving mental health benefits.

b. Criteria for other BHT Services
Presented by Ms. McKelvey
For Cal MediConnect in Q2 2019, there have been 43 members receiving BHT, 11 opt outs of SCFHP Case Management, and 1 MTM referrals. For Cal MediConnect year to date, there have been 79 members receiving BHT, 19 opt outs of SCFHP Case Management, and 3 MTM referrals.

The county has not provided data for number of members in Q2 2019 receiving County Mental Health.

10. Adjournment

Next meeting is Wednesday, October 16th, 2019 at 6:30pm.

The meeting was adjourned at 7:46pm

_____ _____

Jimmy Lin, MD
Chair of Utilization Management Committee

Date

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Old Business and Follow Up Items

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Post Bariatric Surgery Update

Bariatric Weight Loss Surgery
1/1/2017 – 8/1/2019

Source: Frequency of Selected Procedures measure (FSP) from 1/1/2017 with current eligibility

Line of Business	Net 10	Net 20	Net 30	Net 40	Net 50	TOTAL
Medi-Cal	26	83	6	5	6	**126**
Cal MediConnect	-	-	-	-	-	**6**
Total	-	-	-	-		**132**

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MCG Criteria

Gastric Restrictive Procedure, Sleeve Gastrectomy, by Laparoscopy

MCG Health
Inpatient & Surgical Care
23rd Edition

ORG: S-516 (ISC)
Link to Codes

Care Planning - Inpatient Admission and Alternatives

Clinical Indications for Procedure

- Procedure indicated by **ALL** of the following(1)(2)(3):
  - Severity of obesity judged appropriate for procedure as indicated by **1 or more** of the following(13):
    - Patient has BMI[A] of 40 or greater. BMI Calculator
    - Patient has BMI[A] of 35 or greater and clinically serious condition related to obesity (eg, type 2 diabetes, obesity hypoventilation, obstructive sleep apnea, nonalcoholic steatohepatitis, pseudotumor cerebri, severe osteoarthritis). BMI Calculator
    - Adult patient[B] has BMI[A] of 30 or greater with type 2 diabetes mellitus with inadequately controlled hyperglycemia (eg, HbA1c greater than 8% (64 mmol/mol) despite optimal medical treatment (eg, oral medication, insulin)).[C][D]
  - Patient is candidate for bariatric surgery as indicated by **ALL** of the following(1)(13):
    - Failure to achieve and maintain significant weight loss with nonsurgical treatment
    - Correctable cause for obesity not identified (eg, endocrine disorder)
    - Patient has demonstrated reliable participation in preoperative weight-loss program that is multidisciplinary (eg, low-calorie diet, supervised exercise, behavior modification).(15)
    - Current substance abuse not identified
    - Patient is fully grown or nearly fully grown.[E]
    - Expectation that patient will be able to adhere to postoperative care (eg, judged to be committed and able to participate in postoperative requirements)(16)
    - Patient is receiving treatment in multidisciplinary program experienced in obesity surgery that can provide **ALL** of the following(15):
      - Surgeons experienced with procedure
      - Preoperative medical consultation and approval
      - Preoperative psychiatric consultation and approval
      - Nutritional counseling

- Exercise counseling
- Psychological counseling
- Support group meetings

Alternatives to Procedure

- Alternatives include(2)(3)(13)(17)(18)(19):
  - Gastric restrictive procedure with bypass
    - See Gastric Restrictive Procedure with Gastric Bypass ISC guideline.
    - See Gastric Restrictive Procedure with Gastric Bypass by Laparoscopy ISC guideline.
  - Gastric restrictive procedure without bypass. See Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy ISC guideline.
  - Biliopancreatic diversion(20)(21)
  - Multidisciplinary nonsurgical program, including low-calorie diet or very-low-calorie diet, supervised exercise, behavior modification, and possible medication(15)(22)(23)(24)(25)

Operative Status Criteria

- Inpatient

Preoperative Care Planning

- Preoperative care planning needs may include(1)(2)(3)(16)(18)(19):
  - Preoperative evaluation, including:
    - Medical consultation
    - Psychiatry or psychology consultation
    - Nutrition consultation
    - Exercise counseling
    - Routine preoperative evaluation. See Preoperative Education, Assessment, and Planning Tool SR.
  - Diagnostic test scheduling, including:
    - Esophagogastroduodenoscopy
    - Polysomnography
  - Preoperative treatment, procedures, and stabilization, including optimal control of comorbidities (eg, hypertension, diabetes, coronary artery disease)
  - Preoperative discharge planning as appropriate. See Discharge Planning in this guideline.

Hospitalization

Optimal Recovery Course

Day	Level of Care	Clinical Status	Activity	Routes	Interventions	Medications
1	• OR to floor[F] • Discharge planning	• **Clinical Indications met [G]**	• Bed rest • Ambulatory in the evening	• IV fluids, medications • Clear liquids as tolerated	• Pulse oximetry • Drain management[H]	• Prophylactic antibiotics • Possible PCA • Antithrombotic prophylaxis
2	• Floor to discharge • Complete discharge planning	• **Procedure completed** • **Hemodynamic stability** • **No evidence of postoperative or surgical site infection** • **Clear liquid diet tolerated** • **Pain absent or managed**	• **Ambulatory**	• **Oral hydration, medications, and diet** • Clear liquid diet	• Drain absent • Possible UGI or contrast study[I]	• **PCA absent [J]**

		• **Discharge plans and education understood**				

(27)(28)(29)(30)(31)(32)(33)N

Recovery Milestones are indicated in **bold**.

Goal Length of Stay: 1 day postoperative

Note: Goal Length of Stay assumes optimal recovery, decision making, and care. Patients may be discharged to a lower level of care (either later than or sooner than the goal) when it is appropriate for their clinical status and care needs.

Extended Stay

Minimal (a few hours to 1 day), Brief (1 to 3 days), Moderate (4 to 7 days), and Prolonged (more than 7 days).

- Extended stay beyond goal length of stay may be needed for(33):
  - Staple line leak(34)(35)(36)
    - Expect brief to moderate stay extension.
  - Conversion to open procedure
    - Expect brief stay extension.
  - Complications of procedure(37)(38)(39)(40)
    - Complications include peritonitis, thromboembolic disease, wound infection, suture line bleeding, pneumonia, respiratory failure, portomesenteric thrombosis, and splenic injury.
    - Expect brief to moderate stay extension.
  - Clear liquid diet not tolerated
    - Expect brief stay extension.
  - Care for comorbidities(41)(42)(43)
    - Patient with complex comorbidities such as chronic obstructive pulmonary disease, renal disease, or heart failure may require continued inpatient care.
    - Expect brief stay extension.

See Common Complications and Conditions ISC for further information.

Hospital Care Planning

- Hospital evaluation and care needs may include(1)(2)(3)(16)(18)(19)(26):
  - Diagnostic test scheduling and completion, including upper gastrointestinal series
  - Treatment and procedure scheduling and completion, including:
    - Perioperative antibiotic prophylaxis
    - Antithrombotic prophylaxis.(44)(45) See Venous Thrombosis and Pulmonary Embolism: Common Complications and Conditions ISC for further information.
  - Monitoring patient's status for deterioration and comorbid conditions (see Inpatient Monitoring and Assessment Tool SR); key items include(46):
    - Signs of leak at anastomosis or staple line(35)(36)
    - Thrombotic complications. See Venous Thrombosis and Pulmonary Embolism: Common Complications and Conditions ISC for further information.
    - Respiratory status

Discharge

Discharge Planning

- Discharge planning includes[K]:
  - Assessment of needs and planning for care, including:
    - Develop treatment plan (involving multiple providers as needed).
    - Evaluate and address preadmission functioning as needed.
    - Evaluate and address patient or caregiver preferences as indicated.
    - Identify skilled services needed at next level of care, with specific attention to(1):

- Gastrointestinal status assessment
- Nutrition and hydration management
- Ongoing education required(48)

- Evaluate and address psychosocial status issues as indicated. See Psychosocial Assessment SR for further information.

- Early identification of anticipated discharge destination; options include:
  - Home, considerations include:
    - Access to follow-up care
    - Home safety assessment. See Home Safety Assessment SR for further information.
    - Self-management ability if appropriate. See Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Assessment SR for further information.
    - Caregiver need, ability, and availability
  - Post-acute skilled care or custodial care as indicated. See Discharge Planning Tool SR for further information.
- Transition of care plan complete
  - Patient, family, and caregiver education complete. See Gastric Restrictive Procedure, Sleeve Gastrectomy, by Laparoscopy: Patient Education for Clinicians SR for further information.
    - See Teach Back Tool SR for further information.
  - Medication reconciliation completion includes(49):
    - Compare patient's discharge list of medications (prescribed and over-the-counter) against provider's admission or transfer orders.
    - Assess each medication for correlation to disease state or medical condition.
    - Report medication discrepancies to prescribing provider, attending physician, and primary care provider, and ensure accurate medication order is identified.
    - Provide reconciled medication list to all treating providers.
    - Confirm that patient, family, or caregiver can acquire medication.
    - Educate patient, family, and caregiver.
      - Provide complete medication list to patient, family, and caregiver.
      - Importance of presenting personal medication list to all providers at each care transition, including all provider appointments
      - Reason, dosage, and timing of medication (eg, use "teach-back" techniques)(50)
    - Encourage communication between patient, family, caregiver, and pharmacy for obtaining prescriptions, setting up home medication delivery, and reviewing for drug-drug interactions.(51)
    - See Medication Reconciliation Tool SR for further information.
  - Plan communicated to patient, family, caregiver, and all members of care team, including(52):
    - Inpatient care and service providers
    - Primary care provider
    - All post-discharge care and service providers
  - Appointments planned or scheduled, which may include:
    - Primary care provider(53)
    - Behavioral health provider(54)
    - Dietitian
    - Endocrinologist
    - Gastroenterologist
    - General surgeon(55)
    - Specialists for management of comorbidities as needed(56)
    - Other
  - Outpatient testing and procedure plans made, which may include:
    - Laboratory testing(1)
    - Other
  - Referrals made for assistance or support, which may include:
    - Financial, for follow-up care, medication, and transportation
    - Community services
    - Educational program (eg, chronic condition management, self-management)
    - Self-help or support groups(56)
    - Smoking cessation counseling or treatment(1)
    - Substance use counseling or rehabilitation
    - Other
  - Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), which may include:

- Antiembolic or compression stockings(48)
- Weight scale
- Other

Discharge Destination

- Post-hospital levels of admission may include:
  - Home.

Evidence Summary

Criteria

Systematic reviews of randomized controlled trials have found that bariatric surgery with medical treatment, compared to medical treatment alone, resulted in greater weight loss, improved glycemic outcomes in diabetics, and in some studies improvement in other obesity-related morbidities (eg, quality of life, sleep apnea, hypertension).(1)(4)(5)(6)(7)(8) **(EG 1)** A randomized trial comparing laparoscopic sleeve gastrectomy and laparoscopic Roux-en-Y gastric bypass in 211 morbidly obese patients (mean initial BMI 44) found at 5-year follow-up that both procedures resulted in similar weight loss and adverse postoperative events.(9) **(EG 1)** In the same trial, sleeve gastrectomy resulted in a lower rate of remission of gastroesophageal reflux (25% vs 60%), and a higher rate of reflux worsening (32% vs 6%).(9) **(EG 1)** A randomized controlled trial comparing medical therapy alone or combined with either laparoscopic sleeve gastrectomy or Roux-en-Y gastric bypass in patients with obesity and type 2 diabetes (134 patients, initial mean BMI 37, initial mean glycated hemoglobin 9.2) found after 5-year follow-up that either surgery resulted in improved outcomes.(10) **(EG 1)** In this same trial, compared to medical therapy alone, surgery resulted at 5-year follow-up in greater weight loss (5.3 kg (11.7 lb) (medical) vs 23.2 kg (51.2 lb) (Roux-en-Y gastric bypass) vs 18.6 kg (41 lb) (laparoscopic sleeve gastrectomy)), a higher percentage of patients with a glycated hemoglobin less than 6% (5.3% (medical) vs 28.6% (Roux-en-Y gastric bypass) vs 23.4% (laparoscopic sleeve gastrectomy)), and a higher percentage of patients no longer needing hypoglycemic medication (2% (medical) vs 45% (Roux-en-Y gastric bypass) vs 25% (laparoscopic sleeve gastrectomy)).(10) **(EG 1)** Within these results, the differences between Roux-en-Y gastric bypass and laparoscopic sleeve gastrectomy were statistically significant for weight loss and percent of patients not needing hypoglycemic medication. (10) **(EG 1)** This trial also found similar reductions in weight and glycated hemoglobin from surgery in patients with an initial BMI of less than 35 and those with a BMI above 35.(10) **(EG 1)** A randomized controlled trial (240 patients, mean initial BMI 46) found, after 5-year follow-up, that compared with laparoscopic sleeve gastrectomy, laparoscopic Roux-en-Y gastric bypass resulted in a higher percentage of excess weight lost (57% vs 49%), but this difference was not felt to be clinically significant. (11) **(EG 1)** In the same trial, both procedures resulted in similar improvements in diabetes control, dyslipidemia, quality of life, and hypertension, with similar postoperative morbidity.(11) **(EG 1)** A systematic review that included 24 risk-adjusted observational studies (458,032 patients) examining the relationship between provider volume and outcomes in bariatric surgery concluded that there was an association between higher surgeon volume (eg, more than 100 cases per year) and higher hospital volume (eg, more than 150 cases per year) with improved patient outcomes such as fewer perioperative complications. (12) **(EG 1)** A

Length of Stay

An observational study of 250 patients who underwent laparoscopic sleeve gastrectomy in an ambulatory surgery center found that all patients were discharged on the day of surgery (exclusion criteria included weight more than 450 pounds (204 kg), anticipated operative time greater than 2 hours, impaired mobility limiting early ambulation, and medical comorbidities requiring more than 23 hours of postoperative care).(27) **(EG 2)** Analysis of a cohort of 338 patients who had laparoscopic sleeve gastrectomy found a mean length of stay of 1.2 days.(28) **(EG 2)** A series of 112 patients who underwent laparoscopic sleeve gastrectomy found an average length of stay of 1.4 days.(29) **(EG 2)** Analysis of a cohort of 247 patients who underwent laparoscopic sleeve gastrectomy found a mean length of stay of 1.1 days.(30) **(EG 2)** A report on 529 patients who had laparoscopic sleeve gastrectomy states that patients are routinely discharged on the first postoperative day.(31) **(EG 2)** Cohort analysis of 59 adolescents who underwent laparoscopic sleeve gastrectomy found a mean length of stay of 1.7 days.(32) **(EG 2)** Analysis of national hospital discharge data shows 50% of hospitalized patients undergoing laparoscopic sleeve gastrectomy as the principal procedure discharged in 1 day.(33) **(EG 3)**

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Footnotes

[A] Overweight is defined as a BMI of 25.0 to 29.9, and obesity as a BMI of 30.0 or greater.(1) [A in Context Link 1, 2, 3]

[B] For adolescents with type 2 diabetes, a BMI of 35 or greater is recommended as an indication for bariatric surgery.(2)(3) [B in Context Link 1]

[C] A multispecialty-developed consensus statement, based upon a systematic review of the published medical literature, concludes that for adult patients with type 2 diabetes (controlled or not) and a BMI of 40 or greater, and for adult patients with inadequately controlled type 2 diabetes whose BMI is 35 to 39.9, bariatric surgery should be recommended to improve glucose control.(13) This same statement concludes that bariatric surgery be considered in adult patients with inadequately controlled type 2 diabetes and a BMI between 30 and 34.9.(13) This evidence review concludes that Roux-en-Y gastric bypass has the most favorable risk/benefit profile for type 2 diabetics, that vertical sleeve gastrectomy is effective, and that gastric banding is only effective to the degree to which it causes weight loss; the review also notes that gastric banding has a higher risk for failure or need for revision.(13) Although effective, due to a higher risk of nutritional deficiencies, it is recommended that biliopancreatic diversion (with or without duodenal switch) be considered only in diabetic patients with a BMI of 60 or greater.(13) It is further recommended that BMI thresholds be reduced by 2.5 in patients of Asian descent.(13) [C in Context Link 1]

[D] A precise definition of adequate glucose control in type 2 diabetes varies to some degree depending on the patient. Nonpregnant adults may have a target HbA1c less than 7%, while those who are elderly, have a history of severe hypoglycemia, whose life expectancy is limited, who have advanced microvascular or macrovascular complications, or who have serious comorbid illness may have a target of less than 8%.(14) [D in Context Link 1]

[E] Full growth or nearly (95%) full growth is recommended for adolescents before they undergo a bariatric procedure.(2)(3) [E in Context Link 1]

[F] ICU admission may be indicated for comorbid conditions such as sleep apnea or airway management needs, failed postoperative extubation, or intraoperative complications. See Intensive, Intermediate, and Telemetry Care Guidelines ISC. [F in Context Link 1]

[G] See Clinical Indications for Procedure in this guideline. [G in Context Link 1]

[H] A closed-suction drain may be placed during surgery.(26) [H in Context Link 1]

[I] UGI contrast studies may be performed to assess leaks, obstruction, or other complications. [I in Context Link 1]

[J] Use oral or parenteral pain medication as needed. [J in Context Link 1]

[K] Discharge instructions should be given in the patient's and caregiver's native language using trained language interpreters whenever possible.(47) [K in Context Link 1]

Definitions

Hemodynamic stability

- Hemodynamic stability as indicated by **1 or more** of the following:
  - Hemodynamic abnormalities at baseline or acceptable for next level of care
  - Patient hemodynamically stable as indicated by **ALL** of the following(1)(2)(3)(4)(5):
    - Tachycardia absent
    - Hypotension absent

- No evidence of inadequate perfusion (eg, no myocardial ischemia)
- No other hemodynamic abnormalities (eg, no Orthostatic vital sign changes)

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Hypotension absent

- Hypotension absent as indicated by **1 or more** of the following(1)(2)(3)(4):
  - SBP greater than or equal to 90 mm Hg and without recent decrease greater than 40 mm Hg from baseline in adult or child 10 years or older
  - Mean arterial pressure[A] greater than or equal to 70 mm Hg in adult or child 10 years or older
  - Mean arterial pressure[A] at patient's baseline (eg, healthy adult with low SBP), or at intentional therapeutic goal (eg, patient with heart failure)
  - SBP greater than or equal to sum of 70 mm Hg plus twice patient's age in years in child 1 to 9 years of age
  - SBP greater than or equal to 70 mm Hg in infant 1 to 11 months of age

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Footnotes

A. The mean arterial pressure takes into account both systolic and diastolic blood pressure readings and is calculated as Mean Arterial Pressure (MAP) = 1/3 SBP + 2/3 DBP.

