Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, January 15, 2020, 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.	**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	6:35	5 min
3.	**Meeting Minutes** Review minutes of the Q4 October 16, 2019 Utilization Management Committee (UMC) meeting **Possible Action:** Approve Q4 2019 UMC Meeting Minutes	Dr. Lin	6:40	5 min
4.	**Chief Executive Officer Update** Discuss status of current topics and initiatives	Ms. Tomcala	6:45	10 min
5.	**Chief Medical Officer Update** **a.** General Update	Dr. Nakahira	6:55	10 min
6.	**Old Business/Follow-Up Items** **a.** General Old Business **b.** Medical Covered Services Prior Authorization Grid	Dr. Boris	7:05	10 min
7.	**UMC Meeting Calendar – 2020** Consider the proposed UMC meeting calendar **Possible Action:** Approve UMC Meeting Dates as presented	Dr. Boris	7:15	5 min
8.	**UM Program Description - 2020** Annual review of UM Program Description **Possible Action:** Approve UM Program Description as presented	Dr. Boris	7:20	5 min
9.	**Annual Review of UM Policies** **a.** HS.02 Medical Necessity Criteria **b.** HS.03 Appropriate Use of Professionals **c.** HS.04 Denial of Services Notification **d.** HS.05 Evaluation of New Technology **e.** HS.06 Emergency Services **f.** HS.07 Long-Term Care Utilization Review **g.** HS.08 Second Opinion **h.** HS.09 Inter-Rater Reliability	Dr. Boris	7:25	5 min

i. HS.10 Financial Incentive
j. HS.11 Informed Consent
k. HS.12 Preventive Health Guidelines
l. HS.13 Transportation Services
Possible Action: Approve UM Policies as presented

10. New UM Policy **a.** HS.14 System Controls **Possible Action:** Approve new UM Policy as presented	Dr. Boris	7:30	5 min
11. Reports **a.** Membership **b.** Standard Utilization Metrics **c.** Dashboard Metrics • Turn-Around Time – Q4 2019 • Call Center – Q4 2019 **d.** Quarterly Referral Tracking – Q4 2019 **e.** Quality Monitoring of Denial Letters (HS.04.01) – Q4 2019 **f.** Referral Tracking System (HS.04.02) - 2019 **g.** Physician Peer-to-Peer (HS.02.02) - 2019 **h.** Behavioral Health UM	Dr. Boris Ms. McKelvey	7:35 7:50	15 min 10 min
12. Adjournment Next meeting: Wednesday, April 15, 2020 at 6:30 p.m.	Dr. Lin	8:00	

Notice to the Public—Meeting Procedures

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

Utilization Management Committee

Meeting Minutes

October 16, 2019

Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

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

MINUTES - Draft

Members Present
Ali Alkoraishi, MD, Psychiatry Specialist
Dung Van Cai, MD, OB/GYN Specialist
Ngon Hoang Dinh, DO, Head & Neck Surgery
Jimmy Lin, MD, Internal Medicine, Chairperson
Habib Tobbagi, MD, PCP, Nephrology Specialist
Indira Vemuri, Pediatric Specialist

Staff Present
Lily Boris, MD, Medical Director
Angela Chen, Manager, Utilization Management
Dang Huynh, Director, Pharmacy
Natalie McKelvey, Manager, Behavioral Health
Amy O'Brien, Administrative Assistant
Luis Perez, Supervisor, Utilization Management
Divya Shah, Health Educator

Members Absent
Laurie Nakahira, DO, Chief Medical Officer

Staff Absent
Christine Tomcala, CEO

1. Introduction

Dr. Jimmy Lin, Chair, called the meeting to order at 6:33 pm. Roll call was taken and a quorum was established. Absent this evening were Laurie Nakahira, DO, Chief Medical Officer and Christine Tomcala, CEO.

Dr. Boris introduced Angela Chen, Manager of Utilization Management as a new member of the Committee. Dr. Boris also introduced Divya Shah, Health Educator, and Dang Huynh, Director of Pharmacy as guest speakers for this evening.

2. Review and Approval Meeting Minutes

The Minutes of the July 17, 2019 Utilization Management Committee meeting were reviewed.

> It was **moved, seconded, and** the Minutes of the July 17, 2019 Utilization Management Committee meeting were **unanimously approved.**

3. Public Comment

There were no public comments.

4. CEO Update

There was no CEO update, as Ms. Tomcala was absent this evening.

5. CMO Update

Dr. Boris gave the following CMO update on behalf of Dr. Nakahira:

a. General Update

Dr. Boris advised SCFHP has been in active participation with California Home Medical Equipment (CHME), and their contract with SCFHP will be terminated, effective December 31, 2019. SCFHP has been transitioning their services. A list of vendors will be uploaded to the website. Dr. Boris advised if there are specific Members that are of concern while the Plan transitions through this process, SCFHP will ensure our UM team reaches out to them. SCFHP has identified all the Members in need of vent and oxygen supplies, and enteral supplies, and most of those Members have already been transitioned to other vendors. Dr. Boris stated the biggest item will probably be in regards to DME repairs.

Dr. Vemuri expressed concerns specific to conflicting information between Shield and CHME. Dr. Boris confirmed SCFHP is using Shield at the present time, and, in an effort to make it seamless for Providers and patients, SCFHP has been transitioning members to Shield. Dr. Boris requested Dr. Vemuri forward her any cases where conflicts in services have occurred, and she is happy to follow-up on those cases.

As of October 1, 2019, Healthy Kids transitioned to Medi-Cal. At present, there are only 2 remaining Members in the Healthy Kids program. For those 2 Members, SCFHP is continuing coverage through the end of December 2019.

b. Update – Completion of CMS IVA Audit

SCFHP finished their audits with their regulators. One report is pending. The CMS IVA audit report came back with some corrective action plans (CAPs).

Dr. Boris opened the floor to questions. Dr. Alkaroishi asked for clarification on which agency is absorbing the Healthy Kids program. Dr. Boris reiterated that the Healthy Kids program is transitioning to Medi-Cal. Dr. Lin requested clarification on the demographics of the Healthy Kids population. Dr. Boris stated she does not have the appropriate data available on the demographics particular to this program.

Dr. Ngon Hoang Dinh and Dr. Ali Alkoraishi arrived at 6:50 p.m.

6. Old Business/Follow-Up Items

Presented by Dr. Boris.

b. Post Bariatric Surgery Update

Per the Committee's request, SCFHP looked at all the Members who had bariatric surgery during the period of 1/1/2017 – 8/1/2019. Medi-Cal had the highest number of Members who received bariatric surgery for a total of 126 Members. By network, Net 20, which is Valley Health Plan, had the most Members who received bariatric surgery, and Net 40, Palo Alto Medical Foundation, had the fewest. There were no bariatric surgeries for Net 6, which is Premier Care. In the Cal Medi-Connect program, only 6 Members received bariatric surgery, for a total number of 132 Members who received a bariatric surgery procedure.

The average age of the recipients is age 42. Of these 87% of the recipients were female, and 13% of the recipients were male. Dr. Boris also conducted a small sampling of pre-op and post-op BMIs. In the pre-op category, the highest BMI was 55, and the lowest BMI was 42. In the post-op category, the lowest BMI was 34, and the highest BMI was 55. It appears the most rapid weight loss occurred early on in the weight loss process.

c. Bariatric CME Request

A Bariatric CME request has been forwarded to the Provider Network Management Team.

d. MCG S-516: Gastric Restrictive Procedures, Sleeve Gastrectomy, by Laparoscopy

The MCG is provided to the committee. Dr. Boris included the most common procedure which is a restrictive laparoscopic sleeve gastrectomy, along with the MCG criteria.

e. How to Access Health Education Handout

Dr. Boris introduced Divya Shah to talk about health education. Ms. Shah summarized how members can enroll in our health education programs, and she provided an overview of the different health-related topics available to Members. Members can self-refer to all programs. They can enroll either via the Customer Service line; via an email to the Health Education department; through the online Member portal; and/or their physician(s) can refer them to health education programs.

f. Health Education Materials and Classes for Members

Ms. Shah summarized some of the classes and workshops available; such as, classes for chronic disease management; counseling for stress and anger management services; fitness membership programs; nutrition and weight management, which includes Weight Watchers; parenting education; prenatal education; our car seat safety program; and smoking cessation classes. For the Weight Watchers program, SCFHP asks Members to complete a trial period, and we provide them with 3 vouchers to try out 3 different sessions of the program. Members are asked for their weight loss tracking sheets to confirm their attendance. Additional vouchers are then sent to cover the next 10 weeks' worth of meetings. Dr. Vemuri inquired as to whether or not Providers can refer their patients to this program. Ms. Shah confirmed Providers just need to complete the 'Health Education Referral' form, available on our website under the Provider section. Once SCFHP receives the form, we follow-up with the Member.

g. Language Assistance Contact Information

Ms. Shah summarized SCFHP's draft of our 'Interpreting Services Reference Guide' which was compiled specifically for our Providers. Once this guide has been finalized, the information will be posted on the SCFHP website as part of our cultural competency toolkit. This information will also be fax blasted to all Providers. Ms. Shah then summarized how to use and access the California Relay services (CA/TTY). Ms. Shah also gave an overview on how to schedule an in-person interpreter. Dr. Lin inquired as to how many Providers use these services. Dr. Boris advised there are a significant number of Providers who request and use the in-person interpreting services. The usage of this particular service is across the board for all facilities; it is not specific to only one facility. Members can also request these services. Dr. Boris advised that if any of our Providers experience an issue with the telephone interpreting services, please send an email to 'quality@scfhp.com', and we will contact our vendor to request they provide their interpreters with additional training. This concluded Ms. Shah's health education presentation.

Divya Shah exited the meeting at 7:00 p.m.

7. Action items

Presented by Dr. Boris.

a. Policy Update: HS.01 Prior Authorization

Dr. Boris advised SCFHP was requested to update policy HS.01 Prior Authorization. Dr. Boris explained that SCFHP added some additional managed-care language which states that SCFHP will arrange for all medically necessary Medi-Cal and Medicare covered services, and to ensure these services are provided in an amount no less than what is offered to Members under fee-for-service. We also added verbiage that the Plan will establish procedures for authorization requirements respective to medically necessary enteral nutrition products or formulas.

b. Medical Covered Services Prior Authorization (PA) Grid and Medical Benefit PA Grid

Dr. Boris presented the 2020 'Medical Covered Services Prior Authorization Grid.' The Plan added some clarifying verbiage respective to hearing aids repairs, as well as requests over the benefit limit. In addition, reference to IMRT was removed, as it has now become the standard of care for most cancer treatments.

Dr. Boris then introduced Dang Huynh to discuss the 2020 'Medical Benefit Drug Prior Authorization Grid'. Dr. Huynh explained one of the main changes to this grid includes the change from 'MCG: MCG Health Care Guidelines', to 'PA: Prior Authorization'. The Plan still utilizes MCG; however, it is clearer to state 'Prior Authorization', as, when MCG is not available, there is a hierarchy of coverage determination criteria. Otherwise, items in yellow denote new verbiage or terms, and items in red denote deletions. Drugs that are not currently included on this grid, but recommended to add were Zolgensma for spinal muscular atrophy, and Xembify, an IVIG. This concludes Dr. Huynh's presentation.

Dr. Lin initiated a discussion regarding the cost of immunotherapy and asked how the State accounted for the costs of some of these drugs. Dr. Boris advised that if a child has a CCS-eligible condition, that cost is carved out to CCS, and the Plan does not see the cost. Dr. Boris reminded them that the medications on our 2020 grid are specific to medications submitted for prior authorization to the UM department, and not through pharmacy outpatient benefit.

A motion was called to approve the revised Policy HS.01 Prior Authorization, and the 'Medical Covered Services Prior Authorization Grid' along with the 'Medical Benefit Prior Authorization Grid'. **It was moved, seconded, and** the revised Policy HS.01 Prior Authorization, the Medical Covered Services Prior Authorization Grid, and the Medical Benefit Prior Authorization Grid were all **unanimously approved.**

8. Reports

Presented by Dr. Boris on behalf of Dr. Nakahira.

a. Membership Reports

Dr. Boris advised the Membership report covers April 2019 through September 2019. At that time, the Plan had 3,512 Healthy Kids Members; 234,478 Medi-Cal Members; and 8,194 Cal Medi-Connect Members. Our total membership as of September 2019 was 246,184 Members. As of October 1, 2019 there will only be 2 Healthy Kids Members, as the remainder will transition to Medi-Cal.

b. Standard Utilization Metrics

Dr. Boris next briefly summarized the Standard Utilization Metrics. Dr. Boris explained the Plan was unable to produce an inpatient readmission report, as the Medi-Cal formula utilized a tool called All Cause Readmissions, which is a different formula used to determine readmissions. Medi-Cal now uses Plan All-Cause Readmissions, and we are going through our data to align with Medi-Cal. We hope to have the report for the next UMC meeting in January. The plan will have the final HEDIS for the end of the year presented at the next UMC meeting in January.

c. Hospital Specific Metrics: Readmission

Dr. Boris next summarized the Hospital Specific Metrics. The Plan looked at Plan All-Cause Readmissions for Medi-Cal by network, by hospital from 1/1/2018-4/29/2019. Total numerator and denominator and percentage of readmissions were used to calculate the data. Zero represents people with MediCare primary and Medi-Cal secondary. 10 is what SCFHP maintains, which is about 19%; 20 represents Valley Health Plan at 18%; Kaiser is relatively low by comparison. Network 50 is PMG and Network 60 is Premier Care. The largest volume of admissions and readmissions was at Valley Health Plan; however, they also have the largest population.

For Medi-Cal and Medi-Care the hospital with the highest rate of readmissions is Santa Clara Valley Medical Center; Regional Medical Center has the second highest rate of readmissions. The numbers do differ from Medi-Cal versus Cal Medi-Connect. On the lower end of the readmissions spectrum is O'Connor Hospital.

By diagnoses, the number 1 diagnosis that leads to the highest number of Plan All-Cause Readmissions is Sepsis. The diseases with next highest number of Plan All-Cause Readmissions are Hypertensive Heart Disease with heart failure; Chronic Kidney Disease; Sepsis specific to E-coli; and a smaller number of Acute Respiratory Failure with Hypoxia cases.

The Plan also looked at Cal Medi-Connect, which is managed by the Plan. Their total Plan All-Cause Readmission rate is about 14% for that time period. There are a large number of Cal Medi-Connect patients who receive their services at Santa Clara Valley Medical Center. Santa Clara Valley Medical Center is the top re-admitter, with El Camino Hospital and Regional Medical Center second, and the Los Gatos campus of El Camino Hospital with the lowest rate of Cal Medi-Connect readmissions. By diagnoses, the number 1 diagnosis is Sepsis, with Hypertensive Heart Disease with heart failure second, and Alcoholic Cirrhosis third. Otherwise, the next most common diagnoses are the more age-related diseases such as COPD, Chronic Kidney Disease, and Diabetes Types I and II.

Part of the reason this analysis was done is to ensure our programs are focused on the patients on whom the Plan should direct their focus and provide support. Dr. Lin inquired about the Plan's case management program. Dr. Boris advised we provide case management via the telephone and in person. This includes behavioral health case managers; social workers; medical case managers; and non-clinical case coordinators. The majority of case management is conducted via telephone. Dr. Lin asked for the number of nurse case managers we have on staff. Ms. Chen advised we currently have 4 nurse Case Managers, and a couple of nurses with a home health background. Ms. McKelvey stated we currently have 4 Licensed Clinical Social Workers and 2 Personal Care Coordinators. Dr. Boris confirmed for Dr. Lin we manage groups 10 and group 40, and all of Cal Medi-Connect. Dr. Alkoraishi inquired as to how the admissions or profiles may have changed since our acquisitions of O'Connor Hospital and St. Louise Regional Hospital. Dr. Boris advised that since our purchases of these hospitals back in March of 2019 there has not been sufficient claims rollout to specifically target the timeframes. The Plan did include the claims data in their initial analysis; however, since the life of the claims has not completely run out, the numbers were too small upon which to draw conclusions. The Plan will continue to monitor.

d. Referral Tracking Quarterly Report – Q3 2019

Dr. Boris next discussed the 'Referral Tracking Report. The Plan does an annual rollup, with quarterly numbers. The report is specific to the number of authorizations and whether or not the Claim was paid. The Plan continues to stand at 50.4% because the claims run out. At the end of the year, the UM department will reach out to approximately 50 members to learn why they did not receive services.

e. Turn Around Time Report – Q3 2019

Next, Dr. Boris discussed the 'Turn-Around Time Report', which goes through August 2019. Dr. Boris advised the Plan did very well on the current CMS audit in terms of timeliness of authorizations. The timeliness of decisions was reviewed with the committee for the urgent, concurrent, retro, and standard authorizations.

f. UM Call Center Metrics – Q2 & Q3 2019

Dr. Boris next reported the UM Call Center metrics. The UM department, on average, takes approximately 2,000 inbound Medi-Cal calls per month. Their abandonment rate is consistently less than 5%. Their average hold time is very low at 30 seconds. For the most part, the UM department has met the standards, with the exception of Q2 and Q3. The UM department also takes approximately 1,000 Cal MediConnect calls, for a total of approximately 3,000 calls per month. Dr. Lin asked how many people in the UM department actually take calls. Dr. Boris and Mr. Perez advised there are 4 people in the UM department who take calls. Dr. Boris advised the UM department met the Provider service levels for Q1-Q4. 80% to 90% of the calls were answered, and the average abandonment rate is 1.7% to 3.9%. The UM department is definitely meeting their call stats.

g. HS.04.01 Quality Monitoring – Q3 2019

Dr. Boris next presented the standard quarterly report on Quality Monitoring, wherein the Plan reviews 30 total denial letters per quarter, and examines all the elements that the Plan is audited on. Half of the letters the Plan reviews are Medi-Cal, and the other half are Cal Medi-Connect, and 100% were denials. The Plan also looks at expedited, as well as standard, requests. They all met turnaround times. The only exception was the standard wherein 3 out of the 4 expedited Cal Medi-Connect authorizations required a phone call from the UM department to the Member, and only 1 Member received a phone call. Otherwise, all the standards were met. On September 8, 2019, the Plan did an update to the QNXT system, and the final quality check should be completed by October 31, 2019.

h. Inter-Rater Reliability (IRR) Report – 2019 2/2

Dr. Boris summarized the Inter-Rater Reliability findings for the UM department Dr. Boris advised all of the staff were tested. Care Coordinator and Nursing remediation was done concurrently; staff reviewed all of the case studies and remediation actions together, which was helpful for all staff involved. This concluded Dr. Boris's presentations for the evening.

9. Behavioral Health UM Reports

a. Early and Periodic Screening, Diagnostic & Treatment (EPSDT)

Ms. McKelvey presented the new APL on the EPSDT benefit for those under 21. For the most part there are no changes; however, there is no longer any capitation to services. Rather, services that are a part of EPSDT will be based on the individual child and what that child needs. The focus is really on prevention and 'Bright Futures'. Screening is a major priority, and the agency has a metric

for screening. Otherwise, any other changes were primarily to the grammar and style of the APL. There are not enough significant changes to warrant any policy changes as far as the Plan is concerned. A discussion ensued between Dr. Vemuri and Ms. McKelvey in regards to the Plan's procedures when a Provider makes a referral for therapy. Dr. Vemuri stated she has one child who was denied twice. It was determined that Dr. Vemuri actually received a "Void" notice which indicates that there was incomplete information. Dr. Boris advised Dr. Vemuri to forward them the information, which they will review in order to provide her with a response.

b. Metrics Reports

Ms. McKelvey went on to discuss the Behavioral Health Q3 metrics for Medi-Cal. Her YTD data shows that there are 175 Members receiving Behavioral Health treatment, with 197 Members receiving Behavioral Health treatment for Q3 2019. Unfortunately, the County has not released any data to the Plan on who receives mental health benefits. The last time the County released this data to the Plan was March 2019. Our mild-to-moderate referrals have slowed down. The number for those receiving Case Management does seem incorrect at 20 Members for Q3 2019. Dr. Lin asked if those in the mild-to-moderate category are taken care of by their primary care physicians. Ms. McKelvey and Dr. Boris agreed, although the low number might be attributed to the Plan being in the process of coordinating therapy referrals for Psychiatry, individual therapy, family therapy, etc. so the number might yet be correct. Dr. Lin also asked how Kaiser fits in to the picture. Kaiser is fully delegated for their behavioral health. Ms. McKelvey advised the Plan has a new MOU with substance abuse which will be presented at an upcoming meeting once she has more information. For Cal Medi-Connect, again, the County has not provided the Plan with any current data on how many Members are receiving behavioral health benefits. There are approximately 40 Cal Medi-Connect Members receiving intensive Case Management. In addition, there were 7 opt-outs in Q3 2019, and they have not received any recent mild-to-moderate referrals from the Call Center. This concluded Ms. McKelvey's presentation.

10. Adjournment

The meeting adjourned at 7:30 p.m.

The next UMC meeting is scheduled for Wednesday, January 15, 2020 at 6:30 p.m.

Minutes prepared by:
Amy O'Brien, Administrative Assistant

_____ _____

Jimmy Lin, MD, Utilization Management Committee Chairperson — Date

Santa Clara Family Health Plan™

Utilization Management Committee

Medical Covered Services 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), available online at www.scfhp.com, for a complete list of covered services.

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

Telephone: 1-408-874-1821
Prior Authorization Request Submission Fax Lines: 1-408-874-1957 or 1-408-376-3548

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 (NEMT) & Non-Medical Transportation (NMT) contact SCFHP Customer Service

Benefits Authorized by Vendors:

Dental Services	
Denti-Cal:	1-800-322-6384
Vision Services	
Vision Service Plan (VSP):	1-844-613-4779

Santa Clara Family Health Plan™

Medical Covered Services Prior Authorization Grid

<table>
<tr><th>Category of Service</th><th colspan="2">Services Requiring Prior Authorization</th></tr>
<tr><td>Behavioral Health Treatment</td><td colspan="2">All Behavioral Health Treatment Services for members age 21 years and under with behavioral conditions that may or may not include autism spectrum</td></tr>
<tr><td rowspan="2">Durable Medical Equipment (DME)

*Benefit and frequency limits apply. Refer to CMS, Noridian, and/or Medi-Cal Provider Manual</td><td>Cal MediConnect</td><td>Medi-Cal</td></tr>
<tr><td>• 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</td><td>• CPAP and BIPAP
• Enteral formula and supplies
• Hospital bed and mattress
• Power wheelchairs, scooters, manual wheelchairs <u>except</u> standard adult and pediatric, and motorized wheelchairs and accessories
• Respiratory: Oxygen, BIPAP, CPAP, ventilators
• Prosthetics & customized orthotics <u>except</u> off-the-shelf covered items
• Hearing aids and repairs
• Other specialty devices
• Requests over the benefit limit</td></tr>
<tr><td>Experimental Procedure</td><td colspan="2">• Experimental procedures
• Investigational procedures
• New technologies</td></tr>
<tr><td>Home Health</td><td colspan="2">• All home health services
• Home IV infusion services</td></tr>
<tr><td>Inpatient Admissions</td><td colspan="2">• 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)</td></tr>
<tr><td>Long-Term Services and Supports (LTSS)</td><td colspan="2">• Community-Based Adult Services (CBAS)
• Long-Term Care (LTC)</td></tr>
</table>

Category of Service	Services Requiring Prior Authorization
Medications	• Refer to the 2020 Medical Benefit Drug Prior Authorization Grid • Physician administered drugs in the doctor's office or in an outpatient setting
Non-Contracted Providers	All non-urgent/non-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
	• Podiatric surgeries
	• Radiation therapy:
	  • Proton beam therapy
	  • Stereotactic Radiation Treatment (SBRT)
	• Sleep studies
	• Spinal procedures **except epidural injections**
	• Surgery for Obstructive Sleep Apnea (OSA)
	• Temporomandibular Disorder (TMJ) treatment

Category of Service	Services Requiring Prior Authorization
	• Transplant-related services prior to surgery **except cornea transplant** • Unclassified procedures • Varicose vein treatment
Transportation	Non-Emergency Medical Transportation (NEMT) for ground and air **except ground transportation from facility to facility and hospital to home**.

Santa Clara Family Health Plan™

Utilization Management Committee

Meeting Calendar - 2020

Santa Clara Family Health Plan

2020

JANUARY

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SEPTEMBER

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Governing Board 12:00pm – 2:30pm	**Credentialing Committee** 12:15pm – 1:30pm
March 26	February 5
June 25	April 1
September 24	June 3
December 17	August 5
Executive/Finance 11:30am – 1:30pm	October 7
January 23	December 2
February 27	**Consumer Advisory Committee** 6:00pm – 7:00pm
April 23	
May 28	
July 23	March 10
August 27	June 9
October 22	September 8
November 19	December 8
Compliance Committee 1:00pm – 3:30pm	**Utilization Management Committee** 6:30pm – 8:00pm
February 27	January 15
May 28	April 15
August 27	July 15
November 19	October 14
Pharmacy & Therapeutics Committee 6:00pm – 8:00pm	**Quality Improvement Committee** 6:30pm – 8:00pm
	February 12
March 19	April 8
June 18	June 10
September 17	August 12
December 17	October 21
Provider Advisory Council 12:15pm – 1:45 pm	December 9
	CMC Consumer Advisory 11:30am – 1:00pm
February 11	March 5
May 13	June 4
August 12	September 3
November 10	December 3

Santa Clara Family Health Plan™

Utilization Management Committee

Program Description - 2020

Santa Clara Family Health Plan

Utilization Management Program Description

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Santa Clara Family Health Plan

Introduction

Santa Clara Family Health Plan (SCFHP) has implemented a Utilization Management (UM) Plan consistent with Medicare regulations, the National Committee for Quality Assurance (NCQA) standards, ~~and~~ the California Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) requirements to ~~consistently~~ measure and monitor processes to improve the effectiveness, efficiency, and value of care and services provided to the members of SCFHP. SCFHP has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.