Orthostatic vital sign changes

- Orthostatic vital sign changes as indicated by **1 or more** of the following(1)(2):
  - Fall in SBP of 20 mm Hg or more 1 to 3 minutes after patient sits or stands from recumbent position
  - Fall in DBP of 10 mm Hg or more 1 to 3 minutes after patient sits or stands from recumbent position

References

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Tachycardia absent

- Tachycardia absent as indicated by **1 or more** of the following(1)(2):
  - Heart rate less than or equal to 100 beats per minute in adult or child 6 years or older

- Heart rate less than or equal to 115 beats per minute in child 3 to 5 years of age
- Heart rate less than or equal to 125 beats per minute in child 1 or 2 years of age
- Heart rate less than or equal to 130 beats per minute in infant 6 to 11 months of age
- Heart rate less than or equal to 150 beats per minute in infant 3 to 5 months of age
- Heart rate less than or equal to 160 beats per minute in infant 1 or 2 months of age

References

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Codes

ICD-10 Diagnosis: E66.01

ICD-10 Procedure: 0DB64Z3, 0DB68Z3

CPT®: 43775

Last Update: 2/11/2019 7:56:41 PM
Build Number: 23.0.194291120.004794

Santa Clara Family Health Plan™

Health Education

Medi-Cal & Healthy Kids

No-cost health education classes and workshops

Staying healthy is not always easy. We know that balancing a busy lifestyle with a healthy lifestyle is challenging. From exercising to managing stress, you may have questions about making the right choices for you. Santa Clara Family Health Plan (SCFHP) offers a wide range of health education classes and workshops to gym memberships, to help keep you moving and informed about healthy choices.

To learn about and to sign up for the health education resources available to you as an SCFHP member:

Call	SCFHP Customer Service **1-800-260-2055** (TTY 1-800-735-2929 or 711) Monday - Friday, 8:30 a.m. to 5:00 p.m.
Email	HealthEd@scfhp.com
Online	You can sign up for health education classes and access your health plan information online. Sign up at www.member.scfhp.com You will need your SCFHP member ID card to sign up. Create your account today!
Doctor	Your PCP can refer you to health education classes and services by filling out the Health Education Referral form at www.scfhp.com/for-members/health-education

Classes & Workshops available to you as an SCFHP member:

- Chronic Disease Management (Asthma, high blood pressure, diabetes and others)
- Counseling & Support Services
- Exercise & Fitness
- Nutrition & Weight Management
- Parent Education
- Pre-natal Education
- Safety Program
- Smoking Cessation
- *And more!*

SCFHP partners with local agencies to provide you with the health resources you need to maintain your health. For more information about classes near you contact us today!

Santa Clara Family Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-260-2055. (TTY: 1-800-735-2929 or 711).
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-260-2055 (TTY: 1-800-735-2929 o 711).
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-260-2055 (TTY: 1-800-735-2929 hoặc 711).

Santa Clara Family Health Plan™

Health Education Referral Form

Phone: **1-800-260-2055**
Fax: **1-408-874-1959**
Email: **healthed@scfhp.com**

This form is for Primary Care Providers. If you are a SCFHP member, you can register for health education classes on the mySCFHP member portal at member.scfhp.com or call SCFHP Customer Service at 1-800-260-2055 (TTY: 1-800-735-2929 or 711) 8:30 a.m. to 5:00 p.m., Monday - Friday.

Member Information

Name: _____ **Date:** _____

Date of Birth: _____ **SCFHP ID:** _____

Address: _____

Home Phone: _____ **Work/Cell Phone:** _____

Physician Information

Referring Physician: _____

Address: _____

Phone: _____ **Fax:** _____

- Classes and materials may be available in English, Spanish, Vietnamese, Chinese, and Tagalog.
- All classes require pre-registration.

Chronic Disease Self-Management	**Parent Education**
☐ Asthma ☐ Diabetes ☐ General Chronic Disease/Condition Management (High Blood Pressure, Heart Disease, Arthritis, etc.)	☐ Basic Parenting **Prenatal Education** ☐ Child Birth Preparation ☐ Prenatal Breastfeeding ☐ Infant Care ☐ Infant & Child CPR/First Aid
Counseling & Support Service	**Programs for Children**
☐ Stress Management ☐ Anger Management	☐ Asthma Camp (Summer. Ages 6-12) ☐ Diabetes Prevention Day Camp (Summer. Grades K-10) ☐ Summer Swimming Lessons (Ages 6 mo. – 18 years)
Exercise & Fitness	**Safety Programs**
☐ Fitness Center (All Year. Ages 13+)	☐ Car Seat Safety
Nutrition & Weight Management	**Smoking Cessation**
☐ Family Nutrition Education ☐ Weight Watchers	☐ Smoking Cessation Workshop ☐ Smoker's Helpline
Other (Please specify)	
_____ _____	

Submit an online version of this form on Provider Link at providerportal.scfhp.com, or email/fax this form to SCFHP Health Education.

Santa Clara Family Health Plan™

Interpreting Services Reference Guide

Telephone Interpreting Services (24 hours a day, 7 days a week)

Language Line Interpreting Services

Phone:	**1-888-898-1364**	Access Code:	**8033**

How to Use Language Line:

1. Call Language Line at **1-888-898-1364**.
2. Press 1 for Spanish or press 2 for other languages. If you are requesting another language, clearly say the name of the language the member speaks. Press 0 if you don't know the name of the language you need.
3. When prompted, enter the access code **8033.**
4. An agent will come on the line. Take note of the agent's ID number and provide the agent with:
    a. Provider's Office Name
    b. Your First and Last Name
    c. Member's First and Last Name
    d. Member's Date of Birth
    e. Member's ID Number

California Relay Services - Available in English and Spanish for members with hearing difficulties.

Voice/TTY English:	**1-800-855-7100, or Dial 711**	TTY Spanish:	**1-800-855-7200, or Dial 711**

In-Person Interpreting Services (72 hours advance notice preferred**)**

Customer Service

Medi-Cal/Healthy Kids:	**1-800-260-2055** Monday – Friday 8:30 a.m. - 5:00 P.M.	Cal MediConnect:	**1-877-723-4795** Monday – Friday 8:00 a.m. - 5:00 P.M.

How to Request In-Person Interpreting Services:

1. Call SCFHP Customer Service at **1-800-260-2055 (Medi-Cal/Healthy Kids)** or **1-877-723-4795 (Cal MediConnect)**. Inform the representative you are requesting Interpreting Services.
2. Provide the following information to schedule an appointment with an interpreter:
    - Member's SCFHP Identification Number
    - Member's Name and Date of Birth
    - Provider's Name and Address
    - Language Needed
    - Appointment Date, Time, and Location
    - Type of Appointment (Doctor's Checkup, Surgery, Consultation, etc.)
    - Onsite Contact Information for Appointment (Representative Name, Department Location, Phone Number)
    - Gender Preference of Interpreter

If you have any issues with telephone or in-person interpreters (no-show interpreters, etc.), please email quality@scfhp.com. Include what interpreter service was used and the interpreter's ID number in the email.

Santa Clara Family Health Plan™

Action Items

Santa Clara Family Health Plan™

Policy Update

POLICY

Santa Clara Family Health Plan

Policy Title:	**Prior Authorization**	**Policy No.:**	HS.01
Replaces Policy Title (if applicable):	Prior Auth for Non-Delegated SCFHP Mbrs., MLTSS Specialty Programs Prior Auth Process; 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 define consistent processes and guidelines for conducting prior authorization / organization determinations.

II. Policy

A. Santa Clara Family Health Plan has developed, maintains, continuously improves and annually reviews a Utilization Management Program. The UM Program Description and written procedures addresses required functions to support the consistent application of criteria.

B. The plan shall provide or arrange for all medically necessary Medi-Cal and/or Medicare covered services, respectfully by the member's benefit, and to ensure that these services are provided in an amount no less than what is offered to members under fee-for-service.

~~B.~~C. Prior Authorization is not required for Emergency Services (including Emergency Behavioral Health Services), Urgent care, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

1. The Plan applies the prudent layperson or reasonable person's interpretation of what may be considered an emergent condition. A policy regarding coverage of emergency services is maintained, revised and reviewed annually and as needed.

~~C.~~D. Prior Authorization is not required for inpatient admissions for stabilization after emergency room treatment

~~D.~~E. Prior authorization is required for inpatient admissions and post stabilization admission in and out-of-network

1. A member or member's representative can initiate prior authorization requests. In this case, the request is processed the same as a provider service request.

Commented [DH1]: DHCS MCOD-action required: The plan is required to submit the written policy that clearly states policy to ensure it reflects the standard of care policy.

POLICY

~~E.~~F. The Plan utilizes standardized criteria for medical necessity determinations and maintains a policy that is reviewed annually.

G. The plan shall provide medically necessary enteral nutrition products, or formulas, and establish procedures for medical authorization requirements and list of enteral nutrition products.

~~F.~~H. The Plan has established turn-around times for each line of business which is monitored for compliance

1. Decisions are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services. In addition, all decisions are clearly documented.

~~G.~~I. The plan allows for 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 network as specified in Continuity of Care benefit.

~~H.~~J. The Plan maintains a procedure for Continuity of Care for both medical and behavioral health services.

~~I.~~K. Out of Area and Out of Network requests are processed in accordance to the Member's Evidence of coverage, the Plan's Continuity of Care procedure for medical and behavioral health and reviewed based on medical necessity.

~~J.~~L. Members and providers have access to the Utilization Management Department at least eight hours a day during normal business hours of at least 8:30 a.m. to 5:00 p.m. Pacific Time.

~~K.~~M. The Nurse Line is available after hours for timely authorization of covered services that are Medically Necessary and to coordinate transfer of stabilized members in the emergency department, if necessary.

1. The Plan gathers all relevant information in order to make a prior authorization determination. This includes considerations outside of the clinical information such as support system, other resources and location.

~~L.~~N. The Plan maintains a policy and procedure for allowing members access to a second opinion

~~M.~~O. The Plan maintains a policy on denials and denial notification

~~N.~~P. The Pan maintains a policy on requiring use of appropriate/qualified professionals for UM functions such as

1. Licensed vs. non-licensed functions
2. Specialist requirements (BH, other)

~~O.~~Q. The Plan maintains policy and procedures to make certain that members have equal access to new technology or new uses of current treatment modalities through an established policy for the evaluation of new technology.

Commented [DH2]: DHCS MCOD-action required: Statement within policy stating

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POLICY

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. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature ~~Sandra Carlson, RN~~Lily Boris, MD	Signature Laurie Nakahira, ~~MD~~DO
Name ~~Director of Medical Management~~Medical Director	Name Chief Medical Officer
Title 08/29/2019	Title 08/30/2019
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1 ~~V~~1	**Original**	**Utilization Management**	**Approved ~~/~~1/18/2017**	
~~V~~1	**Reviewed**	**Utilization Management**	**Approved ~~/~~1/17/2018**	
~~V~~1	**Reviewed**	**Utilization Management**	**Approved ~~0~~1/16/2019**	
2	**Revised**	**Utilization Management**		

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Santa Clara Family Health Plan™

Prior Authorization Grid

Medical Covered Services Prior Authorization Grid

This Prior Authorization Grid contains services that require prior authorization only and is not intended to be a comprehensive list of covered services. Providers should refer to the appropriate Evidence of Coverage (EOC) for a complete list of covered services.

Santa Clara Family Health Plan (SCFHP) Utilization Management Department:

Telephone: 408-874-1821
Prior Authorization Request Submission Fax Lines: 408-874-1957 or 408-376-3548

When faxing a request to SCFHP, please:

1. Use the SCFHP Prior Authorization Request – Medical Services Form found at www.scfhp.com
2. Attach pertinent medical records, treatment plans, test results and evidence of conservative treatment to support medical necessity.

Other Contact Information:

SCFHP Automated Eligibility: 1-800-720-3455
SCFHP Customer Service:
Medi-Cal: 1-800-260-2055
Cal MediConnect: 1-877-723-4795

For Non-Emergency Medical Transportation & Non-Emergency Transportation contact SCFHP Customer Service

Benefits Authorized by Vendors:

Dental Services: Contact Denti-Cal at 1-800-322-6384

Vision Services: Contact Vision Service Plan (VSP) at 1-844-613-4779

Santa Clara Family Health Plan™

Medical Covered Services Prior Authorization Grid

Category of Service	Services Requiring Prior Authorization	
Behavioral Health Treatment	All Behavioral Health Treatment Services for members age 21 years and under with behavioral conditions that may or may not include autism spectrum	
Durable Medical Equipment (DME) **Benefit and frequency limits apply. Refer to CMS, Noridian, and/or Medi-Cal Provider Manual*	**Cal MediConnect**	**Medi-Cal & Healthy Kids HMO**
	• Custom made items • Any other DME or medical supply exceeding $1000 • Prosthetics & customized orthotics exceeding $1000 • Hearing aids and repairs • Other specialty devices • Requests over the benefit limit	• CPAP and BIPAP • Enteral formula and supplies • Hospital bed and mattress • Oxygen • Power wheelchairs, scooters, manual wheelchairs (**except** standard adult and pediatric), and motorized wheelchairs and accessories • Respiratory: Oxygen, BIPAP, CPAP, ventilators • Prosthetics & customized orthotics, **except** off-the-shelf covered items • Hearing aids and repairs • Other specialty devices • Requests over the benefit limit
Experimental Procedure	• Experimental Procedures • Investigational Procedures • New Technologies	
Home Health	• All Home Health Services • Home IV Infusion Services	
Inpatient Admissions	All elective medical and surgical inpatient admissions to: • Acute Hospital • Long Term Acute Care (LTAC) All admissions for: • Acute Inpatient Psychiatric • Partial Hospital Psychiatric Treatment • Substance Use Disorder including Detoxification Rehabilitation and Therapy Services: • Acute Rehabilitation Facilities • Skilled Nursing Facilities (SNF)	
Long-Term Services and Supports (LTSS)	• Community-Based Adult Services (CBAS) • Long-Term Care (LTC)	

Category of Service	Services Requiring Prior Authorization
Medications	• Refer to the 2020 Medical Benefit Drug Prior Authorization Grid • Drugs administered drugs in the doctor's office or in an outpatient setting
Non-Contracted Providers	All non-urgent/emergent services provided by non-contracted providers
Organ Transplant	All Organ Transplants

Outpatient Services and Procedures	• Abdominoplasty/Panniculectomy
	• Bariatric Surgery
	• Breast Reduction and Augmentation Surgery
	• Cataract Surgery
	• Cochlear Auditory Implant
	• Dental Surgery, Jaw Surgery and Orthognathic Procedures
	• Dermatology:
	  • Laser Treatment
	  • Skin Injections
	  • Implants
	• All types of Endoscopy, **except** Colonoscopy
	• Gender Reassignment Surgery
	• Genetic Testing and Counseling
	• Hyperbaric Oxygen Therapy
	• Intensive Outpatient Palliative Care (IOPC)
	• Neuro and Spinal Cord Stimulators
	• Outpatient Diagnostic Imaging:
	  • Magnetic Resonance Imaging (MRI)
	  • Magnetic Resonance Angiography (MRA)
	  • Nuclear Cardiology Procedures
	  • Single-Photon Emission Computerized Tomography (SPECT)
	  • Positron-Emission Tomography (PET/PET-CT)
	• Outpatient Therapies
	  • Occupational Therapy (OT)
	  • Physical Therapy (PT)
	  • Speech Therapy (ST)
	• All Plastic Surgery and Reconstructive Procedures
	• Podiatry
	  • All podiatric surgeries
	  • All podiatric services provided in a nursing or skilled nursing facility
	• Radiation Therapy:
	  • ~~Intensity Modulated Radiation Therapy (IMRT)~~
	  • Proton Beam Therapy
	  • Stereotactic Radiation Treatment (SBRT)
	• Sleep studies

Category of Service	Services Requiring Prior Authorization
	• Spinal Procedures, **except** epidural injections • Surgery for Obstructive Sleep Apnea (OSA) • Temporomandibular Disorder (TMJ) Treatment • Transplant-related services prior to surgery, **except** cornea transplant • Unclassified Procedures • Varicose vein treatment
Transportation	Non-Emergency Medical Transportation for ground and air, **except** ground transportation from facility to facility and hospital to home.

Santa Clara Family Health Plan™

Medical Benefit Drug Prior Authorization Grid

The following drugs require prior authorization for all Santa Clara Family Health Plan members. Additional required actions, restrictions, or limits on use are indicated in the right column.