The UM program description is reviewed and approved by the SCFHP Utilization Management Committee (UMC) annually. SCFHP may provide recommendations for Quality Improvement (QI) activities to improve the comprehensive UM program. The~~A~~ SCFHP C~~c~~hief M~~m~~edical O~~o~~fficer or a medical director is involved in all UM activities, including implementation, supervision, oversight and evaluation of the UM Program. To assess the effectiveness of the UM program and to keep UM processes current and appropriate~~.~~, SCFHP annually evaluates the UM Program for:

- The program structure, scope, processes, and information sources used to determine benefit coverage and medical necessity.
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioners in the program.
- Member and provider experience data

Santa Clara Family Health Plan (SCFHP) Background

Santa Clara Family Health Plan (SCFHP) is a local, public, not-for-profit health plan dedicated to improving the health and well-being of the residents of Santa Clara County. Our mission is to provide high quality, comprehensive health care coverage for those who do not have access to, or are not able to purchase, good health care at an affordable price. Working in partnership with providers, we act as a bridge between the health care system and those who need coverage. We do this by offering comprehensive, affordable medical, dental and vision coverage through our health insurance programs:

Medi-Cal, a public insurance program, and Cal MediConnect, a program for individuals with both Medi-Cal and Medicare. ~~and Healthy Kids (Medi-Cal is a public insurance program, Cal MediConnect is a program for people with both Medi-Cal and Medicare, and Healthy Kids is a locally funded insurance program).~~

Since 1997, SCFHP has partnered with providers to deliver high-quality health care to our members. Through dedication to integrity, outstanding service, and care for our community, we work to ensure that everyone in our county can

receive the care they need for themselves and for their families. We currently serve approximately~~over~~ 250,000 residents of Santa Clara County including over 8,000 of these members in the . ~~For the~~ Cal MediConnect program.~~Line of Business we serve approximately 9,000 members.~~

Section I. Program Objectives & Principles

A. The purpose of the SCFHP Utilization Management (UM) Program is to objectively monitor and evaluate the appropriateness of utilization management services delivered to members of ~~the~~ SCFHP. The UM Program addresses the following information about the UM structure:

1. Guide~~s~~ efforts to support continuity and coordination of medical services
2. Define~~s~~ UM staff members' assigned activities, including ~~the~~ defining which of the UM staff ~~that~~ has the authority to deny medical necessity coverage
3. Address~~es~~ process for evaluating, approving and revising the UM program and supporting policies and procedures
4. Define~~s~~ the UM Program's role in the QI Program, including how SCFHP collects UM information and uses it for QI related activities
5. Improve health outcomes
6. Support efforts that are taken to continuously improve the effectiveness and efficiency of healthcare services

B. The SCFHP maintains the following operating principles for the UM Program:

1. UM decisions are made on appropriateness of care and service, as well as existence of benefit coverage
2. Appropriate processes are used to review and approve provision of medically necessary covered services and are based on ~~the~~ SCFHP policies and procedures through established criteria
3. The SCFHP does not financially reward clinicians or other individuals for issuing denials of coverage, care, or service
4. The SCFHP does not encourage UM decisions that result in under-utilization of care by members
5. Members have the right to:
    a) Participate with providers in making decisions about their individual health care
    b) Discuss candidly with providers the appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
6. The UM program and the utilization review policies and procedures are available to Members and Providers
7. SCFHP policies and procedures shall cover how Contractors, Subcontractors, or any contracted entity, authorize, modify, or deny health care services via Prior Authorization, concurrent authorization, or retrospective authorization, under the benefits provided by SCFHP
8. SCFHP policies, processes, strategies, evidentiary standards, and other factors used for UM or utilization review are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.
9. ~~SCFHP's policies and procedures shall be consistently applied to medical/surgical, mental health, and substance use disorder services and benefits. See Inter Rater Reliability section~~

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~~10.~~9. SCFHP notifies contracting health care Providers, as well as Members and Potential Enrollees upon request, of all services that require Prior Authorization, concurrent authorization or retrospective authorization and ensure that all contracting health care Providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

~~11.~~10. SCFHP conducts all UM activities in accordance with CA Health and Safety Code 1367.01

~~12.~~11. SCFHP conducts their prior authorization requirements and complies with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d)

Section II. Program Structure

A. Program Authority

1. Board of Supervisors and the Board of Directors

The Santa Clara County Board of Supervisors appoints the Board of Directors (BOD) of ~~the~~ SCFHP, a 12-member body representing provider and community partner stakeholders. The BOD is the final decision making authority for all aspects of ~~the~~ SCFHP programs and is responsible for approving the Quality Improvement and Utilization Management Programs. The Board of Directors delegates oversight of Quality and Utilization Management functions to the SCFHP Chief Medical Officer (CMO) and the Quality Improvement Committee (QIC) and provides the authority, direction, guidance, and resources to enable SCFHP staff to carry out the Utilization Management Program. Utilization Management oversight is the responsibility of the Utilization ~~Review~~Management Committee (UMC). Utilization Management activities are the responsibility of the SCFHP staff under the direction of the SCFHP Chief Medical Officer.

2. Committee Structure

The Board of Directors appoints and oversees the QIC, which, in turn, provides the authority, direction, guidance, and resources to the ~~Utilization Management Committee (~~UMC~~)~~ to enable SCFHP staff to carry out the Quality Improvement and Utilization Management Programs.

SCFHP UMC meets quarterly in accordance with the SCFHP bylaws and more frequently when needed. Committee meeting minutes are maintained to summariz~~inge~~ committee activities and decisions, and are signed and dated. The QIC ~~Committee~~ provides oversight, direction and makes recommendations, final approval of the UM Program.

B. The Utilization Management Committee (UMC)

1. Composition, roles, goals, meetings, and additional information will be found in the UM Committee Charter.

2. Responsibilities of the UM Committee

a) Develop, maintain, and execute an effective utilization review and management plan ~~(the Plan)~~ to manage the use of hospital resources in a manner that is efficient and cost effective.
b) The Director of Utilization Management~~Review~~ shall review the ~~P~~utilization review and management plan annually and revise it as necessary.
c) Provide oversight for review and utilization of:
   i. Ancillary services
   ii. Medical necessity of admissions
   iii. Extended length of stay and high cost cases
   iv. Cases of non-covered stays
   v. Short stay inpatient stays

vi. Observation cases.

d) Verify that utilization management functions meet the standards and requirements of all licensing and regulatory agencies, accrediting bodies, third party payers, and external review agencies.
e) Verify that admissions and discharges are appropriate using ~~well~~ well-defined criteria.
f) Review and analyze data from the hospital-wide best practice/pathway activities, case mix index, denials, appeals/recoveries, and other sources and make recommendations for actions based on the findings.
g) Establish and approve criteria, standards, and norms for pre-admission reviews, continued stay reviews, and assist in continuing modification of such criteria, standards, and norms.
h) Recommend changes in patient care delivery if indicated by analysis of review findings.
i) Promote the delivery of quality patient care, according to developed or adopted criteria ~~set by the Medical Staff~~, in an efficient and cost-effective manner.
j) Refer quality concerns identified during the review process to the ~~Enterprise Director of~~ Quality and Compliance ~~Patient Safety and/or Risk Management~~departments as needed for evaluation and action.

~~Promote the delivery of quality patient care, according to criteria set by the medical staff, in an efficient and cost-effective manner.~~

3. Conflict of Interest

No person who holds a direct financial interest in an affiliated health care entity is eligible for appointment to the Utilization Management Committee. ~~For purposes of this policy,~~ SCFHP does not consider employment by the Plan to constitute a direct financial interest in an affiliated entity. No committee member may participate in the review of a case in which either he or she or any of his or her professional associates have been professionally involved, except to provide additional information as requested. ~~Refer to policy and procedure # QI.01 Conflict of Interest.~~

C. The Quality Improvement Committee (QIC)

1. Functional responsibilities for the UM Program
   a) Annual review, revision and approval of the UM Program Description
   b) Oversight and monitoring of the UM Program, including:
      ~~c)~~a. Review and approval of the sources of medical necessity criteria
      ~~d)~~b. Recommend policy decisions
      ~~e)~~c. Monitor for over and under-utilization of health services
      ~~f)~~d. Design and implement interventions to address over and under-utilization of health services
      ~~g)~~e. Guide studies and improvement activities
      ~~h)~~f. Oversight of annual program evaluation and review

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~~i)~~g. Review results of improvement activities, HEDIS measures, other studies and profiles and recommend necessary actions

D. Health Services Department

The Health Services Department at SCFHP is responsible for coordination of programs including the UM Program. The ~~Utilization Management~~UM staff administer the UM Program. Non-clinical staff may receive and log utilization review requests in order to ensure adequate information is present. Some utilization requests are ~~automatically~~ approved by the ~~care coordinator (~~non-clinical staff~~)~~. Appropriately qualified and trained clinical staff use~~s~~ evidence~~d~~ based criteria or generally accepted medical compendia and professional practice guidelines to conduct utilization reviews and make UM determinations relevant to their positions and their scope. ~~(p~~Potential denials are referred to licensed physicians and pharmacists for review~~reviewers)~~. The CMO and Medical Director (MD), conduct reviews that require additional clinical interpretation or are potential denials. The medical directors apply medical necessity criteria that are reviewed and adopted on an annual basis. The CMO or qualified designee, including medical directors and pharmacists, ~~is~~are the only staff members that make~~s~~ medical necessity and coverage denial decisions.

1. Communication Services

The UM Staff shall provide the following communication services for members and practitioners:

a) UM personnel are available ~~at least eight hours a day~~ during normal business hours for inbound collect or toll-free calls regarding UM issues. The UM Department shall operate during normal health plan business hours~~ are Monday through Friday, 8:30am to 5:00pm pacific time zone~~.

b) Telephone lines are staffed with ~~professionals~~ individuals who have access to most information/resources needed to provide a timely response. Callers have the option of leaving a voice mail message either during or after business hours

c) UM staff can receive inbound communication regarding UM issues after normal business hours. These calls are returned promptly the same or next business day. ~~Staff is also a resource for other Plan Departments for UM and Case Management questions~~

d) UM staff are identified by name, title and organization name when initiating or returning calls regarding UM issues

e) The ~~D~~UM department has both local and toll-free telephone and telefax numbers and offers TDD/TTY services for deaf, hard of hearing or speech impaired members. Language assistance/interpretation is also available for members to discuss UM issues at no cost to the member

~~f) Language assistance for members to discuss UM issues is available at no cost to the member~~

~~g) SCFHP provides members with 24 hour access to the Nurse Advice Line for information regarding wellness/prevention and to assist members with the following:~~

~~1. Determine whether to seek care~~

~~2. Determine the most appropriate level of care for their condition~~

~~3. Obtain answers to questions about medication~~

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~~4. Obtain information about providers~~
~~5. Obtain information about non-urgent illnesses or injuries~~
~~6. Apply self-care prior to a health care visit~~
~~7. Receive bi-lingual or translation services~~

2. Roles / UM Staff Assigned Activities

a) Chief Medical Officer (CMO)

The Chief Medical Officer is a physician who holds an active, unrestricted California license and is designated with responsibility for development, oversight and implementation of the UM Program. The CMO shall serves as ~~the chair~~ a voting committee member of the QIC, and makes periodic reports of committee activities, UM Program activities and the annual program evaluation to the BOD. The CMO works collaboratively with SCFHP community partners~~ -~~to continuously improve the services that the UM Program provides to members and providers. The CMO is the senior level physician for medical determinations and his/her role includes:

- Setting UM medical policies
- Supervising operations
- Reviewing UM cases
- Participating in UMC
- Evaluation of the UM program

b) Medical Directors (MD)

The Medical Directors are licensed physicians with authority and responsibility for providing professional judgment and decision making regarding matters of UM. Medical Director responsibilities include, but are not limited to, the following:

1. Support processes where medical decisions are rendered by, and are not influenced by fiscal or administrative management considerations. The decision to deny services based on medical necessity is made only by Medical Directors
2. Ensure that the medical care provided meets the standards of practice and care
3. Ensure that medical protocols and rules of conduct for plan medical personnel are followed
4. Develop and implement medical policy.
5. A medical director is designated to be involved with UM activities, including implementation, supervision, oversight and evaluation of the UM program
6. Any changes in the status of the CMO or Medical Directors shall be reported to the Department of Health Care Services (DHCS) within ten calendar working days of the change.

7. The SCFHP may also use external specialized physicians to assist with providing specific expertise in conducting reviews. These physicians hold current, unrestricted licenses in the state of California and are board ~~-~~certifi~~cation~~ed by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) in specific areas of medical expertise. The CMO is responsible for managing access and use of the panel organization of specialized physicians. An example of external specialist physicians would be psychiatry or psychology for making determinations regarding mental health care.

c) ~~Health Services~~UM Director and UM Manager

The ~~Health Services~~UM Director and U~~tilization~~M Manager are responsible for the day ~~-~~to ~~-~~day management of the UM department, the overall UM Department operations and for coordination of services between other departments. These responsibilities include:

1. Develop and maintain the UM Program in collaboration with the Medical Director and other Health Services leadership~~Managers~~ including Behavioral Health ~~Manager(s) and~~, Case Management, ~~-~~Long Term Support Services (LTSS), Pharmacy, and Quality ~~Management staff~~.
2. Coordinate UM activities with ~~the Quality Department and~~ other SCFHP units.
3. Maintain compliance with the regulatory standards and requirements.
4. Monitor utilization data for over and under utilization.
5. Coordinate interventions with ~~the Health Services~~ Medical Director(s) and staff to address under and over utilization concerns when appropriate.
6. Monitor utilization data and activities for clinical and utilization studies.
7. Maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans and community partners, sharing information about requirements and successful evaluation strategies
8. Implement the annual~~a yearly~~ UM ~~p~~Program evaluation and ~~m~~Member and ~~p~~Provider ~~s~~Satisfaction ~~s~~Surveys

d) UM Supervisor

Responsible for the daily operational management of the ~~Utilization Management Department~~UM department activities, ~~such as:~~including: authorization processing, letter creation, provider outreach and education, productivity and quality monitoring oversight, training and development, and the daily supervision of non-clinical ~~Utilization~~ UM Care Coordinat~~ion~~ors ~~staff~~.

e) Pharmacy Director

The Pharmacy Director, or designee, is a unrestricted California licensed pharmacist (~~Pharm. D.~~RPh) responsible for coordinating daily operations, and revewing and managing pharmacy utilization reports to identify trends and patterns. The Pharmacy Director provides ~~-~~clinical expertise relative to the Pharmacy, Quality, and Utilization Management components of SCFHP ~~plan~~ management~~, including Member and Provider Services, and Claims operations~~operations.~~.~~ The scope of responsibilities of the Pharmacy ~~Services~~ Director includes:

1. Render pharmaceutical service decisions (approve, defer, modify or deny) pursuant to criteria established for the specific line of business by the CMO and the SCFHP Pharmacy and Therapeutics Committee or generally accepted medical compendia and professional practice guidelines
2. Assure that the SCFHP maintains a sound pharmacy benefits program.
3. Manage the SCFHP ~~Medication~~ Formulary on an ongoing basis
4. Manage the Drug Utilization Review program
5. Monitor compliance with delegation requirements and the performance of the Pharmacy Benefits Management ~~firm's services~~
6. Provide clinical expertise and advice for the on-going development of pharmacy benefits.
7. Review medication utilization reports to identify trends and patterns in medication utilization
8. Develop and manage provider and client education programs to improve medication prescribing patterns and to increase patient compliance
9. Ensure compliance with Federal and State regulatory agencies
10. Manage the contract with, and delegated activities of, the pharmacy benefits management organization

f) Utilization Review and Discharge Planning Registered Nurses

~~Licensed,~~ Registered ~~n~~Nurses, with an unrestricted California license, are responsible for the review and determinations of medical necessity coverage decisions. Nurses may provide prospective, concurrent and retrospective inpatient or outpatient medical necessity coverage determinations using established and approved medical criteria, tools and references as well as their own clinical training and education. Utilization Review Nurses also work collaboratively with case managers and assist with member discharge planning. All cases that do not satisfy medical necessity guidelines for approval are referred to a Medical Director for final determination. The CMO or Medical Director(s) are available to the nurses for consultation and to make medical necessity denials.

g) Utilization Management Review Nurse ~~(LVN)~~

Under the guidance and direction of the UM ~~department RN~~ Manager or ~~Health Services~~UM Director, Registered Nurses or~~-~~ Licensed Vocational ~~n~~Nurses are responsible for performing prospective and

retrospective pre-service clinical review for inpatient and outpatient authorization requests in compliance with all applicable state and federal regulatory requirements, SCFHP policies and procedures, and applicable business requirements. Following regulatory or evidence-based guidelines, the nurses assess for medical necessity of services and/or benefit coverage which result in approved determination for services or the need to collaborate with Medical Directors for potential denial considerations.