Abbreviations used in this document include:

ST: Step Therapy

~~MCG: MCG Health Care Guidelines~~PA: Prior Authorization

Brand	Generic	Necessary Actions, Restrictions, or Limits on Use
ANTIEMETICS (ASSOCIATED WITH CANCER CHEMOTHERAPY)		
Cinvanti	Aprepitant	PA
Emend IV	Fosaprepitant	PA
Aloxi	Palonosetron	PA
ANTIHEMOPHILIC AGENTS		
Hemlibra	Emicizumab-kxwh	PA
CAR-T CELL IMMUNOTHERAPY		
Yescarta	Axicabtagene ciloleucel	PA
Kymriah	Tisagenlecleucel	PA
ERYTHROPOIESIS STIMULATING AGENTS		
Aranesp	Darbepoetin alfa	PA, ST: Retacrit
Epogen, Procrit	Epoetin alfa	PA, ST: Retacrit
Retacrit	Epoetin alfa-epbx	PA
COLONY STIMULATING FACTORS		
Neupogen	Filgrastim	PA, ST: Zarxio or Nivestym
Neulasta, Neulasta Onpro	Pegfilgrastim	PA, ST: ~~Zarxio or Nivestym* &~~ Fulphila or Udenyca
~~Fulphila~~	~~Pegfilgrastim-jmdb~~	~~ST: Zarxio or Nivestym* & MCG~~
Granix	Tbo-filgrastim	PA, ST: Zarxio or Nivestym
Leukine	Sargramostim	PA, ST: Zarxio, Nivestym, Fulphila, or Udenyca
GAUCHER DISEASE		
Cerezyme	Imiglucerase	PA
Elelyso	Taliglucerase alfa	PA
Vpriv	Velaglucerase alfa	PA
HEREDITARY ANGIOEDEMA		
Berinert, Cinryze, Haegarda	C1 esterase inhibitor, human	PA
Ruconest	C1 esterase inhibitor, recombinant	PA
Kalbitor	Ecallantide	PA
Firazyr	Icatibant	PA

Brand	Generic	Necessary Actions, Restrictions, or Limits on Use
Takhzyro	Lanadelumab-flyo	PA
IV IMMUNOGLOBULIN (IVIG)		
Bivigam, Carimune NF, Cuvitru, Flebogamma DIF, Gamastan, Gamastan S/D, Gammagard, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Hizentra, Hyqvia, Octagam, Panzyga, Privigen	Immune globulin, Immune globulin lyophilized, Immune globulin non-lyophilized	PA
MULTIPLE SCLEROSIS		
Tysabri	Natalizumab	PA
Ocrevus	Ocrelizumab	PA
NEUROMUSCULAR BLOCKING AGENTS		
Dysport	AbobotulinumtoxinA	PA
Xeomin	IncobotulinumtoxinA	PA
Botox	OnabotulinumtoxinA	PA
Myobloc	RimabotulinumtoxinB	PA
OPHTHALMIC AGENTS		
Eylea	Aflibercept	PA
Lucentis	Ranibizumab	PA
Luxturna	Voretigene neparvovec-rzyl	PA
OSTEOPOROSIS OR BONE MODIFIERS		
Prolia, Xgeva	Denosumab	PA
Boniva	Ibandronate sodium (IV)	PA
Aredia	Pamidronate disodium	PA
Reclast, Zometa	Zoledronic acid	PA
PULMONARY HYPERTENSION		
Flolan, Veletri	Epoprostenol	PA
Remodulin	Treprostinil (injection)	PA
RESPIRATORY		
Aralast NP, Glassia, Prolastin-C, Zemaira	α-1 proteinase inhibitor	PA
Nucala	Mepolizumab	PA
Xolair	Omalizumab	PA
Synagis	Palivizumab	PA
Cinqair	Reslizumab	PA

Brand	Generic	Necessary Actions, Restrictions, or Limits on Use
RHEUMATOLOGY/IMMUNOSUPPRESSANTS		
Orencia	Abatacept	PA
Humira, Cyltezo, Amjevita, Hyrimoz, Hadlima	Adalimumab, Adalimumab-adbm, Adalimumab-atto, Adalimumab-adaz, Adalimumab-bwwd	Pharmacy Benefit Only
Cimzia	Certolizumab pegol	Pharmacy Benefit Only
Enbrel, Erelzi	Etanercept, Etanercept-szzs	Pharmacy Benefit Only
Simponi Aria	Golimumab	PA~~, ST: Adalimumab and Etanercept~~
Tremfya	Guselkumab	PA~~, ST: Adalimumab and Etanercept~~
Remicade	Infliximab	PA, ST: Inflectra, Renflexis, or Ixifi
Inflectra, Renflexis, Ixifi	Infliximab-dyyb, Infliximab-abda, Infliximab-qbtx	PA
Taltz	Ixekizumab	Pharmacy Benefit Only
Rituxan, Rituxan Hycela	Rituximab, Rituximab/hyaluronidase	PA, ST: Truxima or Ruxience
Truxima, Ruxience	Rituximab-abbs, Rituximab-pvvr	PA
Actemra	Tocilizumab IV	PA
Stelara	Ustekinumab IV	PA,~~ ST: Adalimumab~~
Entyvio	Vedolizumab	PA,~~ ST: Adalimumab~~
MISCELLANEOUS		
Exondys 51	Eteplirsen	PA
Spinraza	Nusinersen	PA
Onpattro	Patisiran	PA
Krystexxa	Pegloticase	PA
Nplate	Romiplostim	PA
Radicava	Edaravone	PA
UNCLASSIFIED		
Unclassified drugs and biologics		PA

Santa Clara Family Health Plan™

Reports

Santa Clara Family Health Plan™

Membership Report

Santa Clara Family Health Plan

Membership

Year-Month	2019–04	2019-05	2019-06	2019-07	2019-08	2019-09
Healthy Kids	3,465	3,507	3,486	3,501	3,509	3,512
Medi-Cal	239,444	237,655	237,697	236,578	235,389	234,478
Cal MediConnect	7,869	7,915	8,022	8,076	8,134	8,194
Total	**250,778**	**249,077**	**249,205**	**248,155**	**247,032**	**246,184**

Santa Clara Family Health Plan™

Standard Utilization Metrics

Inpatient Utilization: Medi-Cal – Non-SPD 1/1/2019 – 6/30/2019

Source: HEDIS Inpatient Utilization (IPU) data for measurement period ending 6/30/2019

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2019 Q1	2,224	3.79	8,182	3.68
2019 Q2	2,093	3.60	7,896	3.77
Total	4,317	3.69	16,078	3.72

Inpatient Utilization: Medi-Cal – SPD 1/1/2019 – 6/30/2019

Source: HEDIS Inpatient Utilization (IPU) data for measurement period ending 6/30/2019

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2019 Q1	720	10.94	3,354	4.66
2019 Q2	657	10.00	3,221	4.90
Total	1,377	10.47	6,575	4.77

Inpatient Utilization: Cal MediConnect (CMC)
4/1/2018 – 3/30/2019

Source: CMC Enrollment & QNXT Claims Data

Quarter	Discharges	Discharges / 1,000 Members per Year	Days	Average Length of Stay
2018 Q3	452	234.9	2,536	5.61
2018 Q4	456	234.1	2,506	5.50
2019 Q1	526	264.3	3,174	6.03
2019 Q2	113	56.2	628	5.56
Total	1,547	196.5	8,844	5.72

Medi-Cal Inpatient Utilization NCQA Medicaid Benchmark Comparisons 1/1/2019 – 6/30/2019

	Medi-Cal Population		
Measure	**Non-SPD**	**SPD**	**Total**
Discharges / 1,000 Member Months	3.69	10.47	4.62
NCQA Medicaid Percentile Rank[1]	<5th	>90th	<5th
ALOS	3.63	4.72	3.89
NCQA Medicaid Percentile Rank[2]	<25th	>75th	<25th

[1] NCQA Medicaid 50th percentile = 6.55
[2] NCQA Medicaid 50th percentile = 4.27

Santa Clara Family Health Plan

Medi-Cal SPD & CMC Inpatient Utilization
MCG & NCQA Medicare Benchmark Comparisons
1/1/2019 – 6/30/2019

	Discharges / 1,000 Members per Year	Days / 1,000 Members per Year	ALOS
SCFHP Population			
Medi-Cal SPD	132.0	623.8	4.72
CMC	196.5	1,123.3	5.72
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	251.04	1,411.45	5.58

Inpatient Readmissions: Medi-Cal & CMC

- Medi-Cal formerly used ACR (All-Cause Readmissions). The ACR measure was retired after 2018 and replaced with PCR (Plan All-Cause Readmissions).
- The PCR measure is now being used to measure inpatient readmissions for both Medi-Cal and Medicare
- Current PCR data is being updated and will be presented at the next UMC meeting.

Santa Clara Family Health Plan

Frequency of Selected Procedures: Medi-Cal

Source: HEDIS data for 1/1/2019 – 8/30/2019 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	90	0.16	0.64	↓
Male & Female, Age 10-19	56	0.09	0.28	↓
Hysterectomy, abdominal				
Female, Age 15-44	20	0.04	0.09	↓
Female, Age 45-64	23	0.08	0.20	↓
Hysterectomy, vaginal				
Female, Age 15-44	7	0.01	0.10	↓
Female, Age 45-64	16	0.06	0.16	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 1/1/2019 – 8/30/2019 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	5	0.01	0.02	↓
Female, Age 15-44	2	0.00	0.01	↓
Female, Age 45-64	0	0.00	0.02	↓
Cholecystectomy, closed (laparoscopic)				
Male, Age 30-64	5	0.01	0.25	↓
Female, Age 15-44	2	0.00	0.55	↓
Female, Age 45-64	0	0.00	0.58	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 1/1/2019 – 8/30/2019 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	5	0.02	0.18	↓
Female, Age 20-44	2	0.01	0.14	↓
Male, Age 45-64	35	0.15	0.53	↓
Female, Age 45-64	21	0.07	0.51	↓
Mastectomy				
Female, Age 15-44	13	0.02	0.03	↓
Female, Age 45-64	21	0.07	0.13	↓
Lumpectomy				
Female, Age 15-44	17	0.03	0.10	↓
Female, Age 45-64	53	0.19	0.33	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 1/1/2019 – 8/30/2019 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	1	0.00	0.00	↔
Male, Age 20-44	2	0.01	0.01	↔
Female, Age 20-44	22	0.06	0.04	↑
Male, Age 45-64	4	0.02	0.01	↑
Female, Age 45-64	7	0.02	0.06	↓

ADHD Medi-Cal Behavioral Health Metrics

Source: HEDIS data for 1/1/2019 – 8/30/2019 measurement period

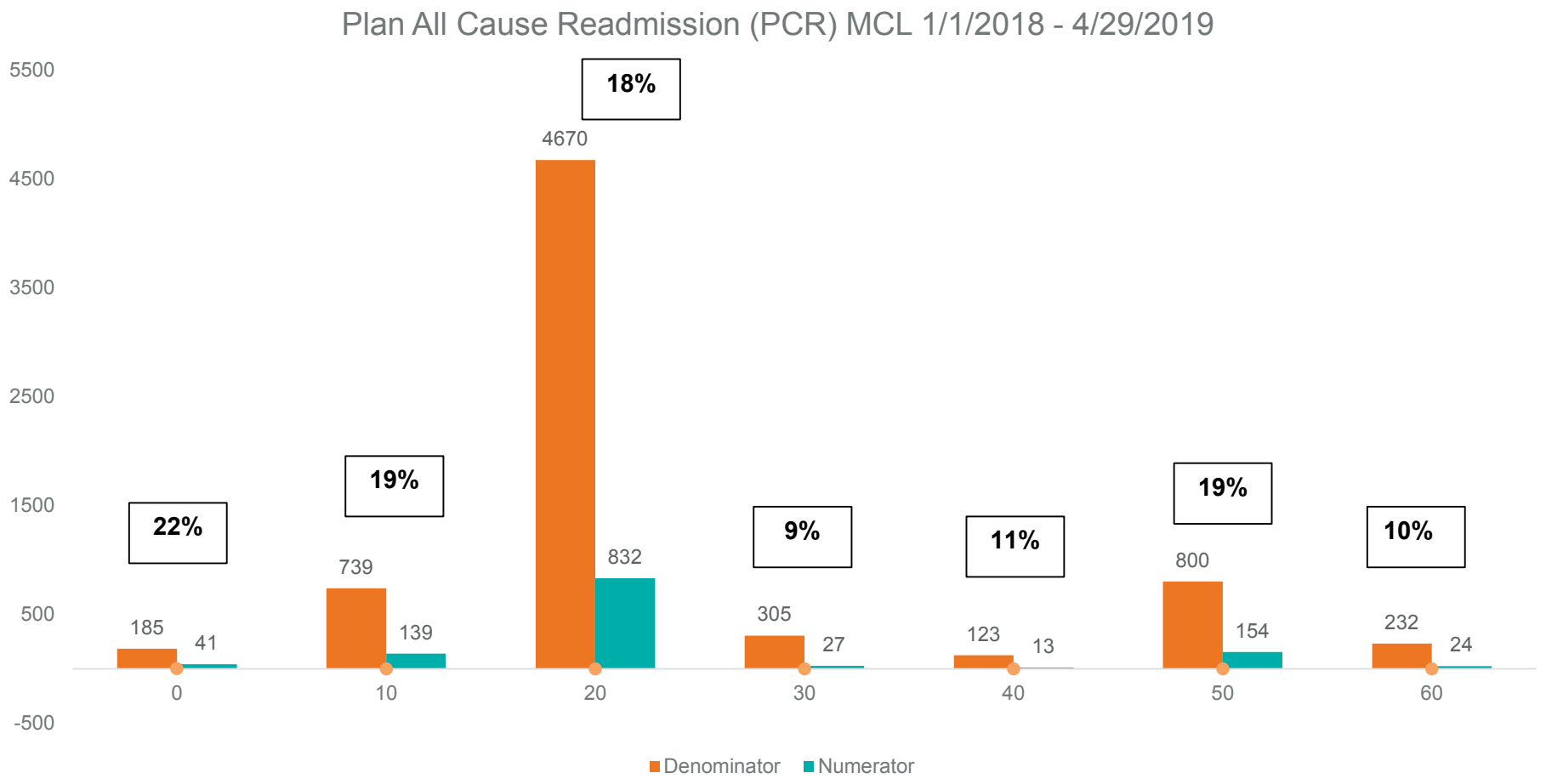
Measure	Rate	NCQA Medicaid 50th Percentile	SCFHP Percentile Rank
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	62.45%	45.00%	>90th
Continuation & Maintenance Phase	74.19%	57.09%	>90th
Antidepressant Medication Management			
Acute Phase Treatment	59.11%	51.76%	>75th
Continuation Phase Treatment	43.74%	36.43%	>75th
Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia	41.67%	78.13%	<10th

Santa Clara Family Health Plan™

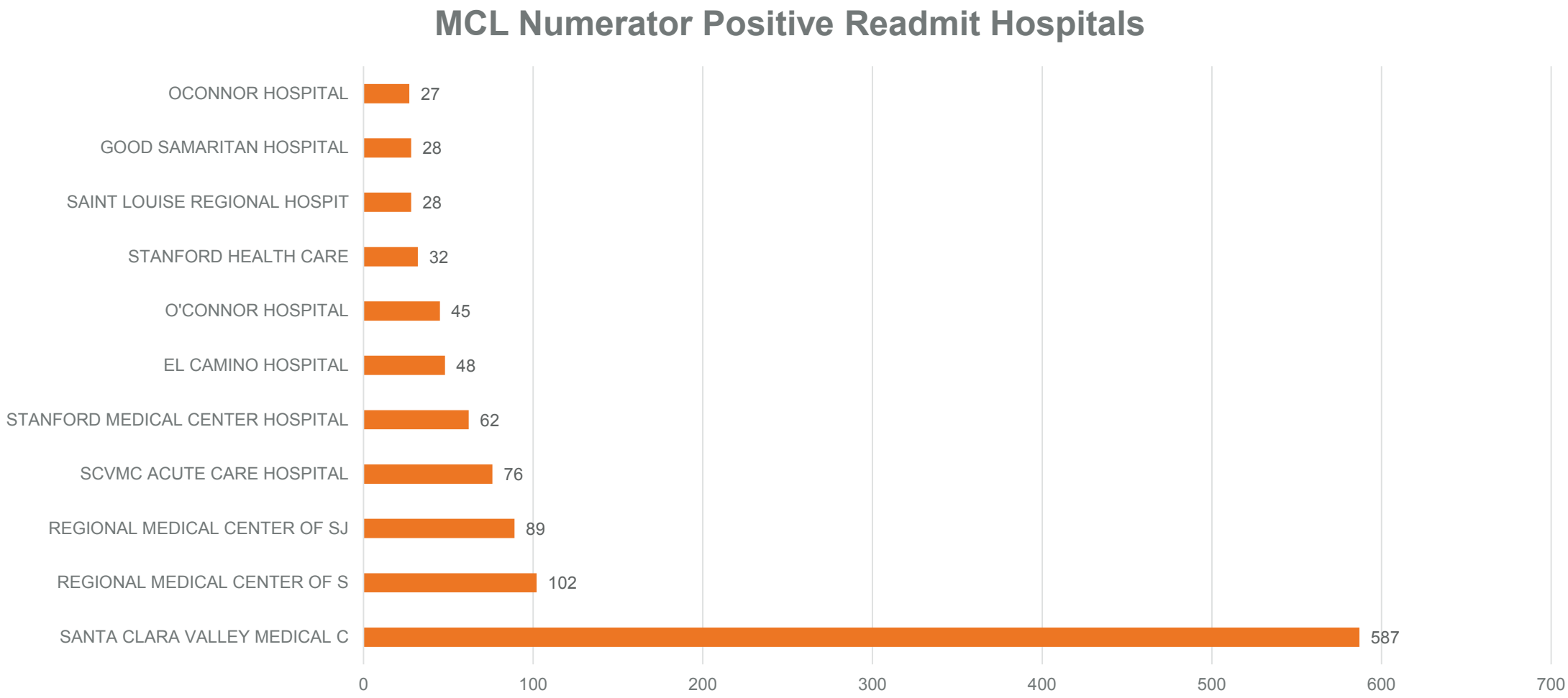
Hospital Specific Metrics

Plan All Cause Readmission (PCR) Medi-Cal (MCL)

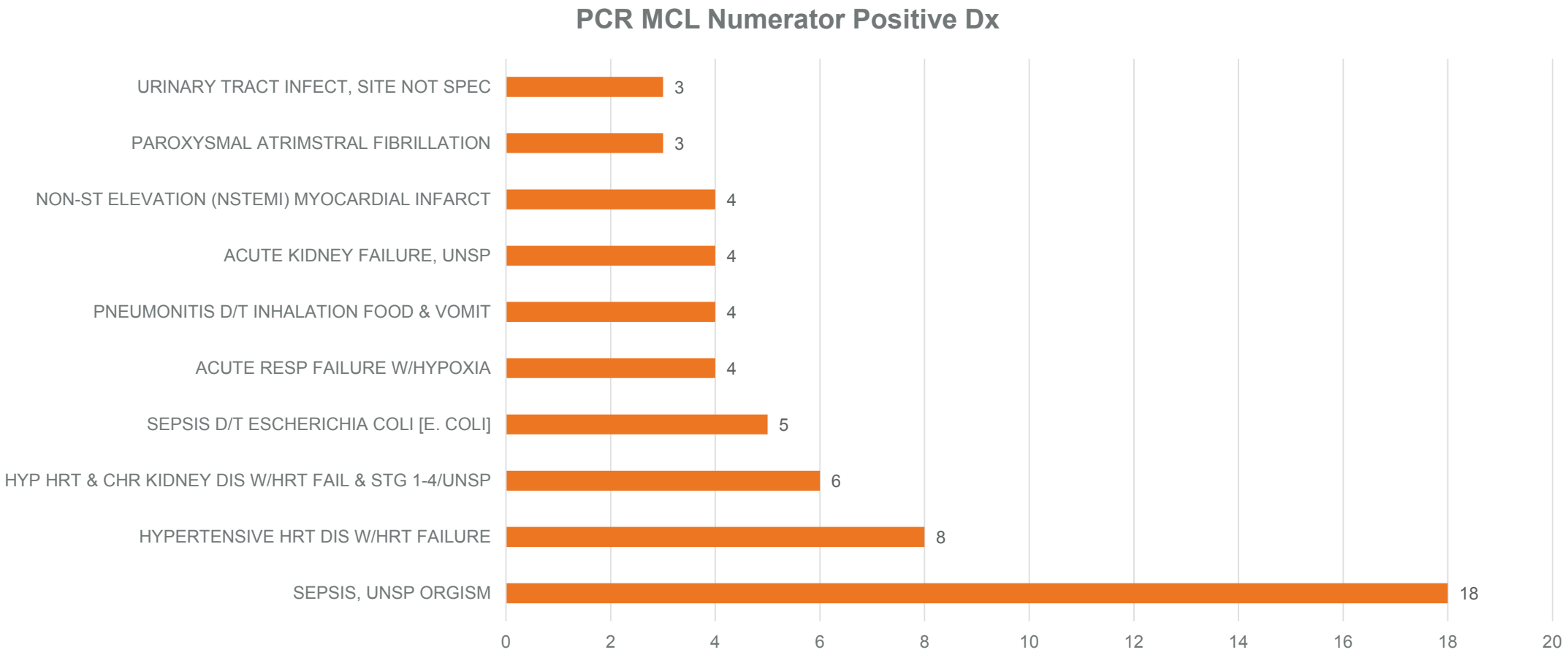
1/1/2018 - 4/29/2019 PCR MCL Numerator Positive



PCR Medi-Cal by Hospital

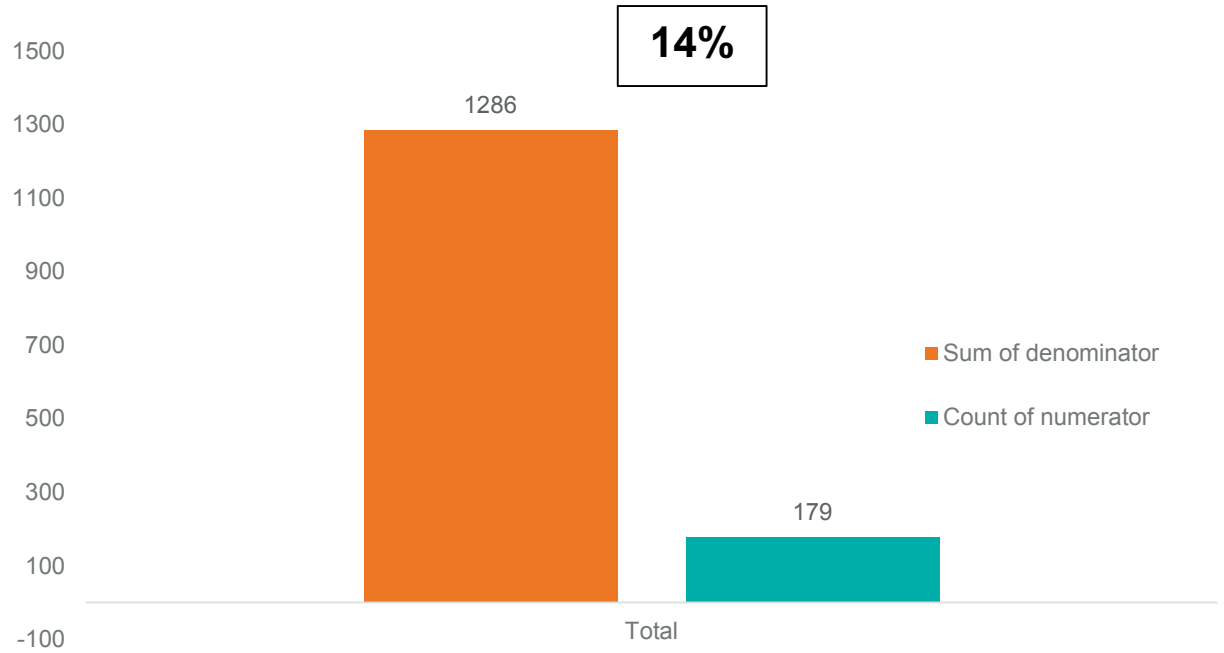


PCR Medi-Cal by Diagnosis

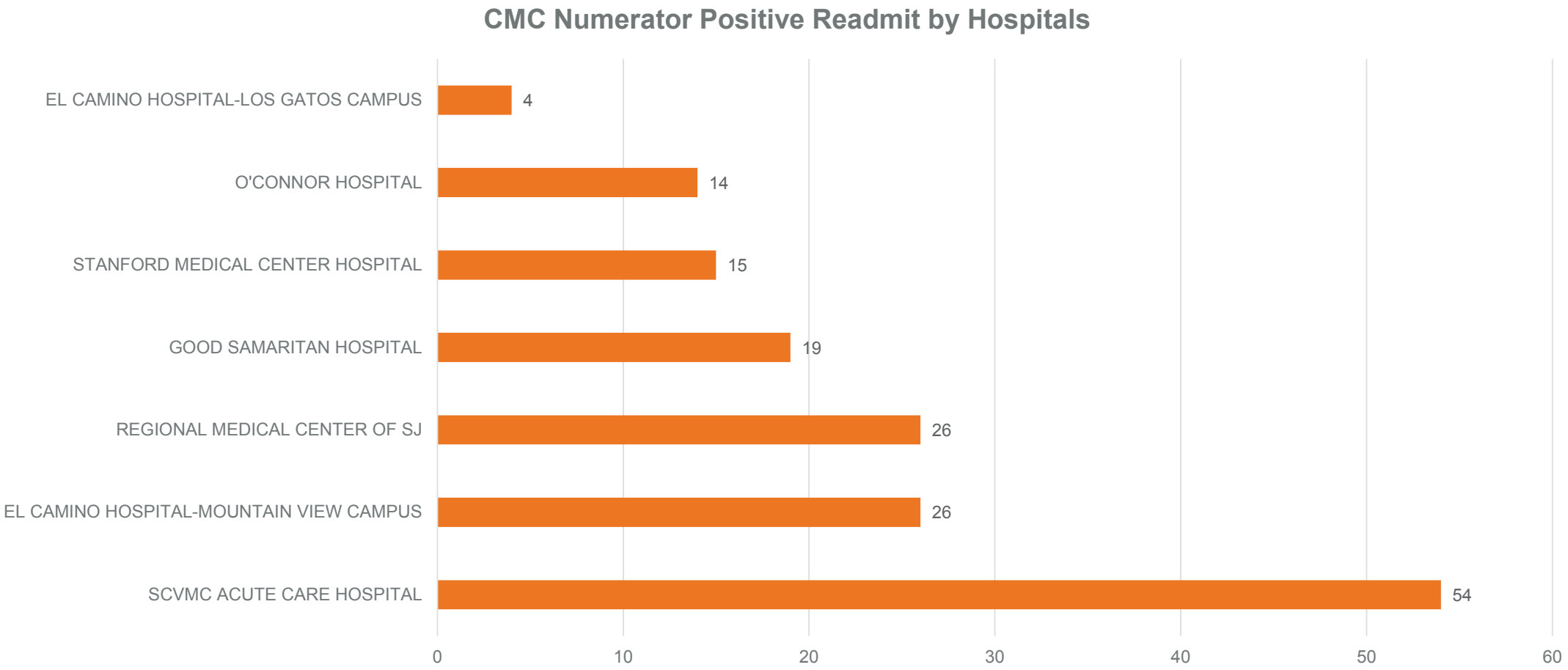


Plan All Cause Readmission (PCR) Cal MediConnect (CMC) Overall

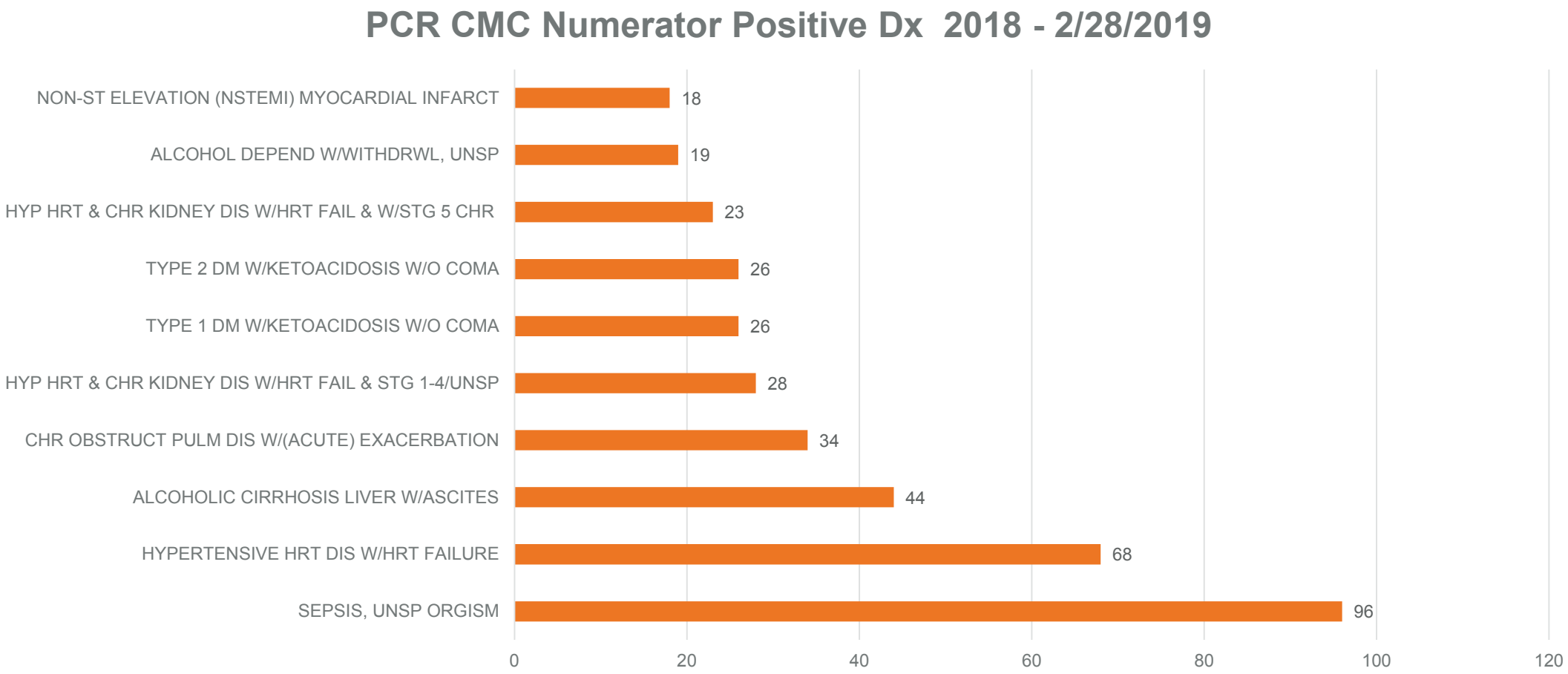
2018 PCR CMC Numerator Positive



PCR CMC by Hospital



PCR CMC by Diagnosis



Santa Clara Family Health Plan™

Referral Tracking Report

Referral Tracking Report

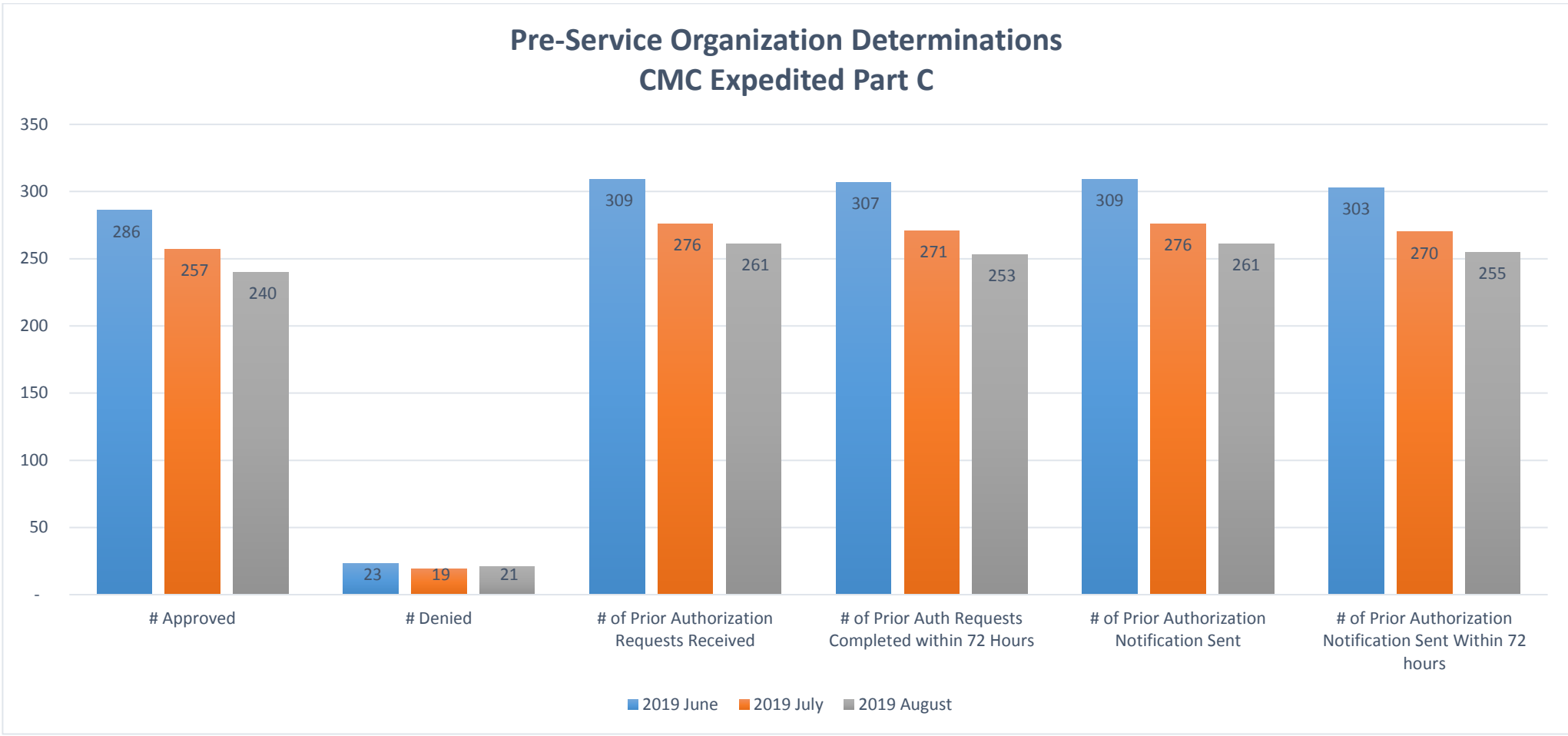
LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Medi-Cal	CBAS		2	2	0	0	0.0%
		Retro Request	24	24	0	0	0.0%
		Routine - Extended Service	61	59	0	2	3.3%
		Routine - Initial Request	17	17	0	0	0.0%
		Urgent - Extended Service	1	1	0	0	0.0%
	CONT OF CARE	Routine - Initial Request	1	1	0	0	0.0%
		Urgent - Initial Request	1	0	0	1	100.0%
	Dental	Routine - Initial Request	10	8	0	2	20.0%
		Urgent - Initial Request	9	7	0	2	22.2%
	DME		1	1	0	0	0.0%
		Non Contracted Provider - Ret..	5	5	0	0	0.0%
		Non Contracted Provider - Ro..	4	1	0	3	75.0%
		Retro Request	6	1	0	5	83.3%
		Routine - Extended Service	2	0	0	2	100.0%
		Routine - Initial Request	152	91	0	61	40.1%
		Urgent - Extended Service	1	1	0	0	0.0%
		Urgent - Initial Request	30	23	0	7	23.3%
	HomeHealth	Non Contracted Provider - Ret..	2	1	0	1	50.0%
		Retro Request	2	0	0	2	100.0%
		Routine - Extended Service	2	2	0	0	0.0%
		Urgent - Extended Service	10	3	0	7	70.0%
		Urgent - Initial Request	28	9	0	19	67.9%
	HOSPICE	Non Contracted Provider - Ret..	8	5	0	3	37.5%
		Non Contracted Provider - Urg..	2	2	0	0	0.0%
		Routine - Initial Request	1	1	0	0	0.0%
	OP-BehavioralGr	Delay Additional info – See N..	1	1	0	0	0.0%
		Non Contracted Provider - Ret..	9	8	0	1	11.1%
		Non Contracted Provider - Ro..	35	21	0	14	40.0%
		Retro Request	10	9	0	1	10.0%
		Routine - Extended Service	31	21	0	10	32.3%
		Routine - Initial Request	9	6	0	3	33.3%
	OP-Behavorial	Non Contracted Provider - Ret..	4	3	0	1	25.0%
		Non Contracted Provider - Ro..	16	6	0	10	62.5%
		Retro Request	4	3	0	1	25.0%
		Routine - Extended Service	7	4	0	3	42.9%
		Routine - Initial Request	16	5	0	11	68.8%
	OPHospital	Non Contracted Provider - Ret..	2	1	0	1	50.0%
		Non Contracted Provider - Ro..	21	5	0	16	76.2%
		Non Contracted Provider - Urg..	10	4	0	6	60.0%
		Retro Request	13	1	0	12	92.3%
		Routine - Extended Service	20	5	0	15	75.0%
		Routine - Initial Request	224	101	0	123	54.9%
		Urgent - Extended Service	4	2	0	2	50.0%
		Urgent - Initial Request	121	55	0	66	54.5%
	OPHospitalGr	Retro Request	3	3	0	0	0.0%
		Routine - Extended Service	41	29	0	12	29.3%
		Routine - Initial Request	330	171	0	159	48.2%
		Urgent - Extended Service	10	6	0	4	40.0%
		Urgent - Initial Request	99	67	0	32	32.3%