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~~h) Nurse Case Managers~~

~~Case management services at the SCFHP are licensed registered nurses (RN) or licensed clinical social workers (LCSW) responsible for the case management for selected members with complex medical conditions. Case managers, in collaboration with the treatment team and with family members when appropriate, coordinate and facilitate the provision of appropriate medical services and available resources to meet the member's individual needs and promote quality, cost-effective outcomes. Please refer to the Case Management Program for additional information. The scope of responsibilities of Nurse Case Mangers includes:~~

1. ~~Assists members, providers and facilities with transitions of care~~
2. ~~Identifies targeted behaviors and assists participant members in moving through stages of change.~~
3. ~~Reviews participant's functional status, formal and informal family support system, determining participant's desired outcome of care and needs for participant education~~
4. ~~Develops and facilitates implementation of a care plan addressing the total healthcare needs of the participants. This is the Interdisciplinary Care Plan (ICP)~~
5. ~~Identifies participant barriers to accessing health care services~~
6. ~~Functions as part of the multi-disciplinary treatment team, facilitating communications with primary managing physician and other members of the condition management team. Initiates the Interdisciplinary Care Team (ICT) process with the member, primary care physician, and others at the request of the member~~

h) Non-Clinical Staff

Non-clinical staff in multiple roles perform a variety of basic administrative and operational functions. Clinical staff provides oversight to the non-clinical staff.
Roles and responsibilities include:

1. ~~Care Coordinators process~~Processing selected approvals that do not require clinical interpretation as indicated in the Care Coordinator Guidelines
2. ~~, and c~~Complete intake functions with the use of established scripted guidelines.

3. ~~Health Services Administrative Assistant a~~Assists with mailings and data collection

~~2.~~

~~i)~~ Behavioral Health Staff Assigned Activities

i)

1. Medical Director or CMO
    i. Reviews denials, changes in requested service.
        a) If there is a change in the authorization request for a behavioral health related inpatient or partial hospitalization stay for a member, this is considered a denial. The denial will be reviewed by the SCFHP MD or CMO who shall consult with a SCFHP psychiatrist as needed.
    ii. Involved in the implementation of the behavioral health care aspects of the UM Program
    iii. Establishes UM policies and procedures relating to behavioral healthcare
    iv. Reviews and decides UM behavioral healthcare cases
    v. Participates in UM Committee meetings

2. Psychiatrist
    i. SCFHP contracts with a board certified psychiatrist to provide consultation and participation in the following:
        ~~ii.~~a. Implementation of the behavioral health care aspects of the UM Program
        ~~iii.~~b. Establishing UM policies and procedures related to behavioral healthcare
        ~~iv.~~c. Participates in UM Committee meetings
        ~~v.~~d. Development and approval of behavioral health criteria
        ~~vi.~~e. Review and decides UM behavioral healthcare cases
        ~~vii.~~f. Oversight of UM referrals and cases

3. Behavioral Health Director or Manager
    i. The BH Director or Manager is a ~~BH~~ clinician ~~and has~~with the responsibility to facilitate the review of all referrals to the BH department for appropriate triage and assignment. The priority for assignment will be for psychiatrically hospitalized members, frequent emergency room (medical and psychiatric ER), emergent or urgent situations of a life-threatening nature, care coordination with Specialty Mental Health members. All other referrals from internal and external sources will be prioritized as staff time is available.
    ~~ii.~~ The BH Director or Manager is responsible to oversee Quality Improvement monitoring to continuously assess application of utilization management

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criteria, turn-around-times, appropriate level of care, etc. The Director or Manager d~~D~~rives compliance with behavioral health related HEDIS measures to support member access to preventive services and management of chronic conditions.

ii.

4. Behavioral Health Case Manager (s)
   i. The BH case manager will review all psychiatric hospitalizations and partial hospitalizations for medical necessity and to provide coordination of care upon discharge. The BH case manager will contact the hospital case manager to ensure that a plan is developed for aftercare. If the hospitalization is reviewed retrospectively, the BH case manager will contact the member or member's parents to arrange for coordination of aftercare. The BH case manager will work to ensure that members receive follow-up care by a behavioral health practitioner within 30 days following a hospital discharge.

j) Pharmacy Staff

~~j)~~

SCFHP staff is composed of clinical pharmacist(s), pharmacy technician(s), and ~~a~~ medical director(s). ~~The Plan~~Pharmacy staff roles and responsibilities include but are not limited to:

1. Review of all prior authorization requests for non-formulary medication therapy
2. ~~Review of all pharmacy appeals~~
3. 2. Delegation oversight of the Pharmacy Benefit Manager
4. 3. Quality Improvement monitoring to continuously assess application of criteria, turn-around-times, step therapy, etc.
5. 4. Provides education to the contracted network staff as necessary
6. 5. Drives compliance with medication related HEDIS measures to support member access to preventive services and management of chronic conditions

E. UM Program Evaluation ~~/ Process for evaluating, approving and revising the UM program and the staff responsible for each step~~

~~1. Annual Evaluation~~

Members of the UM Program management team (CMO, Medical Director, UM and BH Director/Manager ~~and Director of UM operational areas~~) annually evaluate and update the UM Program and develop the a~~A~~nnual UM program evaluation to ensure the overall effectiveness of UM Program objectives, structure, scope and processes. The evaluation includes, at a minimum:

a) Review of changes in staffing, reorganization, structure or scope of the program
b) Analysis of annual aggregated data related to UM processes and activities
c) Resources allocated to support the program
d) Review of completed and ongoing UM work plan activities

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e) Assessment of performance indicators
f) Review of delegated arrangements activities
g) Recommendations for program revisions and modifications

The UM management team presents a written program description and program evaluation to the UMC which is then taken to QIC. The QIC reviews and approves the UM Program description and evaluation on an annual basis. The review and revision of the program may be conducted more frequently as deemed appropriate by the QIC, CMO, CEO, or BOD.

The QIC's recommendations for revision are incorporated into the UM Program description, as appropriate, which is reviewed and approved by the BOD and submitted to DHCS, CMS on an annual basis.

F. Quality Improvement Integration

The UM Program includes a wide variety of quality assurance activities to support positive member outcomes and continuous quality improvement. The CMO guides these activities in collaboration with the Director of Compliance with the oversight of the QIC. Performance results are analyzed and reviewed with opportunities for improvement identified for intervention and performance management.

1. Quality Improvement UM Program activities:

a. HEDIS measurement and reporting
b. Under and Over Utilization monitoring as exampled by:
    1. Readmission rates
    2. Access to preventive health services
    3. Bed days
    4. Length of Stay
c. Appeal, denial, deferral, modification and grievance monitoring
d. Provider profile measurement
e. Potential quality issue referrals
f. Quality Improvement Work Plan indicators
g. Quality improvement projects
h. Inter-rater reliability assessments
i. Focused ad hoc analyses
j. Regulatory compliance
k. Delegation oversight
l. Member and provider satisfaction with the UM process
m. Member and provider education
n. Member notifications for denial reason
o. UM t~~T~~urn~~-~~around ~~-~~times
p. Nurse Advice Line utilization and trends
q. Monitoring of groups with shared savings/capitation agreements
    1. SCFHP monitors groups with CAP agreements for under-utilization so that members receive optimal care regardless of risk agreement with provider group or plans.

2. UM Data Sources

Sources are used for quality monitoring and improvement activities, including those both directly administered by SCFHP and their delegates

a. Claims and encounter data
b. Medical records
c. Medical utilization data
d. Behavioral Health utilization data
e. Pharmacy utilization data
f. Appeal, denial, and grievance information
g. Internally developed data and reports
h. Audit findings
i. Other clinical or administrative data

Actual unit cost and utilization rates by treatment type category are compared to budgeted and benchmark figures. If any significant over or underutilization trend is noted, additional, more detailed reports are reviewed. Reports are structured so that they are available on a patient specific, provider or group specific, service specific, or diagnosis specific basis. Data can be reported in summary or at an individual claim level of detail. The utilization reporting system allows for focused problem identification and resolution.

SCFHP's Pharmacy Benefit Coordinator routinely monitors and analyzes pharmacy use in each product line to detect potential underutilization and overutilization. Pharmacy utilization is also monitored by individual physicians and across practice and provider sites. Appropriate clinical interventions and/or other strategies are implemented when required and monitored for effectiveness.

3. Utilization Management Performance Monitoring

a. Areas to monitor

The Director of ~~Medical Management~~UM monitors the consistency of the UM staff in handling approval, denial and inpatient decisions. Turnaround time of UM decisions, including verbal and written notification is also monitored. CMO and Medical Director decisions are periodically reviewed by a physician for consistency of medical appropriateness determinations. Telephone service, as related to the percentage of calls that go into the hold queue, abandonment rate and average speed of answer are~~is~~ tracked. Additional monitoring of the ~~Utilization Management~~UM Program is performed through comments from the Member Satisfaction Survey, the ~~Physician and Office Manager~~ Provider Satisfaction Survey, ~~Case Management Member Satisfaction Survey,~~ and the quarterly appeals reports Product-line specific, high level, summary cost and utilization data is reviewed and analyzed monthly but not limited to the following areas:

1. Discharges/1,000
2. Percentage of members receiving any mental health service
3. Hospital outpatient services/1,000
4. ED visits/1,000 (not resulting in admission)
5. Primary Care visits/1,000

6. Specialty Care visits/1,000
7. Prescription Drug services
8. Denials
9. Deferrals
10. Modifications
11. Appeals

Actual unit cost and utilization rates by treatment type category are compared to budgeted and benchmark figures. If any significant over or underutilization trend is noted, additional, more detailed reports are reviewed. Reports are structured so that they are available on a patient specific, provider or group specific, service specific, or diagnosis specific basis. Data can be reported in summary or at an individual claim level of detail. The utilization reporting system allows for focused problem identification and resolution.

The Plan's Pharmacy Benefit Manager routinely monitors and analyzes pharmacy use in each product line to detect potential underutilization and overutilization. ~~Pharmacy utilization is also monitored by individual physicians and across practice and provider sites.~~ Appropriate clinical interventions and/or other strategies are implemented when required and monitored for effectiveness.

b. Access to UM Staff

UM ~~tilization and Case Management~~ staff is available during normal business hours ~~Monday through Friday (excluding holidays) from 8:30 a.m. to 5:00 p.m.~~ to answer questions regarding UM decisions,
authorization of care and the UM program. The d~~D~~epartment has both local and toll-free telephone and telefax numbers and offers TDD/TTY services for deaf, hard of hearing or speech impaired members. Language assistance/interpretation is also available for
members free of charge to discuss UM issues. Telephone lines are staffed with professionals who have access to most information/resources needed to provide a timely response. Callers have the option of leaving a voice mail message either during or after business hours. These calls are returned promptly the same or next business day. Staff is also a resource for other Plan Departments for UM and Case Management questions.

G. Appeal Procedures

The SCFHP maintains procedures by which a member, authorized representative and provider can appeal a UM organization determination that results in a denial, termination, or limitation of a covered service. The UM Program procedure for appeals includes provisions for timely and appropriate notification of pre-service, post-service and expedited appeals along with an option for external level review. Appeals are administered in accordance with SCFHP policies and procedures, and regulatory standards.

Detailed information about SCFHP appeal policies and procedures are housed within the appeal and grievance committee and unit.

H. Delegation of Utilization Management Activities

When SCFHP delegates Utilization Management decisions or other UM related activities, the contractual agreements between the SCFHP and this delegated group specify the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities to the SCFHP, how performance is evaluated; and corrective action plan expectations, if applicable. The SCFHP conducts a pre-contractual evaluation of delegated functions to assure capacity to meet standards and requirements. The SCFHP's Delegation Oversight Manager is responsible for the oversight of delegated activities. Delegate work plans, reports, and evaluations are reviewed by the SCFHP and the findings are summarized at QIC meetings, as appropriate. The Delegation~~ed~~ Oversight Manager monitors all delegated functions of each of our delegates through reports and regular oversight audits. The QIC annually reviews and approves all delegate UM programs. Depending on the delegated functions the audit may include aspects of the following areas: utilization management, credentialing, grievance and appeals, quality improvement and claims.

As part of delegation responsibilities, delegated providers must:

- Develop, enact, and monitor a UM Program description that addresses all State, Federal, health plan and accreditation requirements.
- Provide encounter information and access to medical and behavioral health records pertaining to SCFHP members.
- Provide a representative to the QIC.
- Submit quarterly reports, annual evaluations, and work plans.
- Cooperate with annual audits and complete any corrective action judged necessary by the SCFHP.

SCFHP does not delegate the management of complaints, grievances and appeals. SCFHP conducts a pre-delegation review to measure resources of the potential delegate

Section III. Program Scope, Processes & Information Sources

The UM Program consists of comprehensive and systematic functions, services, and processes that provide care management to members, and include medical necessity determinations regarding the appropriateness of health care services in accordance with definitions contained in the member certificate of coverage. The UM Program also encompasses delegated utilization management functions, activities, and processes for behavioral health and pharmacy services.

A. Clinical Review Criteria

The ~~Utilization Management~~UM Program is conducted under the administrative and clinical

direction of the ~~Chief Medical Officer~~CMO and UM ~~Committee~~C. Therefore, it is SCFHP's policy that all medical appropriateness and necessity criteria are developed, and approved by the physician entities prior to implementation. Part of this review process may also include input from appropriate participating subspecialists. As part of the review of the ~~Utilization Management~~UM Program, all criteria are reviewed and updated as needed, but no less than annually. Providers are advised annually that criteria are available upon request, by mail, fax, or email. ~~–~~Internally developed criteria and a general list of services that require prior authorization are also available on SCFHP's web site. MCG® criteria are available to providers upon request with the UM Department. The individual needs of the member and the resources available within the local delivery system are considered when applying ~~Utilization Management~~medical necessity criteria.

1. Adoption of criteria

When adopting m~~M~~edical ~~N~~necessity ~~C~~criteria, SCFHP (with direct oversight by the CMO~~hief Medical Officer~~) will:

a. Have written UM decision-making criteria that are objective and based on medical evidence. The criteria include medical, long term services and support (LTSS), and behavioral healthcare services requiring review.
b. Have written policies for applying the criteria based on individual needs. SCFHP considers the clinical variables for review including:
    a. Age
    b. Comorbidities
    c. Complications
    d. Treatment progress
    e. Psychosocial factors
    f. Home environment: when applicable
c. Have written policies for applying the criteria based on an assessment of the local delivery system. The medical, behavioral health, and LTSS units evaluate the local delivery systems in meeting member's needs.
d. Involve appropriate practitioners in developing, adopting and reviewing criteria via the practitioner involvement in UMC.
e. Annually review the UM criteria and the procedures for applying them, and updates the criteria when appropriate. SCFHP reviews UM criteria against current clinical and medical evidence and updates them when appropriate.

***2.* Hierarchy of criteria**

Utilization review determinations are derived from a consistently applied, systematic evaluation of utilization management decision criteria. The criteria are selected based on nationally recognized and evidence-based standards of practice for medical services and are applied on an individual needs basis. ~~Primary criteria used for utilization review decisions are from Local Coverage Determinations (LCD); Noridian and National Coverage Determinations (NCD); MCG.~~ A hierarchy of criteria for UM decision ~~is~~ shall ~~used as~~ be outlined by UM Policies & Procedure ~~HS.02.01 – Application of Clinical Criteria~~s.~~ –~~

Other applicable publicly available clinical guidelines from recognized medical authorities are referenced, when indicated. Also when applicable, government manuals, statutes, and laws are referenced in the medical necessity decision making process. The QIC annually reviews the Care Coordinator Guidelines and criteria and applicable government and clinical guidelines for changes and updates.

Additionally, the SCFHP has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in benefit plans in order to keep pace with changes and to ensure that members have equitable access to safe and effective care.

B. Medical Necessity

The ~~Utilization Management~~UM Program is conducted under the administrative and clinical direction of the ~~Chief Medical Officer~~ CMO and the ~~Utilization Management Committee~~UMC.
Therefore, it is the policy of SCFHP that all medical appropriateness/necessity criteria are developed, reviewed and approved by the physician entities prior to implementation.

Part of this review process may also include input from appropriate participating subspecialists. As part of the review of the ~~Utilization Management~~UM Program, all criteria are reviewed and updated as needed, but no less than annually. Providers are advised annually that criteria are available upon request. Internally developed criteria and a general list of services that require prior authorization are also available on the web site for SCFHP.

Specific MCG criteria are available to providers by contacting the UM d~~D~~epartment or the physician reviewer. The individual needs of the member and the resources available within the local delivery system are considered when applying ~~Utilization Management~~medical necessity criteria.

Members may request a copy of the medical necessity criteria. ~~–~~When the disclosure of UM criteria is made to the public, the disclosure will be accompanied by the following notice:

> "The materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

The Medicare Model ~~Explanation~~ Evidence of Coverage (EOC) defines medically necessary services or supplies as those that are:~~"~~ "1) Proper and needed for the diagnosis or treatment of your medical condition; 2) Used for the diagnosis, direct care, and treatment of your medical condition; 3) Not mainly for your convenience or that of your doctor; and those that 4) Meet the standards of good medical practice in the local community."

1. Medical Necessity Determinations

Medical necessity determinations are made based on information gathered from many sources. As eEach case is different, ~~. However, these~~these sources may include some or all of the following:

a) Primary cCare PPhysician
b) Specialist ppphysician
c) Hospital Utilization Review Department
d) Patient chart
e) Home health care agency
f) Skilled nursing facility
g) Physical, occupational or speech therapist
h) Behavioral health/chemical dependency provider
i) Patient or responsible family member

The information needed will often include the following:

a) Patient name, ID#, age, gender
b) Brief medical history
c) Diagnosis, co-morbidities, complications
d) Signs and symptoms
e) Progress of current treatment, including results of pertinent testing
f) Providers involved with care
g) Proposed services
h) Referring physician's expectations
i) Psychosocial factors, home environment

The Utilization Review Nurses will use this information, along with good nursing judgment, departmental policies and procedures, needs of the individual member and characteristics of the local delivery system, including the availability of the proposed services within the network service area, or case conference discussions with a SCFHP Medical Director, to make a decision.

If the decision is outside the scope of the Utilization Review Nurse's authority, the case is referred to the Medical Director for a determination. The Medical Director, ~~or P~~pharmacists, or designated behavioral health practitioner as appropriate, are the only pPlan representatives with the authority to deny payment for services based on medical necessity and ~~/~~appropriateness. Psychiatrists, doctoral-level clinical psychologists, or certified addiction medicine specialists have the authority to deny payment for behavioral health care services based on medical necessity and appropriateness. Alternatives for denied care or services are given to the requesting provider and member and are based on the criteria set used or individual case circumstances. In making determinations based on contract benefit exclusions or limitations, the Member Handbook and Group Services Agreement are used as references.

2. Inter-Rater Reliability

The UM Manager monitors the consistency of the UM/BH/MLTSS/Pharmacy staff ~~i~~in handling pre-service approval, denial and inpatient concurrent review decisions. The Inter-Rater Reliability (IRR) testing process evaluates the consistent application amongst the Health Services teams (UM, BH, MLTSS, pharmacy staff), including all staff who apply medical necessity criteria,

including medical directors, registered and licensed vocational nursing staff, pharmacists, pharmacy technicians, and non-clinical staff. Please refer to IRR Policy HS.09.01.

All staff is assessed through the established IRR process at least annually. All new hires are reviewed monthly for the first 90 days and then again annually.

C. Timeliness of UM Decisions

SCFHP maintains a policy and procedure (P&P) meeting that meets state, federal, and NCQA (National Committee for Quality Assurance) regulations and guidelines for meeting timeliness standards of UM decisions and notification. The P&P is comprehensive and includes non-behavioral and behavioral UM decision and notification timeframes, it is reviewed revised at least annually. The operations dashboard is updated monthly and staff is monitored and evaluated on meeting timeliness standards.

D. Clinical Information

When determining coverage based on medical necessity for non-behavioral, behavioral, and pharmacy decisions, SCFHP obtains relevant clinical information and consults with the treating practitioner where necessary. The reviewing medical director or pharmacist shall document any consults conducted and will acknowledge the clinical information considered when making a decision to deny, delay or modify a request for service or care.
Clinical information may include, but is not limited to:

- Office and hospital records.
- A history of the presenting problem.
- Physical exam results.
- Diagnostic testing results.
- Treatment plans and progress notes.
- Patient psychosocial history.
- Information on consultations with the treating practitioner.
- Evaluations from other health care practitioners and providers.
- Operative and pathological reports.
- Rehabilitation evaluations.
- A printed copy of criteria related to the request.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from family members.
- Behavioral Health Assessment

E. Transplants

It is SCFHP's policy that all requests for organ transplants be reviewed by the Medical Director or designee ~~and Case Manager and the~~ . ~~members~~Members are directed to the most appropriate Center of Excellence transplant facility for evaluation based on benefits. The Case Manager coordinates with the facility transplant coordinator to send the transplant recommendation to SCFHP, as appropriate, prior to approval by the Plan. Renal and corneal transplants are excluded from SCFHP review. The Plan's determination of medical necessity will be based on the Transplant Team determination, thus providing an outside, impartial, expert evaluation. Once the member has been approved, the member is enrolled in the United Network for Organ Sharing (UNOS). The patient's acceptance into UNOS serves as the Plan's medical necessity determination. All members that are approved for transplant are followed closely by Case Management as well as Paramount's interdepartmental transplant team, consisting of Medical Directors, Case Managers and Financial, Claims and Actuarial representatives. The purpose of the team is to ensure ongoing medical necessity for transplant, employer group high dollar alert (if self-insured), and reinsurance notification and to ensure appropriate claims payment.

F. New Technology Assessment

SCFHP investigates all requests for new technology or a new application of existing technology ~~using the HAYES Medical Technology Directory® as a guideline~~ to determine whether the new technology is investigational in nature. If further information is needed, the Plan utilizes additional sources, including Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This includes medical and behavioral health procedures and devices. Pharmaceuticals are investigated by the Pharmacy and Therapeutics ~~Working~~ Committee~~Group~~. If the new technology, pharmaceutical or new application of an existing technology or pharmaceutical is addressed in the above documents, the information is taken into consideration by the Medical Director at the time of benefit determination. If the new technology, pharmaceutical or new application of an established technology/pharmaceutical is not addressed in the above documents, the Medical Director will confer with an appropriate board certified specialist consultant for additional information. ~~This information will be presented to the Technology Assessment or Pharmacy and Therapeutics Committee, subcommittees of the Medical Advisory Council, to provide a recommendation to the physician Council regarding coverage~~. The decision will be based on safety, efficacy, cost and availability of information in published literature regarding controlled clinical trials. If a decision cannot be made, a committee of specialists (including medical, pharmacy, and behavioral health practitioners) may be convened to review the new medical technology/pharmaceutical and make a recommendation to the Medical Advisory Council.

G. Emergency Services/Post Stabilization Care

No referrals are required for treatment of an emergency medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman, or her unborn child, in serious jeopardy
b. Serious impairment to bodily functions
c. Serious dysfunction of any bodily organ or part.

Emergency Room services are also covered if referred by an authorized Plan representative, PCP or Plan specialist. Plan notification (referral) is not required for payment of Emergency Room services for an emergency medical condition.

SCFHP properly arranges for the transfer of members after the member has been stabilized subsequent to an emergency psychiatric or medical condition but the provider believes further medically necessary health care treatment is required and the member cannot be safely discharged.

SCFHP does not require prior authorization for post-stabilization care

- The Plan shall fully document all requests for authorizations and responses to such requests for post stabilization medically necessary care which shall include the date and time of receipt, the name of the health care practitioner making the request and the name of the SCFHP representative responding to the request. All non-contracting hospitals are able to locate a contact number at which the hospital can obtain authorization from the SCFHP by the information on the back of the member's identification card or by the website of the Plan
- SCFHP has mechanisms in place to support that a patient is not transferred to a contracting facility unless the provider determines no material deterioration of the patient is likely to occur upon transfer

H. Determination Information Sources

UM personnel collect relevant clinical information from health care providers to make prospective, concurrent and retrospective utilization review for medical necessity and health plan benefit coverage determinations. Clinical information is provided to the appropriate clinical reviewers to support the determination review process. Examples of relevant sources of patient clinical data and information used by clinical reviewers to make medical necessity and health plan benefit coverage determinations include the following:

1. History and physical examinations
2. Clinical examinations
3. Treatment plans and progress notes
4. Diagnostic and laboratory testing results

5. Consultations and evaluations from other practitioners or providers
6. Office and hospital records
7. Physical therapy notes
8. Telephonic and fax reviews from inpatient facilities
9. Information regarding benefits for services or procedures
10. Information regarding the local delivery system
11. Patient characteristics and information
12. Information from responsible family members

I. Health Services

The scope of health services and activities include~~s~~ utilization management, utilization review determinations, referral management, discharge planning, and complex case management~~, and UM documents.~~.

1. Utilization Determinations

Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria. Qualified health care professionals supervise utilization review decisions of assigned UM staff and participate or lead UM staff training. These professionals also monitors all UM staff for consistent application of UM criteria for each level and type of UM decision, monitors all documentation for adequacy and is available to UM staff on site or by telephone. Under the supervision of a licensed medical professional, non-clinical staff collects administrative data or structured clinical data to administratively authorize cases that do not require clinical review.

Only a Medical Director, with a current California license to practice without restriction, makes medical necessity denial determinations. A Medical Director (medical or behavioral health) and/or an appropriately licensed pharmacist is available to discuss UM denial determinations with providers, and providers are notified about determination processes in the denial letter.

When applying medical necessity criteria, SCFHP shall

a. Consider individual needs of members
    i. Age
    ii. Comorbidities
    iii. Complications
    iv. Progress of treatment
    v. Psychosocial situation
    vi. Home environment, as applicable
b. Assessment of the local delivery system
    i. Availability of inpatient outpatient and transitional facilities
    ii. Availability of outpatient services in lieu of inpatient services such as surgery ~~i~~centers vs. inpatient surgery
    iii. Availability of highly specialized services, such as transplant facilities or cancer centers

iv. Availability of skilled nursing facilities, sub-acute care facilities or home care in the organization's service area to support the patient after hospital discharge
v. Local hospitals' ability to provide all recommended services within the estimated length of stay

In accordance with the DHCS contract only qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made on the basis of medical necessity. Additionally, a qualified physician or pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the ~~Plan m~~Medical ~~d~~Director, in collaboration with the ~~Plan~~ Pharmacy and Therapeutics Committee (~~PTC~~P&T) or generally accepted medical compendia and professional practice guidelines.

UM decisions are not based on the outcome of individual authorization decisions or the number and type of non-authorization decisions rendered. UM decision making is based only on appropriateness of care and service and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. UM staff involved in clinical and health plan benefit coverage determination process are compensated solely based on overall performance and contracted salary, and are not financially incentivized by the SCFHP based on the outcome of clinical determination.

Board certified physician advisors are available to the UM Program for consultation on clinical issues as well as consultation for potential denials. The UM Program maintains a list of board-certified physician specialists identified for consultation and documents their involvement in member authorization and appeal records when appropriate.