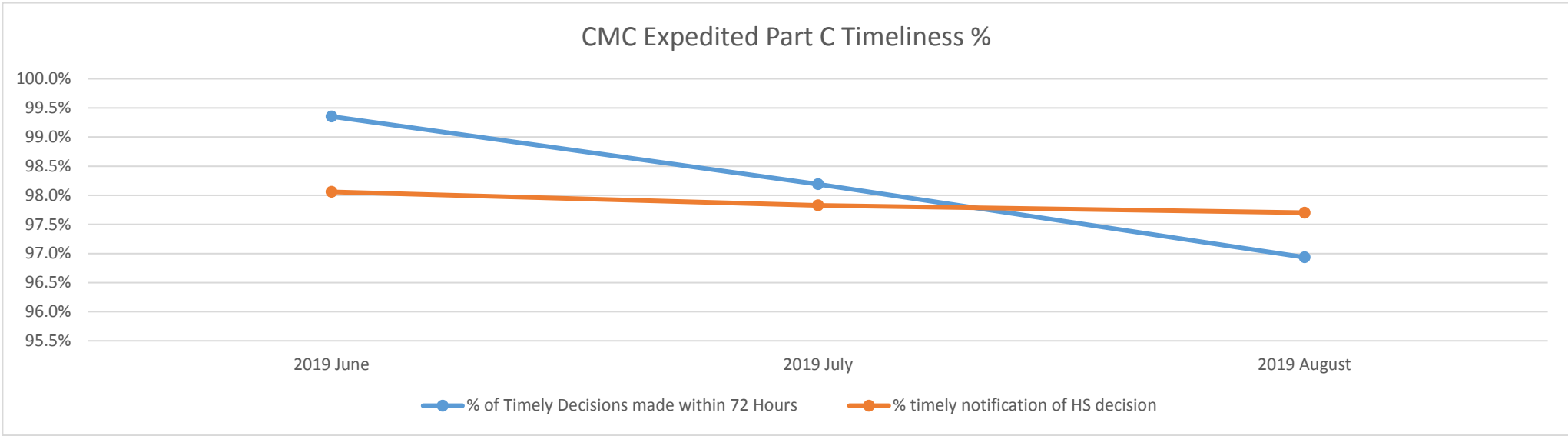
Referral Tracking Report

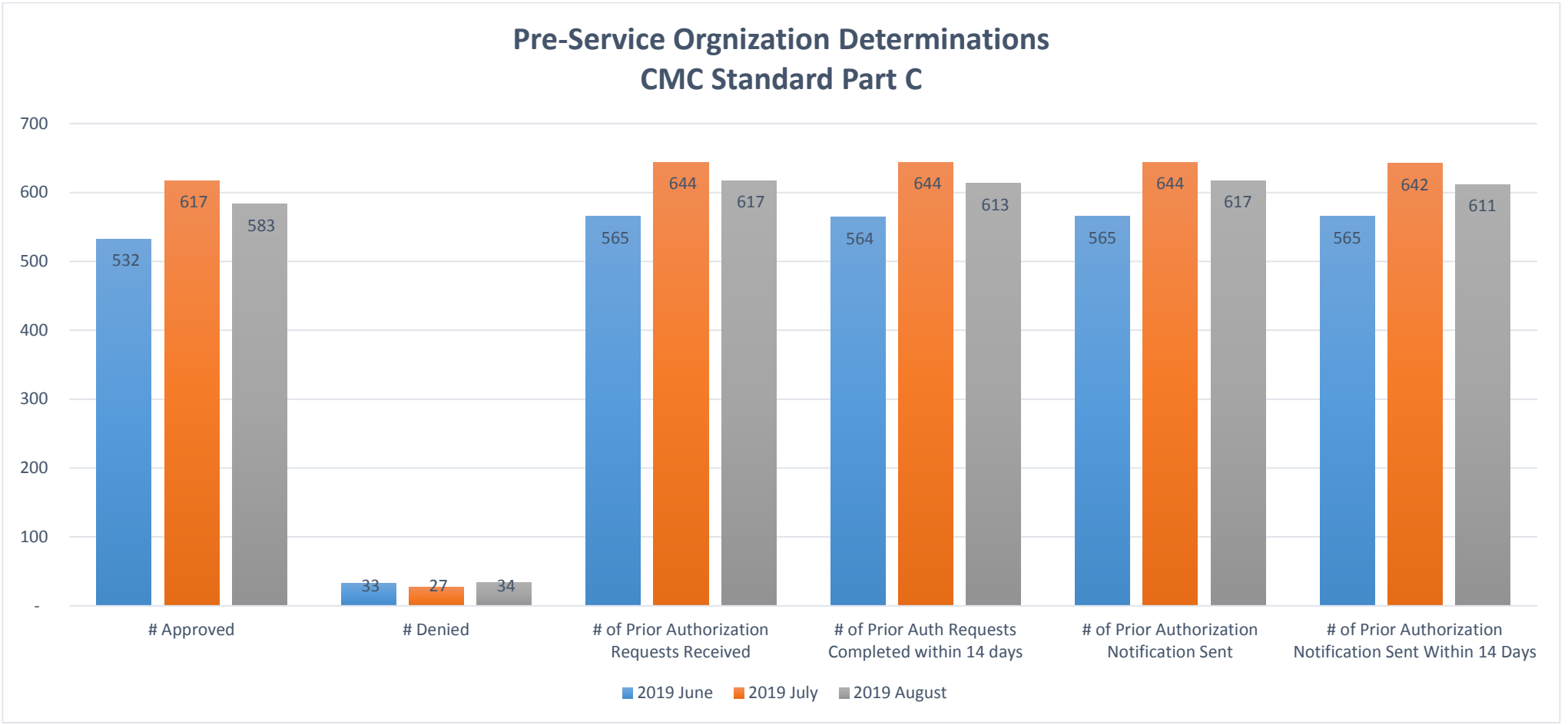
LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Medi-Cal	Transportation	Non Contracted Provider - Ret..	3	2	0	1	33.3%
		Retro Request	139	87	0	52	37.4%
		Routine - Initial Request	237	3	0	234	98.7%
		Urgent - Extended Service	1	0	0	1	100.0%
Grand Total			**1,802**	**894**	**0**	**908**	**50.4%**

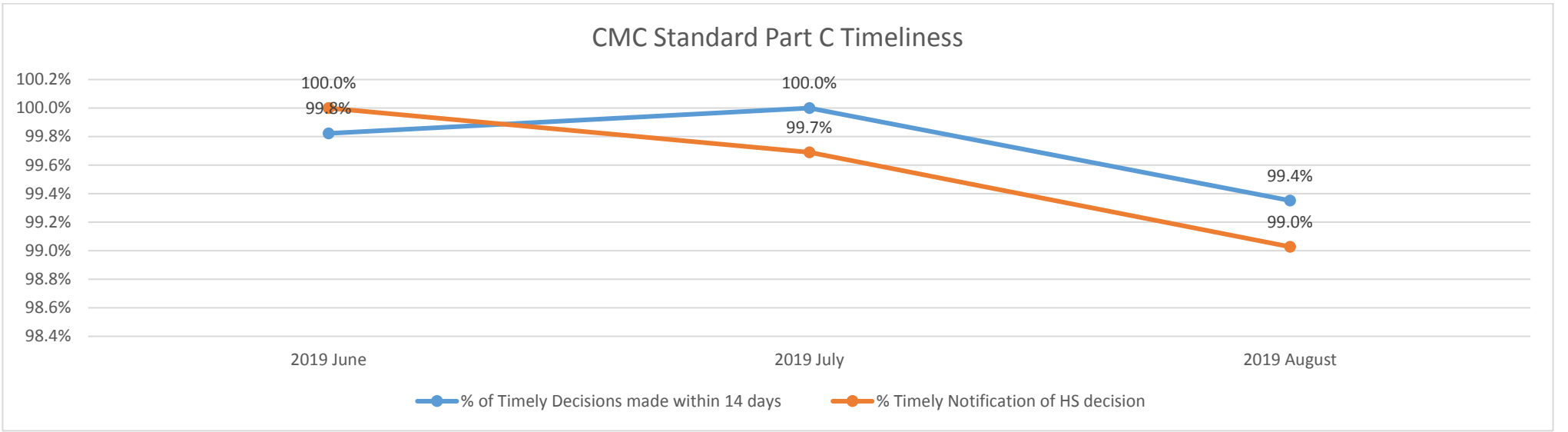
Santa Clara Family Health Plan™

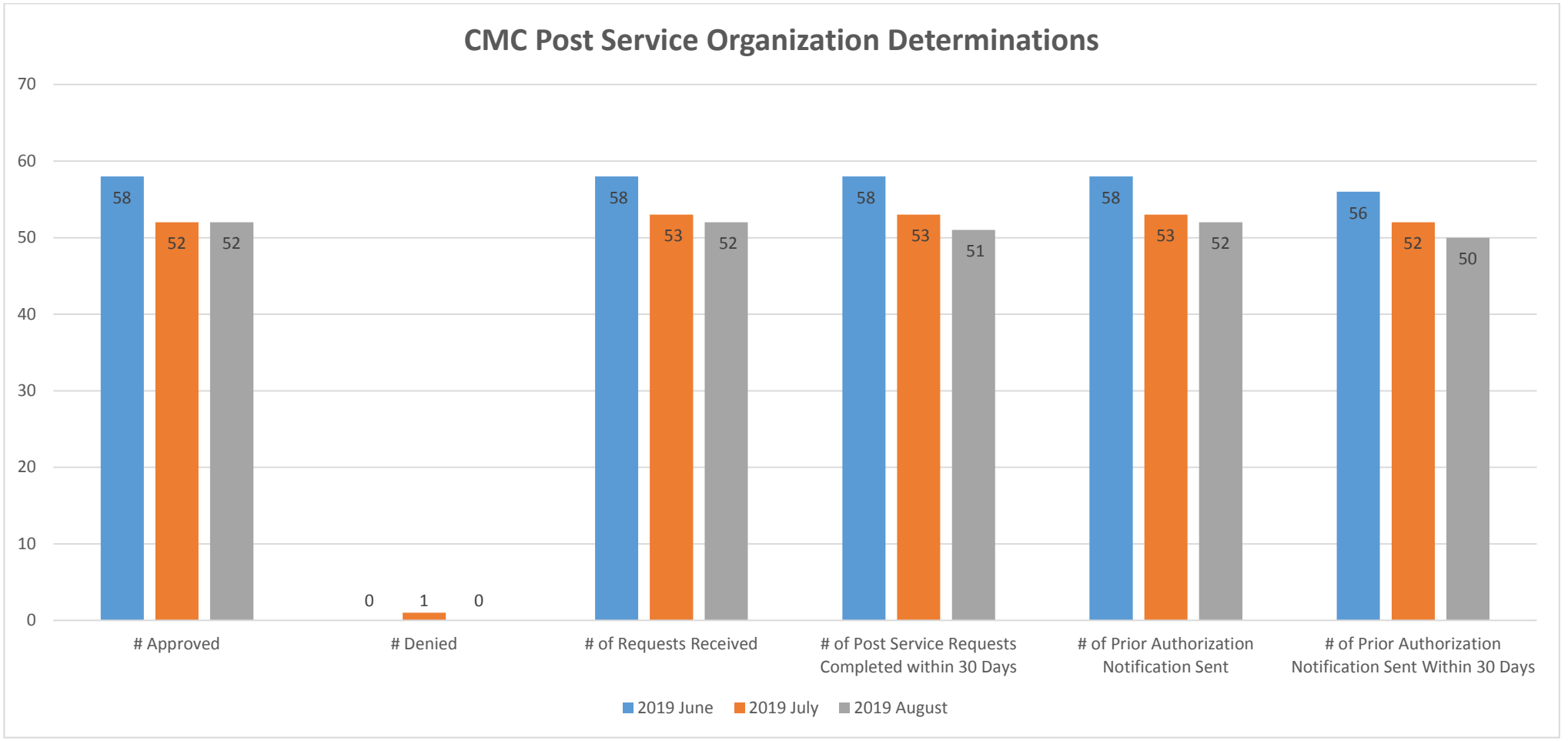
Turn Around Time Report

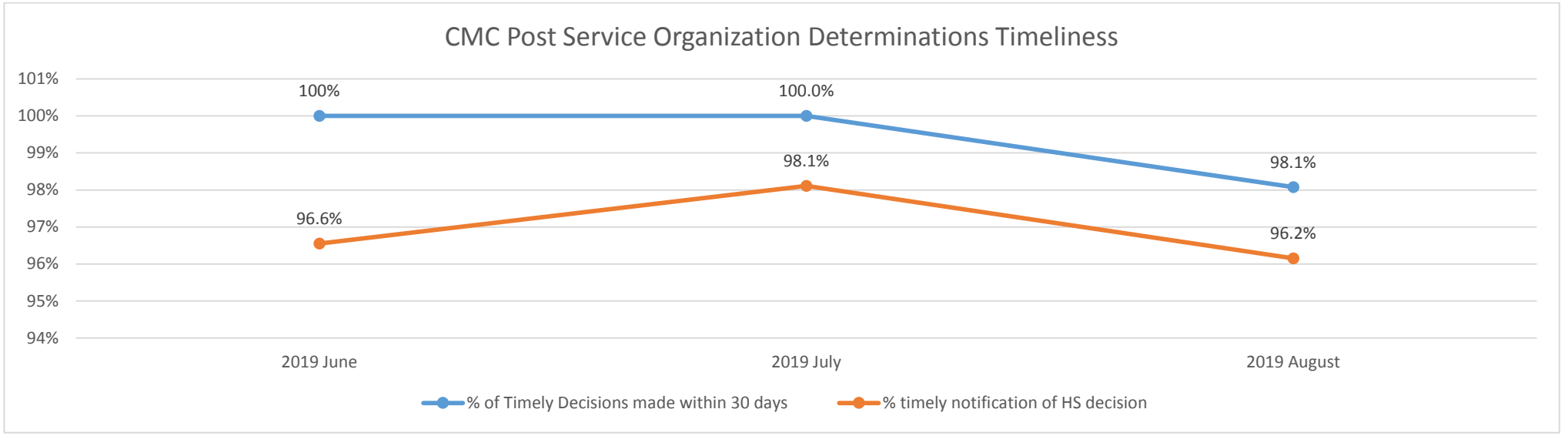

Pre-Service Organization Determinations
CMC Expedited Part C
350
300
250
200
150
100
50
-
286
257
240
23
19
21
309
276
261
307
271
253
309
276
261
303
270
255
Approved
Denied
of Prior Authorization Requests Received
# of Prior Auth Requests Completed within 72 Hours
# of Prior Authorization Notification Sent
# of Prior Authorization Notification Sent Within 72 hours
2019 June
2019 July
2019 August

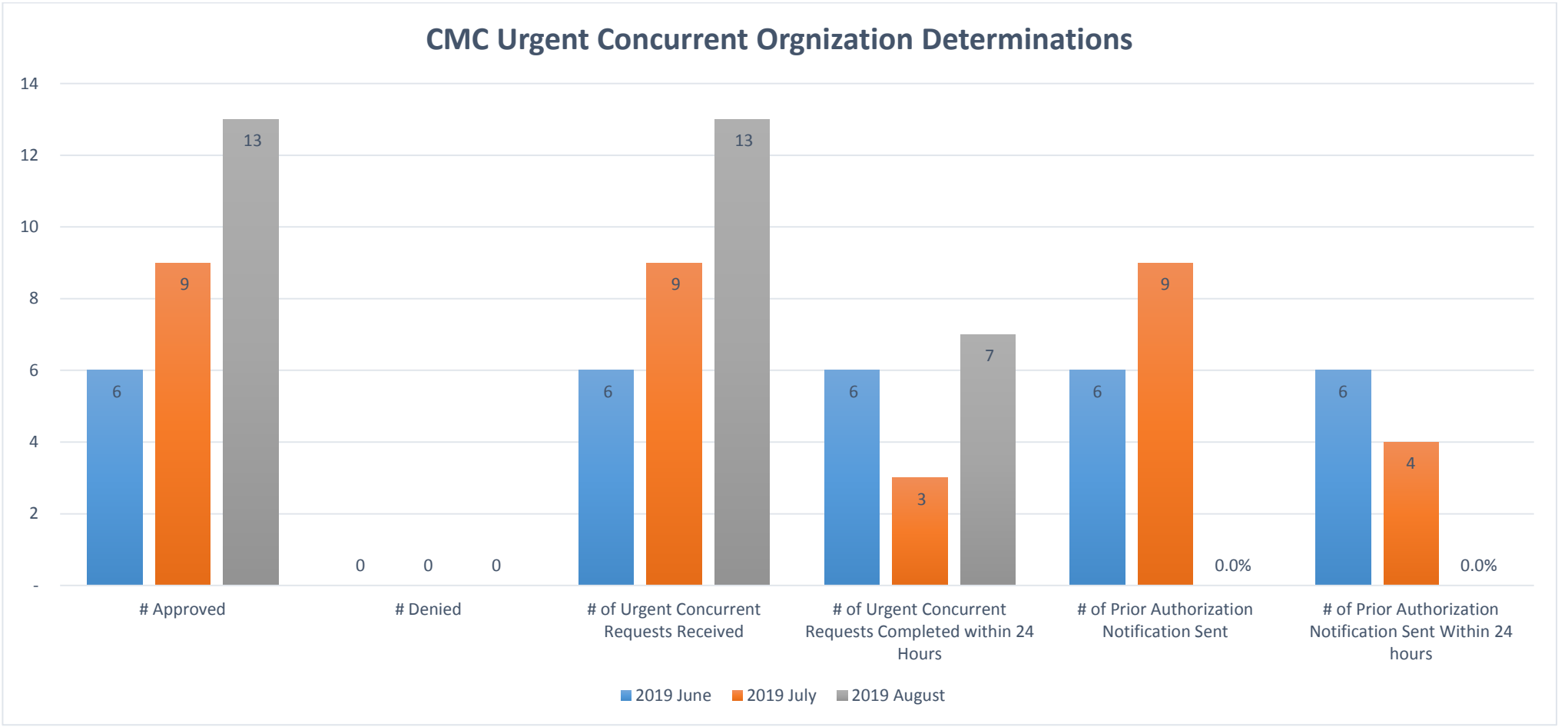

CMC Expedited Part C Timeliness %
100.0%
99.5%
99.0%
98.5%
98.0%
97.5%
97.0%
96.5%
96.0%
95.5%
2019 June
2019 July
2019 August
% of Timely Decisions made within 72 Hours
% timely notification of HS decision

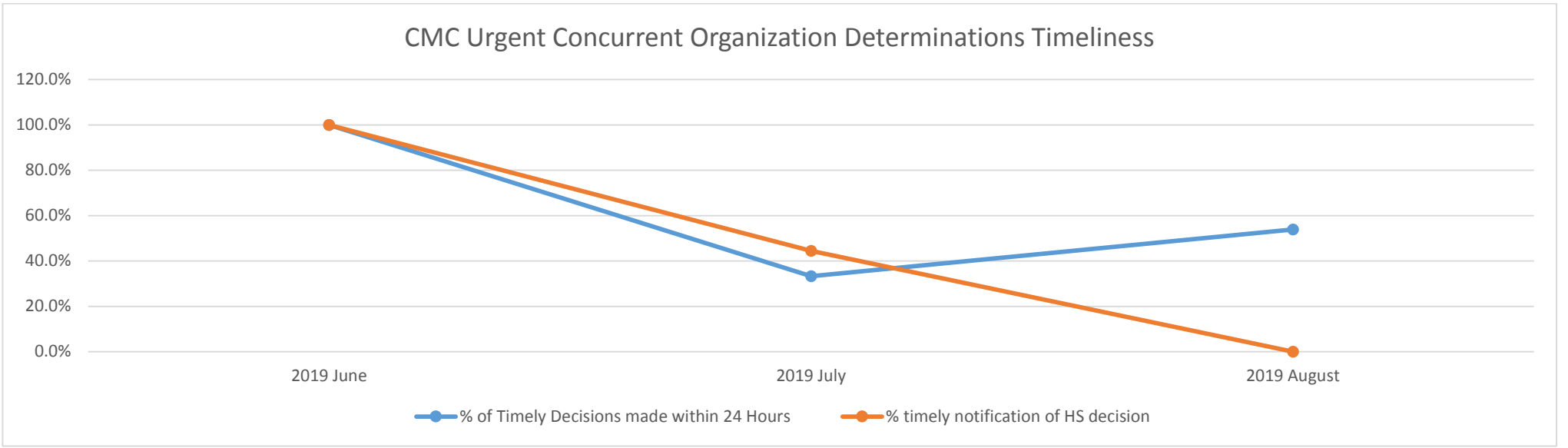

Pre-Service Orgnization Determinations
CMC Standard Part C
700
600
500
400
300
200
100
-
532
617
583
33
27
34
565
644
617
564
644
613
565
644
617
565
642
611
Approved
Denied
of Prior Authorization Requests Received
# of Prior Auth Requests Completed within 14 days
# of Prior Authorization Notification Sent
# of Prior Authorization Notification Sent Within 14 Days
2019 June
2019 July
2019 August

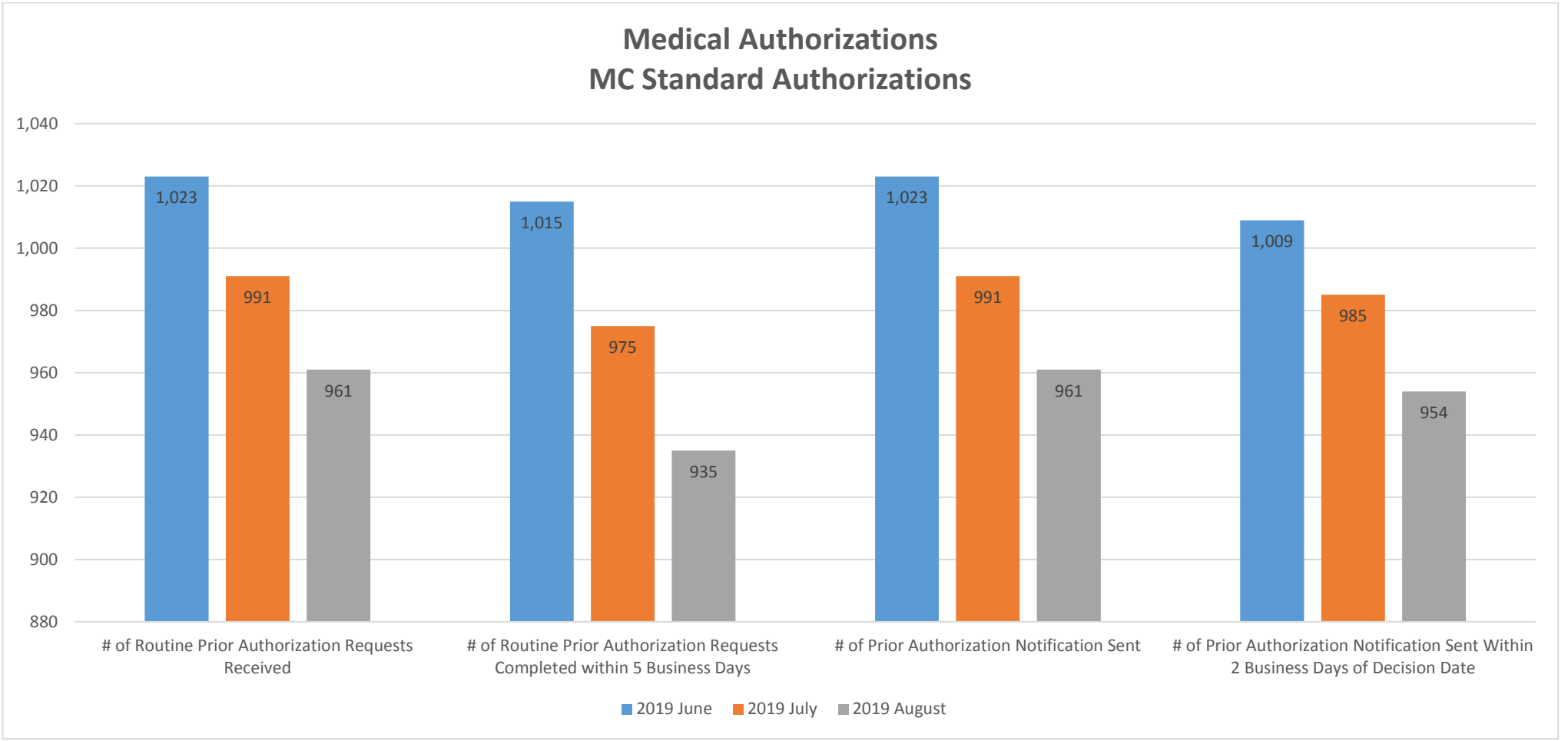

CMC Standard Part C Timeliness
100.2%
100.0%
99.8%
99.6%
99.4%
99.2%
99.0%
98.8%
98.6%
98.4%
100.0%
99.8%
100.0%
99.7%
99.4%
99.0%
2019 June
2019 July
2019 August
% of Timely Decisions made within 14 days
% Timely Notification of HS decision

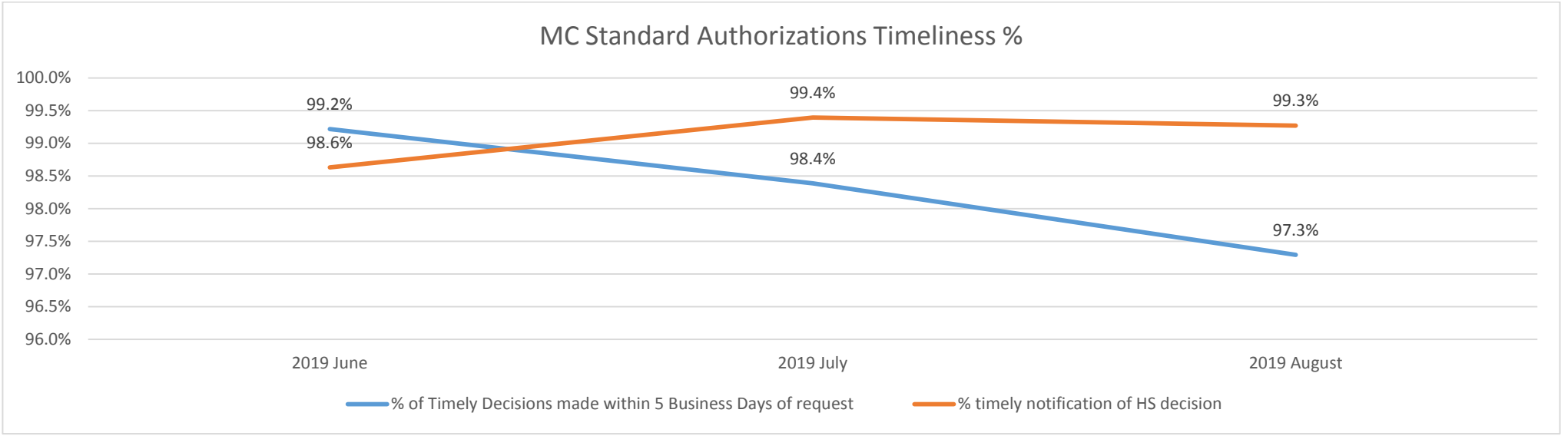

CMC Post Service Organization Determinations
70
60
50
40
30
20
10
0
58
52
52
0
1
0
58
53
52
58
53
51
58
53
52
56
52
50
Approved
Denied
of Requests Received
# of Post Service Requests Completed within 30 Days
# of Prior Authorization Notification Sent
# of Prior Authorization Notification Sent Within 30 Days
2019 June
2019 July
2019 August

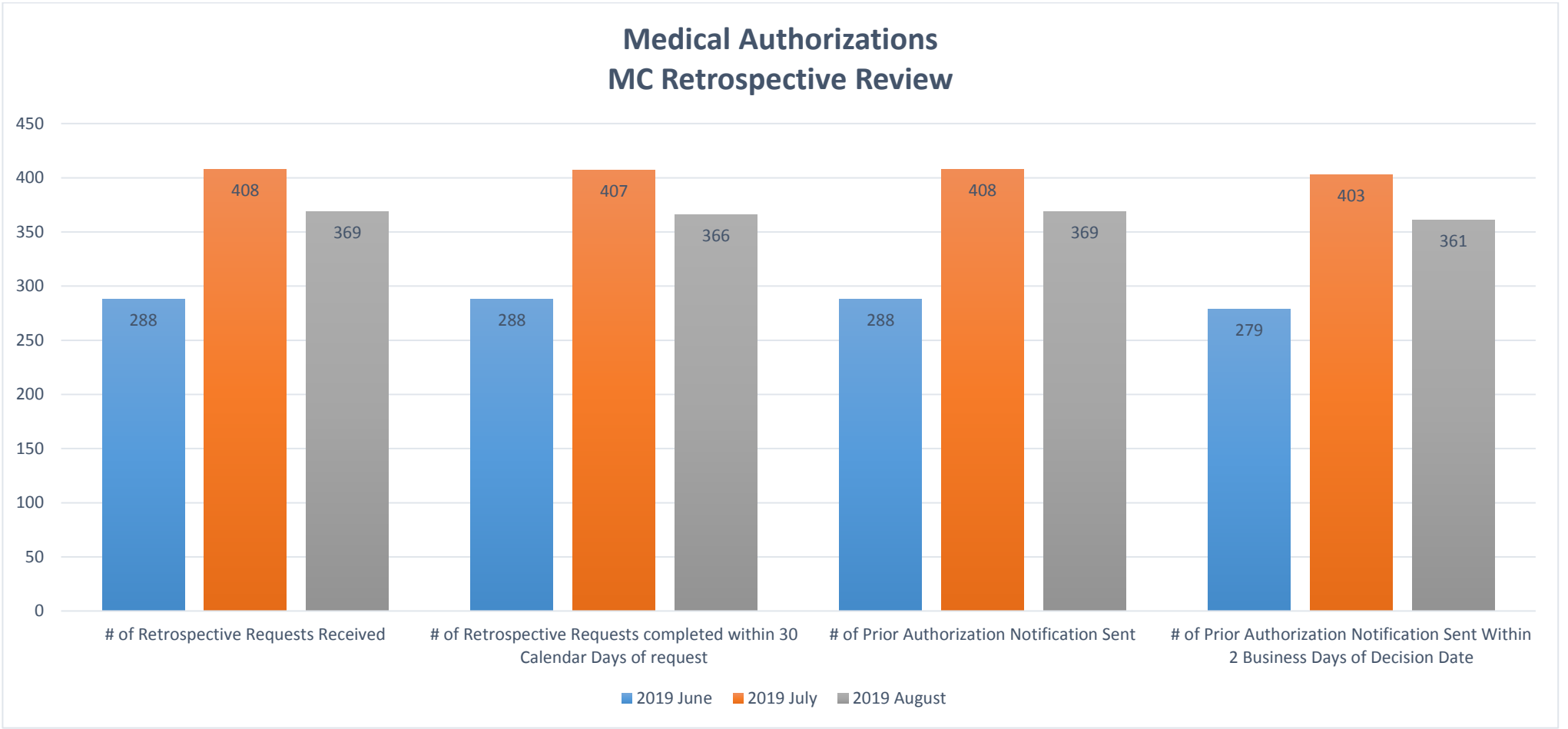

CMC Post Service Organization Determinations Timeliness
101%
100%
99%
98%
97%
96%
95%
94%
100%
100.0%
98.1%
96.6%
98.1%
96.2%
2019 June
2019 July
2019 August
% of Timely Decisions made within 30 days
% timely notification of HS decision

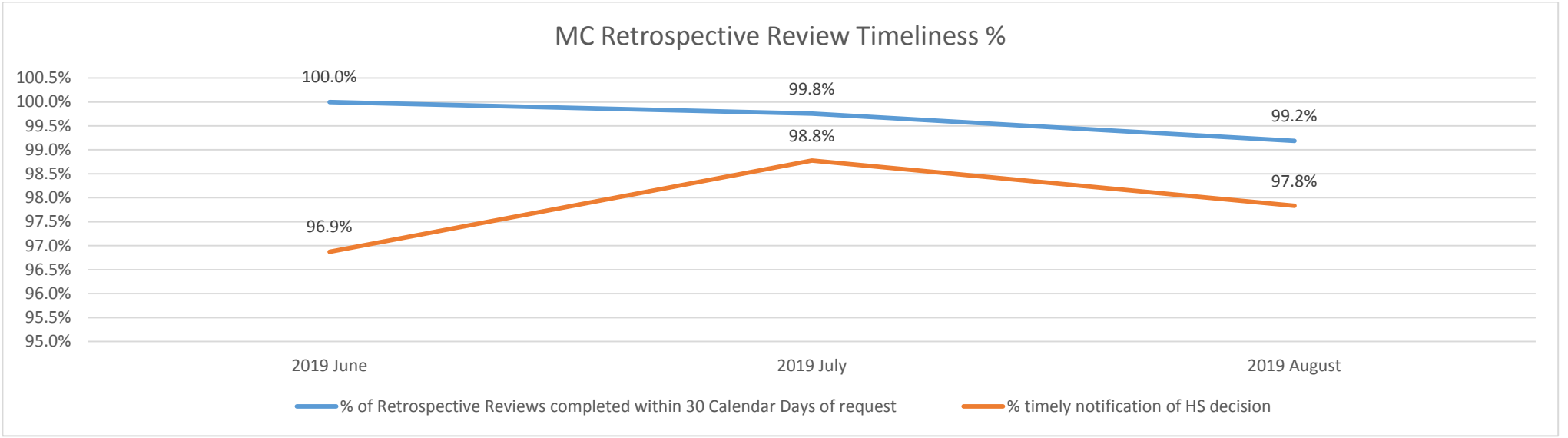

CMC Urgent Concurrent Orgnization Determinations
14
12
10
8
6
4
2
-
6
9
13
0
0
0
6
9
13
6
3
7
6
9
0.0%
6
4
0.0%
Approved
Denied
of Urgent Concurrent Requests Received
# of Urgent Concurrent Requests Completed within 24 Hours
# of Prior Authorization Notification Sent
# of Prior Authorization Notification Sent Within 24 hours
2019 June
2019 July
2019 August

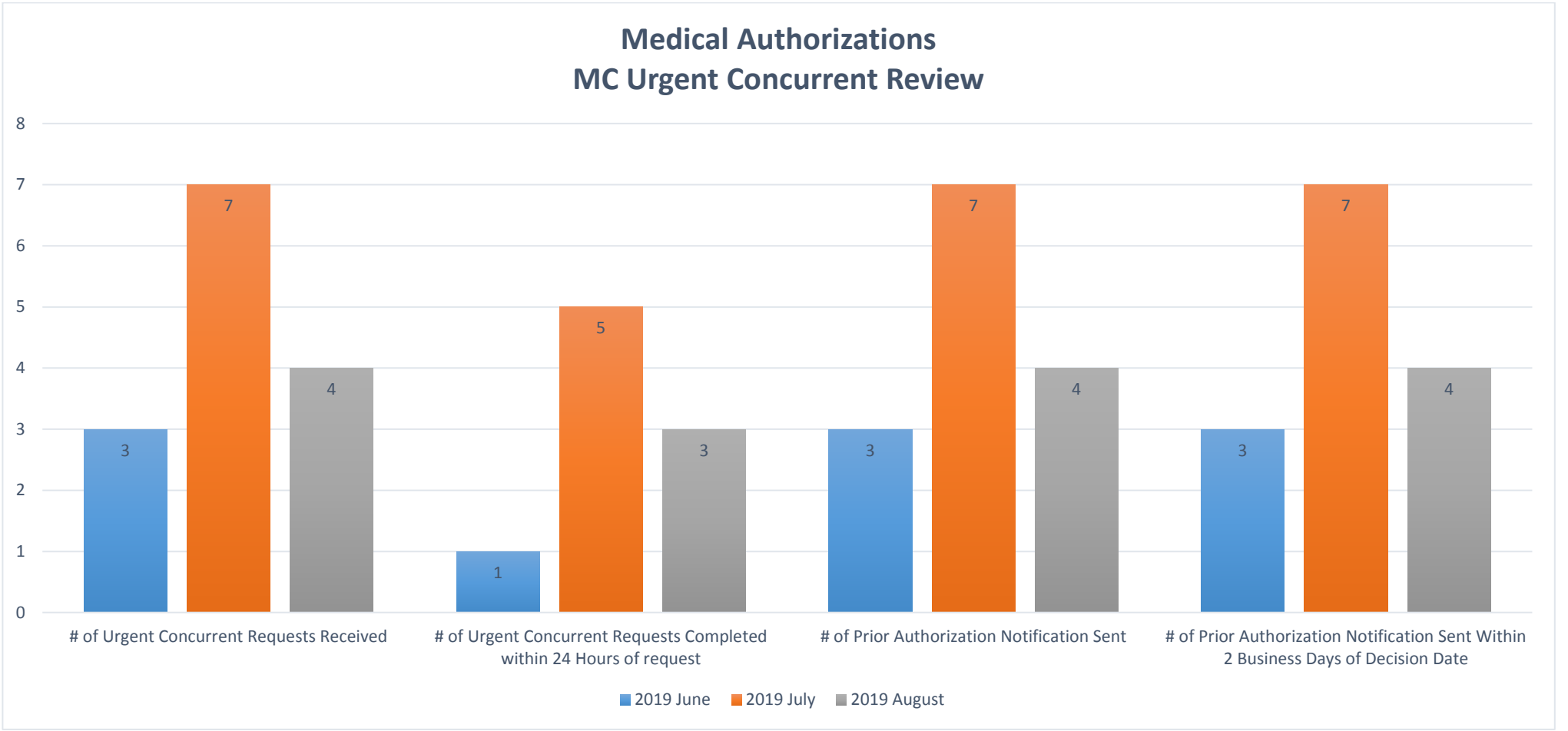

CMC Urgent Concurrent Organization Determinations Timeliness
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
2019 June
2019 July
2019 August
% of Timely Decisions made within 24 Hours
% timely notification of HS decision