For each non-medical necessity denial, the UM Department documents within it's UM system the reason for and the specific benefit provision, administrative procedure or regulatory limitation used to classify the denial. The UM staff references the sources (e.g. Certificate of Coverage or Summary of Benefits) of the administrative denial. The Plan includes this information in the denial notice sent to the member or the member's authorized representative and the practitioner.

Decisions affecting care are communicated in writing to the provider and member in a timely manner in accordance with regulatory guidelines for timeliness. Notification communication includes appeal rights and procedures. Member notifications comply with appropriate contractual and regulatory guidance for each member's line of business. Member correspondence about authorization decisions includes a statement in each SCFHP threshold language instructing the member how to obtain correspondence in their preferred language.

The UM Program appeals and reconsideration policies and procedures assure members and providers that the same staff involved in the initial denial determination will not be involved in the review of the appeal or reconsideration. Additionally, there is separation of medical decisions from fiscal and administrative management to ~~as~~ensure medical decisions will not be unduly influenced by fiscal and administrative management.

The UM Program includes the following utilization review processes:

a) Prospective Review

Prospective (pre-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted prior to the delivery of a health care service or supply to a member. A prospective review decision is based on the collection of medical information available to the health care provider prior to the time the service or supply is provided.

b) Concurrent Review

Concurrent review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted during a member's ongoing stay in a facility or course of outpatient treatment. The frequency of review is based on the member's medical condition with respect to applicable care guidelines.

c) Retrospective Review

Retrospective (post-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted after the health care service or supply is provided to a member. A retrospective review decision is based on the medical information available to the health care provider at the time the service or supply was provided.

d) Standing Referrals

SCFHP has established and implemented a procedure by which a member may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, and the plan medical director or his or her designee, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or independent practice association. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the member.

e) Terminal Illness

In the circumstances ~~occur~~ where SCFHP denies coverage to member with a terminal illness, which refers to an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider, SCFHP shall provide to the member within five business days all of the following information:

1. A statement setting forth the specific medical and scientific reasons for denying coverage

2. A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine
3. Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the member to request a conference as part of the plan's grievance system

f) Communications

Decisions to approve, modify, or deny requests by practitioners for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting practitioner verbally as appropriate and in writing. See pages 17 through 21 for notification timelines.

In the case of concurrent review, care shall not be discontinued until the member's treating practitioner has been notified of SCFHP's decision and a care ~~P~~plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

Communications regarding decisions to approve requests by practitioners prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to practitioners initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for SCFHP's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider to contact the professional responsible for the denial, delay, or modification with ease. Responses shall also include information as to how the member may file a grievance with the Plan.

For non-behavioral, behavioral, and pharmacy communication to members for denial, delay, or modification of all or part of the requested service shall include the following:

a) Be written in a language that is easily understandable by a layperson
b) Specify the specific health care service requested
c) Provide a clear and concise explanation of the reasons for the Plan's decision to deny, delay, or modify health care services. Reason shall be written in layperson terms, easily understandable by the member
d) Specify a description of the criteria or guidelines used for the Plan's decision to deny, delay, or modify health care services
e) Specify the clinical reasons for the Plan's decision to deny, delay, or modify health care services
f) Include information as to how he-/-she may file a grievance to the Plan
g) Include information as to how he-/-she may request an independent medical review

h) Include a statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the decision was based , upon request

g) Referral Management

1. In-network

SCFHP network physicians are the primary care managers for member healthcare services. The network primary care physicians provide network specialist and facility referrals directly to members without administrative pre-authorization from the UM Program, and primary care physicians may coordinate prior authorization for utilization review on a number of services such as DME, home health, and nutritional supplements. These referrals are primarily for routine outpatient and diagnostic services and are tracked by the UM Program from claims and encounter data. All elective inpatient surgeries and non-contracted provider referrals require prior authorization. The UM Program care management system tracks all authorized, denied, deferred, and modified service requests and include timeliness records. These processes are outlined in the Provider Manual and in internal policies and procedures.

2. Emergency Services

No referrals or prior authorization requests are required for treatment of an emergency medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

i. Placing the health of the individual or, with respect to a
ii. ~~p~~Pregnant woman, the health of the woman, or her unborn child,
iii. ~~i~~In serious jeopardy
iv. Serious impairment to bodily functions
v. Serious dysfunction of any bodily organ or part

Emergency Room services are also covered if referred by an authorized Plan representative, PCP or Plan specialist. Plan notification (referral) is not required for payment of Emergency Room services for an emergency medical condition.

3. Out of Network

Requests for out-of-network Referrals are reviewed individually and determinations are made based on the patient's medical needs and the availability of services within the Provider Network to meet these needs. A physician reviewer shall assess any requests for out of network referrals.

4. Specialist Referrals

-The Primary Care Physician (PCP) may request a consultation from a participating specialist physician at any time. No referral is required from SCFHP prior to consultation with any participating specialists.

5. Tertiary Care Services

All referrals to Plan tertiary care centers are reviewed on an individual basis. The member's medical needs and the availability of the requested services within the non-tertiary care network are taken into consideration.

6. Second Opinions

A request for a second opinion may be initiated by a member or a treating healthcare provider of a member, and at no charge to the member. The processing of a request for a second opinion will be treated with the same criteria for turn-around-time as other UM referral requests. If a second opinion is not available within the Member's network, an out-of-network opinion will be arranged, at no cost other than normal co-payments, to the member. The member Evidence of Coverage provides all members with notice of the policy regarding the manner in which a member may receive a second medical opinion. The second opinion policy is reviewed, revised and approved annually.

7. Predetermination of Benefits/Outpatient Certification

Certain procedures, durable medical equipment and injectable medications are prior authorized. SCFHP uses MCG criteria for Imaging, Procedures and Molecular Diagnostics. When MCG criteria does not exist within SCFHP's purchased products, criteria are developed internally by the ~~Technology Assessment Work Group~~Utilization Management Committee, ~~or~~ Pharmacy and Therapeutics Committee, or a workgroup as appropriate. Additionally, potentially cosmetic surgery and other procedures may be reviewed prospectively, at the request of providers and members, to issue coverage determinations.

8. Authorization Tracking

SCFHP tracks a defined sub-set of out-patient authorizations for completion of the authorization to claims paid cycle. This allows for monitoring of possible barriers leading to member non-compliance with prescribed care. In addition, the plan tracks authorizations while in process for timeliness and compliance with regulations and guidelines.

h) Discharge Planning

Discharge planning is a component of the UM process that assesses necessary services and resources available to facilitate member discharge to the appropriate level of care. UM nurses work with facility discharge planners, attending physicians and ancillary service providers to assist in making necessary arrangements for member post-discharge needs. Behavioral health case managers will work with psychiatric hospital facilities to facilitate member discharge to the

most appropriate level of care and community case management. Long Term Services and Supports case managers assist members discharging from long term care.

i) UM Documents

In addition to this program description other additional documents important in communicating UM policies and procedures include:

1. The Provider Manual provides an overview of operational aspects of the relationship between the SCFHP, providers, and members. Information about the SCFHP's UM Program is included in the provider manual. In addition the Provider Manual describes how providers may obtain a copy of the clinical guidelines used to make medical determinations.
2. The Provider Manual and the web site also provide information about services/procedures requiring pre-authorization. Changes and updates are communicated to providers via faxed communications, newsletters, bulletins and the website.
3. Provider Bulletin is a monthly newsletter distributed to all contracted provider sites on topics relevant to the provider community and can include UM policies, procedures, and activities.
4. Evidence of Coverage (EOC) documents are distributed to members based on their product line. Members have the right to submit a complaint or grievance about any plan action, and the ~~Evidence of Coverage~~EOC document directs members to call the Customer Service phone number to initiate complaints or grievances involving UM issues and actions. Member complaints or grievances are documented in the data system and forwarded to the UM unit for follow-up response. The SCFHP Grievance and Appeal unit coordinates with the UM unit on appropriate responses to member complaints or grievances.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the UM Program information is available on the SCFHP website.

J. Behavioral Health Management

SCFHP provides access to all standard Medicaid based fee-for-service benefits, including applicable Behavioral Health services. Behavioral Health utilization management practices are in compliance with parity requirements of Medicaid managed care rules and the Affordable Care Act.

SCFHP members receive comprehensive behavioral health and substance abuse services according to their specific benefit package. SCFHP Medi-Cal members obtain mental health and substance use

disorder services primarily through the Santa Clara County Behavioral Health Department (CBHD). The Severely Mentally ~~i~~Ill (SMI) population will be referred through the County Call Center to County Behavioral Health Services, Federally Qualified Healthcare Clinics or Community-Based Organizations. The CBH~~S~~D will be responsible for payment of services to those who are determined by the CBHD to be SMI. The non-SMI diagnoses will be considered Mild to Moderate and after triage by the County Call Center, will be referred to Network providers by the SCFHP BH department.

Cal Medi-Connect (CMC) members will be treated the same as Medi-Cal members and referred through the County Call Center. The difference in terms of payment for CMC members is that the professional services for psychiatry, psychology and Licensed Clinical Social Work services are to be billed to SCFHP under the member's Medicare benefit. The Mild to Moderately diagnosed members will be screened by the County Call Center and referred by SCFHP BH department. SCFHP is responsible for payment. Members may contact their County Call Center, or receive physician referral within the member's medical home. SCFHP maintains procedures for primary care providers to coordinate care and services for members in need of behavioral health services including, but not limited to, all medical necessary services across the behavioral health provider network.

Santa Clara Family Health Plan does not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.

1. **Behavioral Health Integration**

   The SCFHP uses a variety of mechanisms that ensure behavioral health services and management processes are actively integrated into the UM Program and include

   a) A behavioral healthcare practitioner is involved in quarterly HCQC meetings to support, advise and coordinate behavioral healthcare aspects into UM Program policies, procedures and processes.
   b) A behavioral healthcare practitioner participates as a member of the UM interdisciplinary care team. The UM interdisciplinary care team consists of a Medical Director, Registered Nurse, Pharmacist and Behavioral Healthcare practitioner. The team meets routinely to perform member case reviews. The interdisciplinary care team evaluates topics such as access, availability, health management systems, practice guidelines, clinical and service quality improvement activities, member satisfaction, continuity and coordination of care, and member's rights and responsibilities.
   c) SCFHP routinely receives clinical reports from Santa Clara County Behavioral Health Services Department, which are reviewed by the Manager of Behavioral Health Department or other designee.
   d) SCFHP participates in quarterly operational meetings with the CBH~~S~~D to review and coordinate administrative, clinical and operational activities.

2. Santa Clara County Behavioral Health Care Services

a) Specialty behavioral health services for Medi-Cal members, excluded from the SCFHP contract with DHCS, are coordinated under a Memorandum of Understanding executed with SCFHP. This is a carve-out arrangement for behavioral health management with the State of California directly overseeing and reimbursing the behavioral health services provided to Medi-Cal members.

3. The referral procedure for SCFHP members includes

a) SCFHP Primary Care Providers (PCPs) render outpatient behavioral health services within their scope of practice.
b) PCPs refer the members to Santa Clara County Behavioral Health Services Department for evaluation and coordination of medically necessary specialty behavioral health services by the Access Team, including inpatient psychiatric care.
c) PCPs refer members to qualified Medi-Cal providers for the provision of services not covered by CBHD.
d) Members may contact the County Call Center to be screened and referred to SCFHP BH department for referrals to Network providers of Mild to Moderate services under Medi-Cal, or Cal MediConnect ~~or Healthy Kids~~ coverage

K. Pharmacy Management

~~1.~~ ~~*Scope*~~

~~a)~~ SCFHP delegates pharmacy utilization management activities in the Cal MediConnect line of business to ~~the~~ a pharmacy benefit management ~~(~~PBM)~~company MedImpact~~. ~~MedImpact~~ The PBM possesses a UM program that manages pharmacy services under the delegated arrangement. Overall UM Program oversight is performed by the Chief Medical Officer or designee with supporting policies and procedures reviewed and approved by the Quality Improvement Committee. The Chief Medical Officer and the Director of Pharmacy ~~(a licensed pharmacist)~~ are responsible for operational and clinical management of the pharmacy UM program. The scope of the UM Program encompasses all delegated processes performed by ~~MedImpact~~the PBM. These processes include: intake and triage ~~services~~requests, authorization guideline development, implementation of ~~UM~~ formulary tools and medication utilization review determinations. The Pharmacy and Therapeutics Committee provides oversight for evidence-based, clinically appropriate UM guideline criteria. Guidelines are developed in conjunction with review of peer-reviewed literature with consideration for such factors as safety, efficacy and cost effectiveness, and also with the input evaluation of external clinical specialists appropriate to the subject matter. In accordance with state, federal, and NCQA requirements, the pharmacy unit monitors timeliness and maintains policies and procedures on timeliness of UM decisions~~,~~ and notifications for pharmacy. An annual review process and ad hoc assessments support the development of guidelines that are current with the latest advancements in pharmaceutical therapy. The UM Program is evaluated annually and submitted to the Utilization Management Oversight Committee UMC for approval. This evaluation includes, but is not limited to: medication UM activities, UM structure and resources, measures

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to assess the quality of clinical decisions, overall effectiveness of the UM Program and opportunities for UM Program improvement.

~~b) Pharmacy Benefit Manager~~

~~MedImpact staff, who are delegated to perform pharmacy utilization management services and activities, involve both clinical and administrative personnel. The PBM Staff roles and responsibilities include, but are not limited to:~~

- ~~i. Medical Directors are licensed physicians with oversight of the UM Program, and also provide consultation services.~~
- ~~ii. Clinical Pharmacist Reviewers are licensed pharmacists with responsibility to perform utilization management services.~~
- ~~iii. Prior Authorization Clerks perform administrative functions such as data entry and generating reports.~~
- ~~iv. Prior Authorization Coordinators review medication requests based on MedImpact criteria as approved by SCFHP.~~
- ~~v. Prior Authorization Customer Service Representatives perform intake functions and triage customer inquiries.~~
- ~~vi. Research Coordinators contact provider offices to request additional information to compete a prior authorization request.~~

L. Long Term Services and Supports

SCFHP has established and implemented guidelines for Long Term Services and Supports authorizations for services in this area. The LTSS Team including a Long Term Care UM RN and LTSS Case Managers coordinates with the UM ~~D~~department, LTSS providers, and community partners to identify care needs and facilitate access to appropriate services to achieve positive health outcomes.