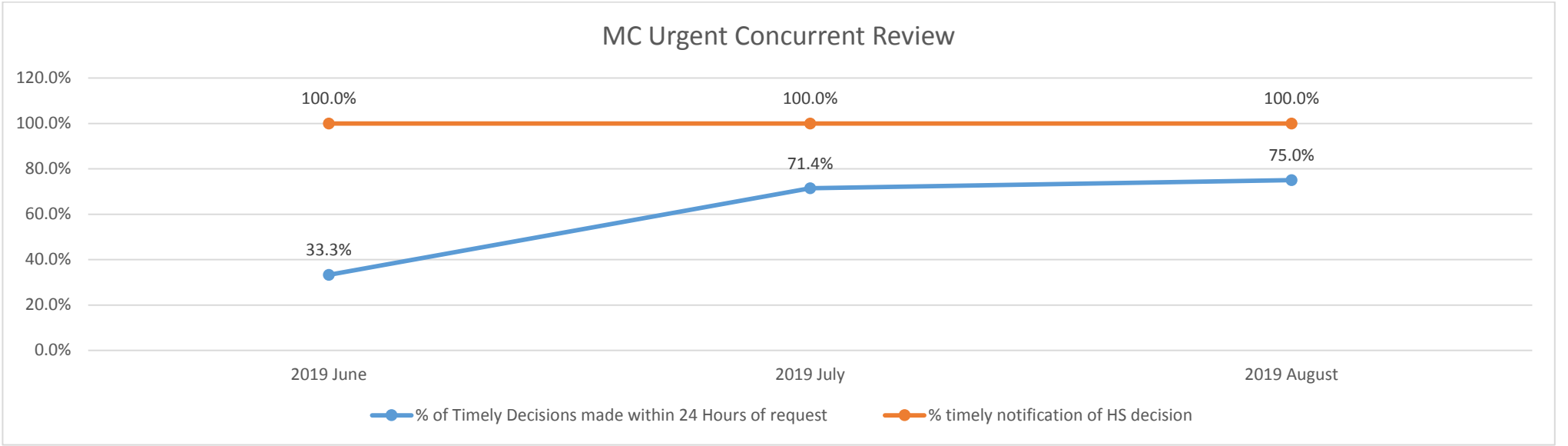

Medical Authorizations
MC Standard Authorizations
1,040
1,020
1,000
980
960
940
920
900
880
1,023
991
961
1,015
975
935
1,023
991
961
1,009
985
954
# of Routine Prior Authorization Requests Received
# of Routine Prior Authorization Requests Completed within 5 Business Days
# of Prior Authorization Notification Sent
# of Prior Authorization Notification Sent Within 2 Business Days of Decision Date
2019 June
2019 July
2019 August

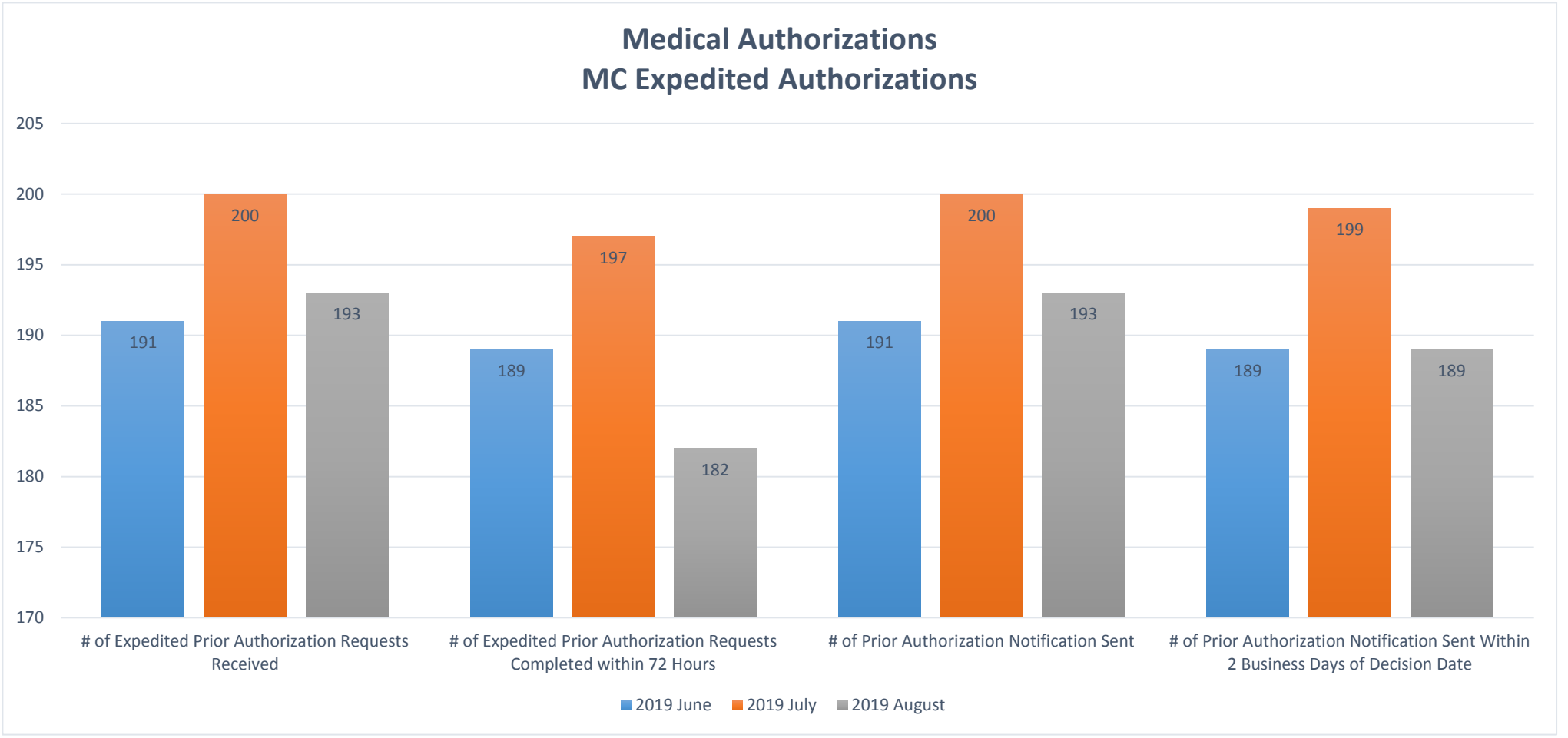

MC Standard Authorizations Timeliness %
100.0%
99.5%
99.0%
98.5%
98.0%
97.5%
97.0%
96.5%
96.0%
99.2%
98.6%
99.4%
98.4%
99.3%
97.3%
2019 June
2019 July
2019 August
% of Timely Decisions made within 5 Business Days of request
% timely notification of HS decision

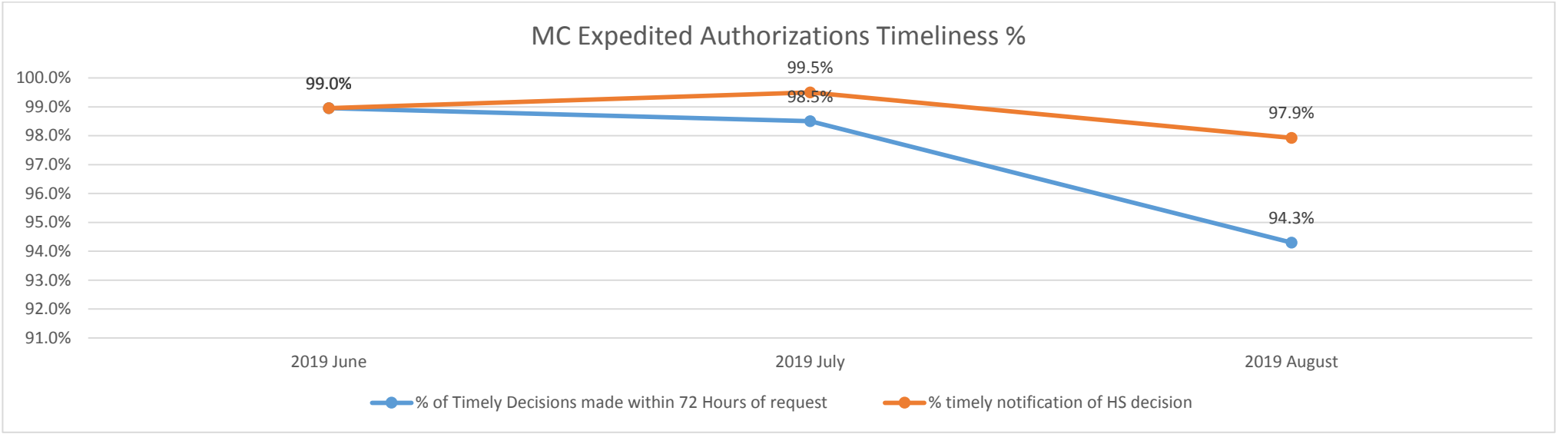

Medical Authorizations
MC Retrospective Review
450
400
350
300
250
200
150
100
50
0
288
408
369
288
407
366
288
408
369
279
403
361
# of Retrospective Requests Received
# of Retrospective Requests completed within 30 Calendar Days of request
# of Prior Authorization Notification Sent
# of Prior Authorization Notification Sent Within 2 Business Days of Decision Date
2019 June
2019 July
2019 August


MC Retrospective Review Timeliness %
100.5%
100.0%
99.5%
99.0%
98.5%
98.0%
97.5%
97.0%
96.5%
96.0%
95.5%
95.0%
100.0%
99.8%
99.2%
98.8%
97.8%
96.9%
2019 June
2019 July
2019 August
% of Retrospective Reviews completed within 30 Calendar Days of request
% timely notification of HS decision


Medical Authorizations
MC Urgent Concurrent Review
8
7
6
5
4
3
2
1
0
3
7
4
1
5
3
3
7
4
3
7
4
# of Urgent Concurrent Requests Received
# of Urgent Concurrent Requests Completed within 24 Hours of request
# of Prior Authorization Notification Sent
# of Prior Authorization Notification Sent Within 2 Business Days of Decision Date
2019 June
2019 July
2019 August


MC Urgent Concurrent Review
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
100.0%
100.0%
100.0%
71.4%
75.0%
33.3%
2019 June
2019 July
2019 August
% of Timely Decisions made within 24 Hours of request
% timely notification of HS decision


Medical Authorizations
MC Expedited Authorizations
205
200
195
190
185
180
175
170
191
200
193
189
197
182
191
200
193
189
199
189
# of Expedited Prior Authorization Requests Received
# of Expedited Prior Authorization Requests Completed within 72 Hours
# of Prior Authorization Notification Sent
# of Prior Authorization Notification Sent Within 2 Business Days of Decision Date
2019 June
2019 July
2019 August


MC Expedited Authorizations Timeliness %
100.0%
99.0%
98.0%
97.0%
96.0%
95.0%
94.0%
93.0%
92.0%
91.0%
99.0%
99.5%
98.5%
97.9%
94.3%
2019 June
2019 July
2019 August
% of Timely Decisions made within 72 Hours of request
% timely notification of HS decision

Santa Clara Family Health Plan™

Call Center Metrics

Medi-Cal UM Call Metrics

Santa Clara Family Health Plan

Medi-Cal Operations Dashboard - September 2019

Business Unit	Apr	May	Jun	Jul	Aug	Sept	Q1 2019	Q2 2019	Q3 2019	Q4 2019	YTD
CALL STATS											
UM Provider Queue											
# Calls Presented	2,192	2,142	1,798	2,010	2,146	2,045	5,922	6,132	6,201	-	18,255
Provider Average Speed of Answer in Seconds	47	36	29	26	28	42	17	24	32	37	30
Provider Average Hold Time in Seconds	21	28	14	14	17	16	31	30	30	21	19
# of Abandoned Provider Calls	97	92	62	46	61	60	71	251	167	-	489
Provider Abandonment Rate	4.4%	4.3%	3.45%	2.3%	2.84%	2.9%	1.4%	4.4%	3.3%	#DIV/0!	2.7%
Provider Service Level	76.0%	78.0%	80%	80.0%	81.0%	7200.0%	91.3%	76.0%	79.3%	#DIV/0!	84.0%
Average Talk Time	0:02:53	0:02:45	0:02:50	0:02:49	0:02:46	0:02:38	0:02:52	0:02:49	0:02:44	#DIV/0!	0:02:49

Cal MediConnect UM Call Metrics

Santa Clara Family Health Plan

8

Cal MediConnect Operations Dashboard - September 2019

Business Unit	Apr	May	Jun	Jul	Aug	Sept	Q1 2019	Q2 2019	Q3 2019	Q4 2019	YTD
CALL STATS											
Provider											
# Calls Presented	1,342	1,156	1,043	1,252	1,269	1,299	3,653	3,541	3,820	-	11,014
Provider Average Speed of Answer in Seconds	50	35	28	28	28	46	14	38	34	#DIV/0!	34
Provider Average Hold Time in Seconds	23	16	14	14	17	16	24	18	16	#DIV/0!	16
# of Abandoned Provider Calls	60	46	32	34	35	51	63	138	120	-	321
Provider Abandonment Rate	4.5%	4.0%	3.5%	2.7%	2.8%	3.9%	1.7%	3.9%	3.1%	#DIV/0!	2.9%
Total Provider Calls Handled	1264	1,102	1,008	1,216	1227	1,238	3,581	3,374	3,681	-	10,636
# of Provider Calls Handled in ≤ 30 seconds	1010	892	818	1,002	1,017	946	3,346	2,720	2,965	-	2,965
Provider Service Level	75.0%	77.0%	78.0%	80.0%	80.0%	73.0%	93.4%	80.6%	80.5%	#DIV/0!	27.9%
Average Talk Time	0:02:44	0:02:23	:02:50	0:02:49	0:02:46	0:02:38	0:02:32	0:02:33	0:02:44	#DIV/0!	0:02:44

Santa Clara Family Health Plan™

Quality Monitoring

Quarterly Quality Report in Accordance with Procedure HS.04.01 Quarter 3, 2019

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 4th 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 4th 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 Medi-Connect 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 interpretation services availability
        12. Member's letter includes nondiscriminatory notice.
        13. Provider notification includes the name and direct phone number of the appropriately licensed professional making the denial decision

III. Findings

A. For Q3 2019, the dates of services and denials for were pulled in October 2019.
   1. 30 unique authorizations were pulled with a random sampling.
      a. 50% or 15/30 Medi-Cal LOB and 50% or 15/30 CMC LOB
      b. 100% or 30/30 were denials
      c. 20% or 6/30 were expedited request; 80% or 24/30 were standard request.
         1. 100% or 6/10 of the expedited authorizations are compliant with regulatory turnaround time of 72 calendar hours
         2. 100% or 30/30 of the standard authorizations are compliant with regulatory turnaround time (5 business days for Medi-Cal LOB and 14 calendar days for CMC LOB)
      d. 100% or 30/30 are medical denials and or 0/30 are administrative denials
      e. 100% or 30/30 of cases were denied by MD
      f. 100% or 30/30 were provided member and provider notification.
      g. 75% or 3/4 expedited CMC authorizations were provided oral notifications to member.
      h. 100% or 30/30 of the member letters are of member's preferred language.
      i. 100% or 30/30 of the letters were readable and rationale for denial was provided.
      j. 100% or 30/30 of the letters included the criteria or EOC that the decision was based upon.
      k. 100% or 30/30 of the letters included interpreter rights and instructions on how to contact CMO or Medical Director.

IV. Follow-Up

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

1. The current medical management system which houses all authorization "QNXT" was upgraded on 9/8/19. As such, our current reporting was discovered to be negatively affected by the upgrade. However, based on this small sampling, it is reassuring to see excellent compliance with our regulatory standards.
2. The current quality assurance reports are also not functional because of the QNXT upgrades.
3. We have implemented weekly meetings with the IT team to initiate QA and changes needed in reporting. We expect these changes to be complete by 10/31/2019.
4. Only one authorization lacked follow up call. This will be monitored.
5. The results are complete and presented to the committee.

Santa Clara Family Health Plan™

Inter-Rater Reliability

Santa Clara Family Health Plan™

InterRater Reliability Summary – Behavioral Health Department
2019

1. In accordance with Policy HS.09, Santa Clara Family Health Plan (SCFHP) scheduled IRR testing is completed biannually. Behavioral Health Department IRR Testing for September 2019 is complete. This testing is required twice a year. IRR testing is scheduled for SCFHP 1st and 2nd half of the calendar year. In accordance with NCQA/DHCS, DMHC guidelines, and SCFHP policy, 10 random BH authorizations are selected to test BH staff with the authority to Authorize services. Our BH staff consists of non-licensed Personal Care Coordinators (PCC).
2. It is the policy of SCFHP to monitor the consistency and accuracy of review criteria applied by all reviewers - physicians and non-physicians - who are responsible for conducting Behavioral Health service reviews and to act on improvement opportunities identified through this monitoring.
3. The Chief Medical Officer or Manager of Behavioral Health will review and approve the assessment report of decision making performance of staff responsible for conducting Behavioral Health approval reviews for BH staff. The report results and recommendations for improvement will be presented annually to the Utilization Management Committee.
4. The Plan classifies reviews into one of two performance categories: Proficient (80% - 100% of the records are in compliance with the criteria); Not proficient (below 80% in compliance) Scores below 80% require increased focus by Supervisors/Managers with actions described in Policy/Procedure HS.09/HS.09.01 or an individual corrective action plan.

The following are the findings for all BH UM staff tested on Septermber 2019:

Reviewer	Percent Score	UM (BH) Staff Position	Pass/Failed
1	100	Manager Behavioral Health	Pass
2	100	Project Manager BHT	Pass
3	100	Behavioral Health PCC	Pass
4	100	Behavioral Health PCC	Pass
5	90	Behavioral Health PCC	Pass

In the testing, we found that 5/5 of our staff are proficient during this review. There was no need for any corrective action planning. The Project Manager for Behavioral Health Treatment has provided trainings to Behavioral Health staff to monitor and implement any necessary UM Chagnes.

Currently all Behavioral Health Department staff who are completing authorizations have received a passing grade.

Our common finding after the testing process was:

1. Staff who are currently authorized to review/approve BH services through SCFHP express comfort in knowing the process/where to go to for clarification.
2. Ongoing support throughout the department helps all performing UM functions to operate at an efficient level – all of those who completed BH IRR testing passed with 90-100% grading.

The corrective action's plan after identifying the common findings:

1. Mandatory remedial training with post testing for all non-proficient staff – Required.
    a. None necessary to Provide at this time
2. Mandatory bi-annual review of guidelines and criteria, as well as biannual testing, will continue to be scheduled for all staff who complete Behavioral Health Authorizations.