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M. Confidentiality

SCFHP has written policies and procedures to protect a member's personal health information (PHI). The Health Services Department collects only the information necessary to conduct case management services or certify the admission, procedure or treatment, length of stay, frequency and duration of health care services. We are required by law to protect the privacy of the member's health information. Before any PHI is disclosed, we must have a member's written authorization on file. Within the realm of utilization review and case management, access to a member's health information is restricted to those employees that need to know that information to provide these functions. A full description of SCFHP's Notice of Privacy Practices may be found on our website at: www.scfhp.com.

~~N. Annual Evaluation~~

~~The Health Services Department members: including UM Program management team : including the CMO, Medical Director, UM and BH Manager and Directors of UM operational areas annually evaluate and update the UM Program and develop the Annual UM program evaluation to ensure the overall effectiveness of UM Program objectives, structure, scope and processes. This team is responsible for developing an annual evaluation of the Utilization Management Program to identify strengths and areas for improvement. The written evaluation compares auditing results, utilization reports, quality indicators, survey results, and initiatives and priorities from previous years. Additionally, the Director of Health ServicesUM will have processes in place to trigger quarterly reports used for evaluating the efficiency and effectiveness of the Utilization Management Plan throughout the year.~~

~~In coordination and collaboration with the UM Chief Medical Officer, Medical Director, the Director of Quality Improvement, the Utilization Management Committee,M and Quality Improvement Committees, and the Chief Medical Officer, and Quality Management Committee, the Case Management Department implements identified opportunities for improvement that foster and promote positive change in the case management of SCFHP members. The Director of Case Management is responsible for submitting the department's annual Case Management Plan with incorporated strategies for improvement.~~

~~O.~~N. Interdepartmental collaboration

SCFHP departments collaborate~~s~~ to prevent conflicting information and to align member self-management tools, member education and information provided to the member.

Commented [AC1]: This was already discussed in Section E

Santa Clara Family Health Plan™

Utilization Management Committee

Annual Review of UM Policies / New UM Policy

Santa Clara Family Health Plan

Utilization Management Policy Review

#	Policy Name	Key Summary of Changes
HS.02	Medical Necessity Criteria	Removed Healthy Kids. Removed statement "formerly known as Milliman Care Guidelines®." Removed general references. Relocated statement of plan's defined hierarchy of criteria application. Add medical necessity review takes into account circumstances, relative to appropriate clinical criteria and policies. Remove criteria disclosure statement. Revised responsibilities. Updated references.
HS.03	Appropriate Use of Professionals	Removed Healthy Kids. Defined UM abbreviation. Revised "D. Non-licensed and licensed staff receive training and daily supervision by UM Supervisor, UM Manager, Medical Management Director and Medical Directors." To "… by "UM Department management designee and medical directors." Removed financial policy statement, policy exist. Removed general references. Updated references.
HS.04	Denial of Services Notification	Removed "that are followed by HS", removed "Approved templates are customized", elaborated/spelled out/or combined elements. Ensure threshold language. Removed Healthy Kids. Moved CMS 10.5.4. language to procedure.
HS.05	Evaluation of New Technology	Removed duplicate statement. Removed "Pharmaceuticals are investigated by the Pharmacy and Therapeutics Working Group." Removed Healthy Kids.
HS.06	Emergency Services	Removed Healthy Kids. Removed duplicate language. Replaced benefits with Provider Network Management under Responsibilities.
HS.07	LTC Utilization Review	Removed "reauthorization" from purpose. Defined LTC abbreviation. Removed Non-contracted provider and OON procedure. Revised Bed Hold language to align with DHCS. Edited HS07 to HS.07, added footer for version. Added "up to" in front of 7 days. Removed Healthy Kids.
HS.08	Second Opinion	Removed "as appropriate" from "by appropriate health care professional as appropriate." Removed Healthy Kids. Removed "beyond the applicable co pays." Removed procedural statement on notification. Revised TAT statement to general "not to exceed any applicable regulatory requirements."
HS.09	IRR	Changed "standardize" to "outline" in purpose. Statement of process for IRR in purpose. Updated NCQA reference. Changed HS leadership to UM Management. Removed pharmacy cases.
HS.10	Financial Incentives	Removed Compliance responsibilities. Removed Healthy Kids. Spelled out SCFHP. Removed non-applicable references.
HS.11	Informed Consent	Annual Review. Removed Healthy Kids.

HS.12	Preventive Health Guidelines	Removed Healthy Kids. Revised responsibilities and frequency of review. Removed references.
HS.13	Transportation Services	Removed Healthy Kids. Removed reference to procedure. Updated responsibilities. Fixed indent J. added version number to footer. Fixed previous Committee name and Date.
HS.14	System Controls	New policy required per NCQA requirements.

Santa Clara Family Health Plan

POLICY

Policy Title:	Medical Necessity Criteria	**Policy No.:**	HS.02
Replaces Policy Title (if applicable):	Clinical Decision Criteria and Application Policy; Utilization Management Review Standards, Criteria and Guidelines; UM Interrater Reliability Testing	**Replaces Policy No. (if applicable):**	CSCFHP_UM121_01; UM039_02 UM038_
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC ☒ ~~Healthy Kids~~	☒ ~~CMC~~

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I. Purpose

To define Santa Clara Family Health Plan's use of Medical Necessity Criteria for utilization management activities, which includes the mandate that they are applied appropriately and consistently to determinations of medical necessity of coverage.

II. Policy

The Plan maintains a Utilization Management (UM) Program description and Prior Authorization Procedure which further describe the Plan's utilization of Medical Necessity Criteria. The following factors apply:

A. Criteria is based on sound clinical evidence to make utilization decisions
B. Criteria is specific to the services and procedures requested~~.~~
C. Criteria~~.~~ is used to evaluate the necessity of medical and behavioral healthcare decisions
D. The Plan annually defines the hierarchy of application of criteria for each line of business
~~D.~~E. In addition to the UM hierarchy of guidelines, the Plan is licensed to use MCG™ guidelines ~~(formerly known as Milliman Care Guidelines®)~~ to guide utilization management decisions
~~E.~~F. The criteria is reviewed and adopted at least annually by the UM Committee

1. The UM Committee consists of ~~is includes~~ external physicians, both primary care providers and specialists (including pediatric and behavioral health specialists), in developing, adopting, and reviewing criteria

~~F.~~G. The medical necessity review~~criteria~~ takes into account individual member needs and circumstances, relative to appropriate clinical criteria and SCFHP policies ~~and the local delivery system~~

Commented [AC1]: Reference: 2020 HP Standards and Guidelines, UM1

~~G.A. The Plan annually defines the hierarchy of application of criteria for each line of business~~
H. The plan defines the availability of criteria and states in writing how practitioners can obtain UM criteria and how the criteria is made available to the practitioners and members upon request
I. The plan~~-~~ evaluates the consistency with which health care professionals involved with any level of applying UM criteria in decision making and takes appropriate corrective actions to improve areas of non-compliance at least annually

POLICY

J. Where applicable, UM criteria is developed for parity diagnoses, for the diagnosis and treatment of serious mental illnesses, autistic disorders, and other pervasive-developmental disorders and serious emotional disturbances of a child.

1. This includes criteria consistent with standards of practice for the following mental parity conditions: Schizophrenia, Schizoaffective disorder, Bipolar disorder, Major Depressive Disorders, Panic disorder, Obsessive-compulsive disorder, Pervasive developmental disorder or autism, Anorexia Nervosa, Bulimia Nervosa and Severe Emotional Disturbances of Children.

~~2. When SCFHP discloses medical necessity criteria to the public, the criteria includes the following disclosure: "The materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."~~

III. Responsibilities

~~Health Services~~Chief Medical Officer or designee shall reviews annually and submits criteria, policies and procedures to ~~the medical officer and UM/QIC~~the Utilization Management Committee for approval.

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.~~

National Committee for Quality Assurance. 2020 Program Standards and Guidelines – UM 2: Clinical Criteria for UM Decisions

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Lily Boris, MD	Laurie Nakahira, DO
Name	Name
Medical Director	Chief Medical Officer
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 04/20/2016**	
v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/16/2019**	
v2	**Revised**	**Utilization Management**		

POLICY

Santa Clara Family Health Plan

POLICY

Policy Title:	**Appropriate Use of Professionals**	**Policy No.:**	HS.03
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal ☒ ~~Healthy~~ CMC~~Kids~~		☒ ~~CMC~~

Commented [AC1]: No longer needed

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I. Purpose

To ~~-~~provide clear directives that U~~u~~tilization ~~m~~Management (UM) activities are carried out by qualified personnel, not limited to but including utilization of licensed healthcare professionals for any determination requiring clinical judgment.

II. Policy

A. Santa Clara Family Health Plan's Health Services Department carries out various utilization management activities which require different levels of licensure or expertise.

B. The Plan specifies the type of personnel responsible for each level of ~~UM~~ decision making which includes:
   - Non-licensed staff may apply established and adopted UM Care Coordinator guidelines that do not require clinical judgment.
   - Only qualified licensed healthcare professionals assess ~~-~~clinical information used to support UM decisions.
   - Only a physician, designated behavioral health practitioner or pharmacist may make a medical necessity denial decision.

C. Licensed professionals supervise all medical necessity decisions and provide day to day supervision of assigned UM staff.

D. Non-licensed and licensed staff receive training and daily supervision by ~~UM Supervisor, UM Manager, Medical Management Director and Medical Directors~~UM Department management designee and medical directors.

E. The Plan~~-~~ maintains written job descriptions with qualifications for practitioners who review denials based on medical necessity which addresses education, training, experience and current appropriate clinical licensure.

F. The Plan~~SCFHP~~ maintains a fulltime Medical Director and Chief Medical Officer. Each maintain an un-
restricted physician license in the state of California.

G. The Plan requires that each UM denial file includes the reviewer's initial, unique electronic signature, identifier or a signed / initialed note by the UM staff person attributing the denial decision to the professional who reviewed and decided the case.

POLICY

H. The plan maintains written procedures for using board certified consultants to assist in making medical necessity determinations which documents evidence of the use of the consultants when applicable.

~~I. The Plan maintains a Policy prohibiting financial incentives for UM decisions, including incentives to deny requests or to encourage underutilization.~~

Commented [AC3]: Statement not necessary as there is a separate policy (HS.10 Financial Incentive).

III. Responsibilities

Health Services follows appropriate professionals supported by Human Resources for licensing verification and Provider Network Management monitoring of the professional licensing organizations.

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.~~

National Committee for Quality Assurance. 2020 Standards and Guidelines - UM 4: Appropriate Professionals

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V. Approval/Revision History

First Level Approval	Second Level Approval
Signature Lily Boris, MD	Signature Laurie Nakahira, DO
Name Medical Director	Name Chief Medical Officer
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1		**Utilization Management**	**Approve 01/08/2017**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/16/2019**	
v2	**Revised**	**Utilization Management**		

Santa Clara Family Health Plan

POLICY

Policy Title:	**Denial of Services Notification**	**Policy No.:**	HS.04
Replaces Policy Title (if applicable):	Member Notification about Adverse Medical Service Decisions	**Replaces Policy No. (if applicable):**	UM-01-96
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~Healthy~~ CMC ~~Kids~~	☒ ~~CMC~~

I. Purpose

To define Santa Clara Family Health Plan's expectations for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations.

II. Policy

A. The plan maintains strict processes on notification of denial decisions to members and providers. Notification includes verbal and written processes. A procedure is maintained that outlines timeliness guidelines ~~that are followed by Health Services~~.

B. A "peer to peer" review mechanism is in place to allow providers to discuss a denial with a physician reviewer prior to submitting an appeal. This is documented when such discussions occur.

C. Letters will be provided in the language noted on the member's plan file within the ~~DHCS~~ threshold language requirement.

~~Per 10.5.4 of Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, the plan will exercise good faith effort to provide verbal notification to the member and provider of the coverage decision proceeded by written notification for expedited requests. The plan will make an outbound call to the member and provider to the telephone number on file to provide verbal notice. This good faith effort to the member and provider will be completed and documented within 72 hours of the request with written notice of the decision to be sent within 3 calendar days of the verbal notice.~~

~~C.~~D. Letters to members for denial, delay, or modification of all or part of the requested service include~~: the following.~~:

~~1. Approved templates are customized to each line of business and filled out appropriately for each member request~~

~~2.~~1. ~~Specifies the denied or modified service or care requested and provides a~~A clear and concise~~–~~ explanation of the reason(s) for the Plan's decision to deny or modify the requested service.

~~3.~~2. A reference to the ~~S~~specific benefit provision, ~~as the~~ criteria or guidelines used for the Plan's decision

~~4.~~3. ~~S~~A specifi~~c~~es ~~the~~ clinical reason(s) or rationale for the Plan's decision without the use of detailed medical verbiage and/or technical language that is easily understandable for a reasonable layperson~~ in the member's preferred language~~.

~~5.~~4. The specific information needed and the specific criterion used ~~i~~if the denial is due to not enough

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clinical information to support full clinical review~~, the letter specifies the information needed and the specific criterion used~~

~~6.~~5. Notice ~~Advises that upon request, members and providers can obtain~~that a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based is available~~,~~ upon request.

~~7. The letter and member specific language for reason of denial is easily understood for a layperson~~

~~8. Provided in the language noted on the member's plan file within the DHCS threshold language requirement~~

~~9.~~ Notice that ~~Advises that n~~notifications are available in other languages upon request and that

~~10.~~6. ~~Advises that~~ translation services in alternative formats can be requested for members with limited language proficiency

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POLICY

~~11.~~7. The ~~written notification to the requesting provider includes the~~ name of the determining health care professional as well as the telephone number to allow the physician or provider to easily contact the determining health care professional on the written notification to the requesting provider

~~12.~~ Instruction on how to file an appeal~~The Plan's written denial notification to members and their treating practitioners contains the following information relevant to the appeal~~

8. including:

i. A description of appeal rights, including the right to submit written comments; documents or other information relevant to the appeal

ii. An explanation of the appeal process; including members' rights to representation and appeal time frames

iii. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials

iv. A description on how to appeal to the Independent Medical Review body appropriate to their line of business (i.e. State DMHC for Medi-Cal, Maximus for Medicare ~~non pharmacy~~)

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III. Responsibilities

Health Services coordinates with both internal and external stakeholders in development, execution, maintenance and revisions to ~~D~~denial n~~N~~otifications. This includes but is not limited to collaboration with Quality, Benefits, IT, UM Committee, QIC, providers and community resources.