Santa Clara Family Health Plan™

InterRater Reliability Summary
2019 #2

1. In accordance with Policy HS.09, Santa Clara Family Health Plan (SCFHP) UM Staff scheduled and completed the second of two required Bi-Annual IRR testing sessions on 9/2019. The second IRR testing session is expected to be completed within the second half of calendar year 2019. In accordance with NCQA/DHCS, DMHC guidelines, and SCFHP policy, a total of 10 hypothetical UM authorizations are created for testing purposes for all of our Utilization Management (UM and MLTSS) staff, including non-licensed Care Coordinators (CC), licensed professional staff, and Medical Directors (MD).
2. The intent of the IRR testing process is to evaluate the consistency and accuracy of review criteria applied by all reviewers - physicians and non-physicians - who are responsible for conducting Utilization Management reviews and to act on improvement opportunities identified through this monitoring.
3. The Utilization Management Leadership team will review and approve the evaluation summary report reflecting the decision making performance of the staff responsible for conducting Utilization Management reviews. The report results and recommendations for improvement will be presented to the Utilization Management Committee.
4. The Plan classifies reviews into one of two performance categories: Proficient (80% - 100% of the records are in compliance with the criteria); Not proficient (below 80% in compliance) Scores below 80% require increased focus by UM Management with actions described in Policy HS.09 or a corrective action plan.

The following are the findings for all UM staff tested on:

Name	Position	Pass / Fail	%
1	CC	Pass	95.00%
2	CC	Pass	92.50%
3	CC	Pass	92.50%
4	CC	Pass	95.00%
5	CC	Pass	95.00%
6	CC	Pass	87.50%
7	CC	Pass	80.00%
a	Nursing	Fail	77.05%
b	Nursing	Fail	68.85%
c	Nursing	Pass	80.33%
d	Nursing	Fail	72.13%
e	Nursing	Pass	95.08%
f	Nursing	Pass	88.52%
x	Physician	Pass	90.48%
y	Physician	Pass	84.13%
z	Physician	Pass	95.24%

In the 2nd testing in 2019, we found that 100% of our staff that participated in the IRR testing.

3 Nursing staff had a score of <80% and the areas of failure were in mostly the identification of the TAT (5 business days for Medi-Cal, 14 Calendar days for CMC and 72 hours for urgent cases). Remediation was conducted on 10/3/2019. All care coordinator and nursing staff participated at below.

10/3/2019 Remediation		
ID	**Position**	**Sign In Sheet**
1	CC	Present
2	CC	Present
3	CC	Present
4	CC	Present
5	CC	Present
6	CC	Present
7	CC	Excused passed on Jury Duty
a	Nursing	Present
b	Nursing	Present
c	Nursing	Present
d	Nursing	Present
e	Nursing	Present
f	Nursing	Present

The staff were divided into two groups, all 10 cases and all elements were reviewed for staff.
All Care Coordinators and all Nursing staff questions were answered. Excellent discussion on the main teaching points occurred. Staff appreciative of peer and feedback.

Retesting will occur on the next scheduled IRR.

The one new staff from last IRR who had not completed the IRR testing, did complete it this time and passed.

This completed the 2019 IRR testing cycle.

Santa Clara Family Health Plan™

Behavioral Health UM Reports

Santa Clara Family Health Plan™

EPSDT
All Plan Letter

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: August 14, 2019

ALL PLAN LETTER 19-010
SUPERSEDES ALL PLAN LETTER 18-007 and 07-008

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: REQUIREMENTS FOR COVERAGE OF EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES FOR MEDI-CAL MEMBERS UNDER THE AGE OF 21

PURPOSE:
This All Plan Letter (APL) clarifies the responsibilities of Medi-Cal managed care health plans (MCPs) to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to eligible members under the age of 21. This policy applies to all members under the age of 21 enrolled in MCPs. This guidance is intended to reinforce existing state and federal laws and regulations regarding the provision of Medi-Cal services, including EPSDT, and does not represent any change in policy.

BACKGROUND:
In 1967, Congress expanded the Medicaid benefit for children with the creation of the EPSDT benefit. The EPSDT benefit is set forth in the Social Security Act (SSA) Section 1905(r) and Title 42 of the United States Code (USC) Section 1396d.[1, 2] The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in Medi-Cal. According to guidance from the Centers for Medicare and Medicaid Services (CMS), titled *EPSDT — A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014) on page 1, "The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it—the right care to the right child at the right time in the right setting."[3]

Under the EPSDT benefit, states are required to provide any Medicaid-covered service listed within the categories of mandatory and optional services in the SSA Section

[1] SSA Section 1905 is available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
[2] 42 USC Section 1396d is available at: http://uscode.house.gov/view.xhtml?req=(title:42%20section:1396d%20edition:prelim
[3] *EPSDT — A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* is available at: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf

1905(a), regardless of whether such services are covered under California's Medicaid State Plan, for members who are eligible for EPSDT services when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

The SSA Section 1905(r) and Title 42 of the USC Section 1396d(r) defines EPSDT services as follows:

> (r) Early and periodic screening, diagnostic, and treatment services
> The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:
>
> (1) Screening services—
>
> (A) which are provided—
>
> (i) at intervals which meet reasonable standards of medical and dental practice, as determined by the state after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines, and
>
> (ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and
>
> (B) which shall at a minimum include—
>
> (i) a comprehensive health and developmental history (including assessment of both physical and mental health development),
>
> (ii) a comprehensive unclothed physical exam,
>
> (iii) appropriate immunizations (according to the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history,
>
> (iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and
>
> (v) health education (including anticipatory guidance).
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> (2) Vision services—
>
> (A) which are provided—
>
> (i) at intervals which meet reasonable standards of medical practice, as determined by the state after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services—

(A) which are provided—

(i) at intervals which meet reasonable standards of dental practice, as determined by the state after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services—

(A) which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the state after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan.

<u>Bright Futures Periodicity Schedule and Guidelines for Pediatric Preventive Care</u>

The Patient Protection and Affordable Care Act (ACA) specified that coverage of preventive care and screenings must be conducted with evidence-informed, comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), which is an agency of the United States Department of Health

and Human Services.[4] HRSA participated in the development of, and provides ongoing support to, the national health promotion and prevention initiative known as Bright Futures, which is led by the American Academy of Pediatrics (AAP). The AAP develops theory-based and evidence-based guidance and recommendations for preventive care screenings and well-child visits for children and regularly publishes updated tools and resources for use by clinicians and state agencies. These tools include the "Bright Futures Guidelines" and the "Recommendations for Preventive Pediatric Health Care," which is also known as the "periodicity schedule." The periodicity schedule indicates specific preventive screenings and procedures that are to be provided to children at age-specific periodic intervals specific ages from birth through age 21.[5]

EPSDT in California

For members under age 21, MCPs must provide a more robust range of medically necessary services than they do for adults that include standards set forth in federal and state law. This includes the contractual obligation to provide the EPSDT benefit in accordance with the AAP/Bright Futures periodicity schedule.[6]

The EPSDT benefit in California is established in the Medi-Cal Schedule of Benefits set forth in Welfare and Institutions Code (WIC) Section 14132(v), which states that, "Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code."[7]

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[4] See Title 1 of the ACA, Part A, Subpart II—Improving Coverage, SEC.2713. Coverage of Preventive Health Services. The ACA is available at: https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

[5] For more information about the AAP/Bright Futures initiative, and to view the most recent periodicity schedule and guidelines, go to https://brightfutures.aap.org/Pages/default.aspx. Additional information on the periodicity schedule is available at: https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx

[6] MCP Contracts, Exhibit A, Attachment 10, Services for Members under Twenty-One (21) Years of Age. Current MCP contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. The forthcoming 2017 Final Rule contract amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018) clarifies that the AAP guidelines and periodicity schedule specifically means Bright Futures guidelines and recommendations. To date the amendment is pending approval by CMS.

[7] WIC Section 14132 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14132.

WIC Section 14059.5 was amended, effective January 1, 2019, to define medical necessity for EPSDT services and included the following requirements:[8]

> (a) For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
>
> (b)(1) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.
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> (2) The department and its contractors shall update any model evidence of coverage documents, beneficiary handbooks, and related material to ensure the medical necessity standard for coverage for individuals under 21 years of age is accurately reflected in all materials.

REQUIREMENTS:
The EPSDT benefit includes the specific services listed above in Title 42 of the USC Section 1396d(r). For members under the age of 21, MCPs are required to provide and cover all medically necessary EPSDT services, defined as any service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of the MCP's contract, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Additional services must be provided if determined to be medically necessary for an individual child.[9]

Medical necessity decisions are individualized. Flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements.

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[8] WIC Section 14059.5 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14059.5.
[9] *EPSDT — A Guide for State: Coverage in the Medicaid Benefit for Children and Adolescents*, pages 23 and 24.

Therefore, MCPs are prohibited from imposing service limitations on any EPSDT benefit other than medical necessity. The determination of whether a service is medically necessary or a medical necessity for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child.

Pursuant to WIC Section 14059.5(b)(1), for individuals under 21 years of age, a service is considered "medically necessary" or a "medical necessity" if the service meets the standards set forth in federal Medicaid law for EPSDT (Title 42 of the USC Section 1396d(r)(5)). Therefore, an EPSDT service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services. MCPs must apply this definition when determining if a service is medically necessary or a medical necessity for an EPSDT eligible member.

MCPs must use the current AAP/Bright Futures periodicity schedule and guidelines when delivering the EPSDT benefit, including but not limited to screening services, vision services, and hearing services. MCPs must provide all age-specific assessments and services required by the MCP contract and the AAP/Bright Futures periodicity schedule. However, this does not alleviate MCPs of their responsibility to provide any medically necessary EPSDT services that exceed those recommended by AAP/Bright Futures.

All members under the age of 21 must receive EPSDT preventive services, including screenings, designed to identify health and developmental issues as early as possible. MCPs must provide members with appropriate referrals for diagnosis and treatment without delay. MCPs are also responsible for ensuring EPSDT members have timely access to all medically necessary EPSDT services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

In addition, MCPs must comply with the Americans with Disabilities Act mandate to provide services in the most integrated setting appropriate to members and in compliance with anti-discrimination laws.[10, 11]

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[10] *Olmstead v. L.C.* (1999) 527 U.S. 581. Decisions from the Supreme Court of the United States are available at: https://www.supremecourt.gov/

[11] California Government Code (GOV) Section 11135. GOV Section 11135 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=11135.&lawCode=GOV

Behavioral Health Treatment

MCPs are responsible for providing medically necessary Behavioral Health Treatment (BHT) services, consistent with the requirements in this APL, for eligible members under the age of 21.[12]

Member Information, Case Management/Care Coordination, and Transportation

Consistent with the MCP contract, MCPs must ensure the provision of Comprehensive Medical Case Management services, including coordination of care for all medically necessary EPSDT services delivered both within and outside the MCP's provider network. MCPs are also responsible for the coordination of carved-out and linked services and referral to appropriate community resources and other agencies, regardless of whether the MCP is responsible for paying for the service.[13]

MCPs must also ensure the coverage of Targeted Case Management (TCM) services.[14] MCPs are responsible for determining whether an EPSDT member requires TCM services and must refer members who are eligible for TCM services to a Regional Center (RC) or local governmental health program, as appropriate for the provision of TCM services. If the ESPDT member is receiving TCM services, the MCP is responsible for coordinating the member's health care with the TCM provider and for determining the medical necessity of diagnostic and treatment services that are covered under the MCP's contract that are recommended by the TCM provider. If the MCP determines that an EPSDT member is not accepted for TCM services, the MCP must ensure that the member's access to services are comparable to EPSDT TCM services.

MCPs are also required to provide appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation (NMT) to and from medical appointments for the medically necessary EPSDT services they are responsible for providing pursuant to their contracts with DHCS.[15] Consistent with the requirements in APL 17-010, MCPs must provide NMT for all medically necessary EPSDT services, including those services that are carved-out of the MCP's contract. MCPs are also required to establish procedures for members to obtain necessary transportation services.

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[12] For more information on BHT, see APL 18-006, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, or any future iterations of this APL. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

[13] MCP contracts, Exhibit A, Attachment 11, Comprehensive Case Management Including Coordination of Care Services.

[14] MCP contracts, Exhibit A, Attachment 11, Targeted Case Management Services

[15] For more information on transportation, see APL 17-010, Non-Emergency Medical and Non-Medical Transportation Services, or any future iterations of this APL.

MCPs must effectively inform EPSDT members or their families/primary caregivers about EPSDT, including the benefits of preventive care, the services available under EPSDT, where and how to obtain these services, and that necessary transportation and scheduling assistance is available. In addition to existing requirements for the provision of the Evidence of Coverage to members, this information must be provided annually to EPSDT members or their families/primary caregivers who have not accessed EPSDT services.[16] MCPs have a responsibility to provide health education, including anticipatory guidance, to members under age 21 and to their parents or guardians in order to effectively use those resources, including screenings and treatment.[17, 18] This information must be provided in the member's primary language at a sixth grade reading level as required in the MCP contract and APL 17-011, Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act, and APL 18-016, Readability and Suitability of Health Education Materials, including future iterations of these APLs.

Certain Carved-Out Services

For members under the age of 21, MCPs are required to provide and cover all medically necessary EPSDT services except those services that are specifically carved out of the MCP's contract and not included in the MCP's capitated rate. Carved-out services vary and can include, but are not limited to, California Children's Services (CCS), dental services, Specialty Mental Health Services, and Substance Use Disorder Services. This portion of the APL is not intended to address all carved-out services; however, DHCS is providing necessary clarification to MCPs below specific to CCS and dental services for when these services are carved-out of the MCP's contract.

California Children's Services

Most MCP contracts carve-out coverage for CCS-covered conditions. If an EPSDT eligible child is a member of an MCP, and the MCP's contract carves out coverage for CCS-eligible conditions, then the child may obtain treatment related to the CCS-eligible condition from CCS if the child enrolls in CCS.

Once the MCP has adequate diagnostic evidence that a member has a CCS-eligible condition, the MCP must refer the member to the local county CCS office for determination of eligibility. Until the member's CCS eligibility is confirmed by the local CCS program, and the medically necessary services are being provided under the CCS program, the MCP remains responsible for the provision of all medically necessary

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[16] Title 42 of the Code of Federal Regulations (CFR) Section 441.56. 42 CFR Part 441 is available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=d52504d844298122c9f25162843f660d&mc=true&n=pt42.4.441&r=PART&ty=HTML

[17] 42 USC Section 1396d(r)(1)(B)(v)

[18] *EPSDT — A Guide for State: Coverage in the Medicaid Benefit for Children and Adolescents*, page 4.

EPSDT services. It is part of the MCP's case management obligation to communicate with the county CCS program to ensure that the member's care needs are continuously met and to arrange for the member's EPSDT services when the county CCS program is not doing so.

Dental Services
Although dental services are carved-out of MCP contracts, the contract requires MCPs to cover and ensure that dental screenings/oral health assessments for all members are included as a part of the initial health assessment. For members under the age of 21, a dental screening/oral health assessment must be performed as part of every periodic assessment, with annual dental referrals made no later than 12 months of age or when referral is indicated based on assessment. Fluoride varnish and oral fluoride supplementation assessment and provision must be consistent with the AAP/Bright Futures periodicity schedule and anticipatory guidance. MCPs must also ensure that members are referred to appropriate Medi-Cal dental providers.

Additionally, MCPs must cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists, but may require prior authorization for medical services required in support of dental procedures.[19]

<u>Coordinating with Other Outside Entities Responsible for Providing EPSDT Services</u>
Where another entity, such as a Local Education Agency (LEA), RC, or local governmental health program, has overlapping responsibility for providing services to a member under the age of 21, MCPs must do the following:

- Assess what level of EPSDT medically necessary services the member requires,
- Determine what level of service (if any) is being provided by other entities, and
- Coordinate the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services, and that the child is receiving all medically necessary EPSDT services in a timely manner.

MCPs have the primary responsibility to provide all medically necessary EPSDT services, including services which exceed the amount provided by LEAs, RCs, or local governmental health programs. However, these other entities must continue to meet their own requirements regarding provision of services. MCPs should not rely on LEA programs, RCs, CCS, the Child Health and Disability Prevention Program, local governmental health programs, or other entities as the primary provider of medically necessary EPSDT services.

[19] For more information, see APL 15-012, Dental Services – Intravenous Sedation and General Anesthesia Coverage, or any future iterations of this APL.

The MCP is the primary provider of such medical services except for those services that have been expressly carved-out. MCPs are required to provide case management and coordination of care to ensure that EPSDT members can access medically necessary EPSDT services as determined by the MCP provider. For example, when school is not in session, MCPs must cover medically necessary ESPDT services that were being provided by the LEA program when school was in session.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. MCPs must communicate these EPSDT requirements to all delegated entities and subcontractors. MCPs must ensure that all of their own policies and procedures, as well as the policies, procedures, and practices of any delegates, subplans, contracted providers, or subcontracted Independent Physician Associations or medical groups, comply with these EPSDT requirements and this APL.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's policies and procedures, the MCP must submit its updated policies and procedures to its Managed Care Operations Division (MCOD) contract manager within 30 days of the release of this APL. If an MCP determines that no changes to its policies and procedures are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 30 days of the release of this APL, stating that the MCP's policies and procedures have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

DHCS, in concert with the Department of Managed Health Care, will monitor MCPs for compliance with these requirements. Failure to comply with the requirements contained in this APL may result in a corrective action plan, and/or administrative and financial sanctions,[20] as provided for under the terms of the MCP contracts and any applicable APL and state or federal statutes and regulations, including but not limited to Title 22 of the California Code of Regulations Sections 53350, 53352, and 53860.

[20] For more information, see APL 18-003, titled Administrative and Financial Sanctions, or any future iterations of this APL.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Santa Clara Family Health Plan™

Behavioral Health Metrics

Behavioral Health- Medi-Cal

Quarter 3 2019

Behavior Health and Mental Health	Jul	Aug	Sept	Q3 2019	YTD
# Receiving BHT Benefits	189	175	197	**197**	**175**
# Receiving Mental Health Benefits (SCFHP, VHP, Kaiser)	-	-	-	**unavailable**	**unavailable**
# Receiving SCFHP Case Management	6	2	20	**20**	**2**
Mild to Moderate Referrals	1	8	6	**6**	**16**

Behavioral Health- CMC

Quarter 3 2019

Behavior Health	Source of Info	Jul	Aug	Sept	Q3 2019	YTD
# Behavioral Health - County Mental Health	County Mental Health	-	-	-	**unavailable**	**unavailable**
# Behavioral Health - SCFHP	BHCM	63	40	33	**33**	**40**
Opt outs of SCFHP Case Management	BHCM	4	4	7	**7**	**4**
Mild to Moderate Referrals	County Mental Health	4	0	0	**-**	**-**