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.

Department of Health Care Services. ALL PLAN LETTER 17-011 STANDARDS FOR DETERMINING THRESHOLD LANGUAGES AND REQUIREMENTS FOR SECTION 1557 OF THE AFFORDABLE CARE ACT. Retrieved 12/18/2018*https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-011.pdf*

V. Approval/Revision History

First Level Approval		Second Level Approval	
Signature Lily Boris, MD		Signature Laurie Nakahira, DO	
Name Medical Director		Name Chief Medical Officer	
Title		Title	
Date		Date	
Version Number	**Change (Original/ Reviewed/ Revised)**	**Reviewing Committee (if applicable)**	**Committee Action/Date (Recommend or Approve)**	**Board Action/Date (Approve or Ratify)**

POLICY

v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/16/2019**	
v2	**Revised**	**Utilization Management**		

POLICY

Santa Clara Family Health Plan

POLICY

Policy Title:	**Evaluation of New Technology**	**Policy No.:**	HS.05
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~Healthy Kids~~CMC	~~☒ CMC~~

I. Purpose

To define Santa Clara Family Health Plan's process~~-~~ used ~~-~~where members have equitable access to new technology or new developments in technology that is determined to be safe and effective as aligned with benefits.

II. Policy

A. The Plan establishes and maintains a formal mechanism for selective evaluation and adoption of new or innovative technologies.
   1. New developments in technology and new applications of existing technology is necessary for inclusion considerations in its benefits plan as allowed, to keep pace with changes in the industry and allow for improved outcomes of medical care.

B. The Plan maintains written processes for evaluating new technology and new applications of existing technologies for inclusion in its benefits, where allowed by payors. Processes will address assessment of new technologies for medical procedures, behavioral health procedures, pharmaceuticals, and devices.

C. The Plan investigates all requests for new technology or a new application of existing technology by using Up to Date as a primary guideline to determine if the technology is considered investigational in nature.
   1. Up to Date is an evidence-based clinical decision support resource for healthcare practitioners. If further information is needed, the plan utilizes additional sources, include Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This includes medical and behavioral health procedures and devices. ~~Pharmaceuticals are investigated by the Pharmacy and Therapeutics Working Group.~~

D. If the new technology, pharmaceutical, or new application of an established technology/pharmaceutical is not addressed in the above documents, the Medical Director's critical evaluation will proceed to conferring with an appropriate specialist consultant for additional information.

~~E. If the new technology, pharmaceutical or new application of an established technology/pharmaceutical is not addressed in the above documents, the Medical Director's critical evaluation will proceed to conferring with an appropriate specialist consultant for additional information.~~

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POLICY

III. Responsibilities

Health Services coordinates efforts with internal stakeholders to ensure new technology is assessed for regulatory appropriateness and efficacy. Benefit changes are coordinated with IT and compliance.

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 Lily Boris, MD	Signature Laurie Nakahira, DO
Name Director of Medical Management	Name Chief Medical Officer
Title 02/04/2019	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/16/2019**	
v2	**Revised**	**Utilization Management**		

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Policy Title:	**Emergency Services**	**Policy No.:**	HS.06
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~Healthy Kids~~CMC	~~☒ CMC~~

I. Purpose

To define ~~-~~coverage of Emergency Medical Conditions and Urgent Care services.

II. Policy

A. Emergency Services are available and accessible within the service area 24 hours-a-day, seven (7) days-a-week

B. The Plan maintains contracts with behavioral health practitioners and facilities to provide services to members that require urgent or emergent Behavioral Healthcare for crisis intervention and stabilization

C. SCFHP includes ambulance services for the area served to transport the member to the nearest 24-hour emergency facility with physician coverage

D. The Plan does not require prior authorization for access to ~~E~~emergency ~~S~~services and care necessary to stabilize the member's medical condition

E. The Plan does not require prior authorization for Urgent services for contracted and non contracted providers.

F. The Plan applies prudent layperson or reasonable person's interpretation of what may be considered an emergent condition ~~language~~and to define emergency department access. Each case will be assessed ~~and assesses each case~~ on the presenting symptoms or conditions that steered the member to the Emergency Department.

~~G. No authorization is required for emergency services~~

~~i. To screen and stabilize the member~~

~~ii. Should a member be directed to the ED by an agent of SCFHP (i.e. contracted PCP or specialist, nurse advice line, customer service, etc.) then the ED service will be approved regardless of prudent layperson language.~~

~~H.~~G. In the occasion where an Emergency Department visit was to be denied, that denial must be made by a physician reviewer (except in administrative circumstances such as the claimant was not a member at the time of service).

~~I.~~H. It is the policy of SCFHP to allow 24-hour access for members and providers to obtain timely authorization for medically necessary care where the member has received emergency services and the care has been stabilized but the treating physician feels that member may not be discharged safely

~~J. SCFHP does not require prior authorization for the provision of emergency services and care necessary to stabilize the member's medical condition.~~

~~K.~~I. The Plan will not deny reimbursement of a provider for a medical screening examination in the Emergency Department

Commented [AC1]: Added from HS.01 Prior Authorization

~~L.~~J. If the Plan and the treating provider disagree about the need for post-stabilization care, then the Plan provider will personally take over the care of the patient within a reasonable amount of time for post-stabilization care or the Plan will have another hospital agree to accept the transfer of the member

K. The Plan makes the Emergency Department utilization management processes available to all facilities, including non-contracting hospitals by posting on the Plan website for public view and providing the phone number to call on the membership card.

~~M.~~L. The Plan reviews the Emergency Services poligy on an annual basis at a minimum

~~i. Posting on the Plan website for public view~~

~~ii.~~i. ~~Providing the number on the membership card~~ M. All ED practices are considered at least annually

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III. Responsibilities

Health Services collaborates internally with ~~benefits~~Provider Network Management, compliance and IT to ensure that emergency services are covered.

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 Lily Boris, MD	Signature Laurie Nakahira, DO
Name Medical Director	Name Chief Medical Officer
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	
v1	**Reviewed**	**Utilization Management**	**Approve 01/16/2019**	
v2	**Revised**	**Utilization Management**		

Santa Clara Family Health Plan

POLICY

Policy Title:	**Long Term Care Utilization Review**	**Policy No.:**	HS.07
Replaces Policy Title (if applicable):	**Authorization and Review Process – Long Term Care (LTC)**	**Replaces Policy No. (if applicable):**	HS.14
Issuing Department:	Health Services	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal~~X Medi-Cal~~	☒ CMC~~☐ Healthy Kids~~	~~X CMC~~

I. Purpose

To define and outline the requirements for reviewing and processing Long Term Care (LTC) authorizations ~~and reauthorizations~~ for a member's admission to, continued stay in, or discharge from a Skilled Nursing Facility (SNF)

II. Policy

A. ~~Santa Clara Family Health Plan (SCFHP) Health Services (HS)~~The Plan shall authorize utilization of Medi-Cal long term care (LTC) services for its members when medically necessary and determine level of care and length of stay based on the member's current assessment ~~and~~ consistent with Medi-Cal criteria.

B. Requests for admission to, continued stay in, or discharge from any LTC facility shall be processed in accordance with the California Department of Health Services (DHCS) standard clinical criteria for LTC level of service. LTC level of care Prior Authorization Request (PAR) processing procedure will be in compliance with applicable regulatory requirements.

C. Decisions to deny or ~~to~~ authorize a~~n~~ duration~~,~~ or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition and disease or Managed Long Term Services and Supports (MLTSS) needs.

~~D. Non- contracted providers and oOut of area providers will follow Out of Network/Out of Area Procedure for Utilization review.~~

~~E.~~D. SCFHP notifies LTC providers of required supporting documentation for Utilization review. When PAR submissions do not include required documentation, SCFHP will follow up with the nursing facility with 3 outreach attempts to request the documents and if they are not received, the PAR will be reviewed and possibly denied by a medical professional for insufficient information.

~~F.~~E. ~~-~~On-site level of care review by a~~n~~ Licensed Nurse for an LTC PAR may be performed at the discretion of SCFHP. This review shall include an assessment of the Member and review of the current medical orders, ~~-~~and care plan, therapist treatment plan, the facility's multidisciplinary team notes, or other clinical data to assist SCFHP staff in making an appropriate determination on the authorization request. On-site review may be done when indicated for patterns of high service utilization, frequent acute hospitalization, and/or large number of member complaints or concerns.

~~G.~~F. A~~Rea~~uthorizations of ~~an~~ LTC PAR for continued stay shall be submitted by the nursing facility to SCFHP prior to the expiration of the current~~active~~ LTC ~~PAR~~authorization. The requests shall include a completed LTC PAR signed by a physician, the most recent Quarterly Assessment MDS, and sufficient

documentation to justify the level of care and continued stay. AReauthorizations for LTC may be approved for up to one year.

H.G. The PlanSCFHP may arrange and coordinate with the nursing facility for modification of care or discharge of a member from a nursing facility if it determines that one or more of the following circumstances are present:

- The SNF is no longer capable of meeting the member's health care needs;
- The member's health has improved sufficiently so that he or she no longer needs SNF services; or
- The member poses a risk to the health or safety of individuals in the nursing facility; or.
- The SNF does not meet SCFHP network standards because of documented quality of care concerns.

I.H. Bed Hold The Plan shall include, as a separate benefit, any leave of absence, or Bed Hold, that a nursing facility provides in accordance with the Department of Health Care Services (DHCS) requirements of up to 7 calendar days per discharge. The member's attending physician must write a physician order for a discharge or transfer at the time the member requires a discharge or transfer from an LTC facility to a General Acute Care Hospital and include an order for Bed Hold with the reason.

a) SCFHP shall include as a separate benefit any leave of absence or Bed Hold that a nursing facility provides in accordance with Medi-Cal requirements b)Bed Holds (BH) and should be submitted by the SNF at the time of transfer

c) The member's attending physician must write a physician order for a discharge or transfer at the time a member requires a discharge or transfer from an LTC facility to a General Acute Care Hospital and include an order for Bed Hold.

d) Bed Hold (BH) is limited to seven (7) calendar days per discharge

J.I. The Plan SCFHP shall be responsible for the timely provision of a member's medical needs, supports and services through the LTC post-discharge and transition to community. The discharge planning may include but is not limited to:

- Documentation of pre-admission, or baseline status including: living arrangements, functional status, durable medical equipment (DME) and other services received; understanding of medical condition or functional status by the member or representative, physical and mental health status, financial resources and social supports.
- Initial set-up of services needed after discharge including medical care, medication, DME, identification and integration of long term services and supports, type of placement preferred and agreed to, hospital recommendations and pre-discharge counseling recommended.
- Initial coordination of care, as appropriate with the member's caregiver, other agencies and knowledgeable personnel, as well as providing care coordination contact information for the facility.
- Provision of information for making follow up appointments

References

SCFHP Utilization Management Program Description

1. Duals Plan Letter (DPL) 14-002 Requirements for Nursing Facility Services
2. Duals Plan Letter (DPL) 14-004 Continuity of Care
3. Duals Plan (DPL) 16-003; Discharge Planning for Cal MediConnect
4. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
5. Title 22, California Code of Regulations (CCR) §§ 51120, 51121, 51124, 5125, 51118, and 51212
6. Welfare &Institutions Code §§ 14087.55, 14087.6, 14087.9 and 14103.06

III. Approval/Revision History

First Level Approval	Second Level Approval

Commented [AC1]: Reference: DHCS: 2 - Leave of Absence, Bed Hold, and Room and Board. Long Term Care 506. April 2019

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Commented [AC2]: Reference: DPL 16-003, pg 2
Reference: 3 Way Contract 2.5.2.15.2

Signature Lori Andersen, Director, Managed Long Term Services and Support Services Name/Title Date	Signature Laurie Nakahira, DO, Chief Medical Officer Name/Title Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v~~V~~1	~~4/18/2018~~ ~~o~~Original	Utilization Management	Approved 4/18/2018	
v~~V~~2	~~1/16/2019~~ Reviewed	Utilization Management	Approved 1/16/2019	
v3	Revised	Utilization Management		

POLICY

Policy Title:	Second Opinion	**Policy No.:**	HS.08
Replaces Policy Title (if applicable):	Second Opinion Policy and Procedure	**Replaces Policy No. (if applicable):**	UM-30-96; UM036_01
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~Healthy~~ CMC ~~Kids~~	☐ ~~CMC~~

I. Purpose

To define the process of obtaining second opinions and member access to a second opinion by appropriate healthcare professionals ~~as appropriate~~.

II. Policy

A. A request for a second opinion may be initiated by a member or a treating healthcare provider of a member

B. The member Evidence of Coverage provides all members with notice of the policy regarding the manner in which a member may receive a second medical opinion.

C. The Plan provides or authorizes a second opinion by an appropriately qualified health care professional, if requested by a member or participating health professional.

~~D. When the member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness would be detrimental to the enrollee's ability to regain maximum function, the Plan will authorize or deny the second opinion request within 72 hours.~~

~~E.~~D. ~~When the member's condition is non-urgent, t~~The Plan shall ~~authorizes or denies~~ the second opinion requests ~~in an expeditious manner~~ not to exceed the ~~usual UM policy~~any appliciable regulatory requirements.

~~F.~~E. The member may choose from any provider from any independent practice association or medical group within the network of the same or equivalent specialty to provide the second opinion

~~G.~~F. If the member requests a second opinion from an out-of-network specialist which is approved by the Plan, the Plan shall incur the cost for the second opinion ~~beyond the applicable co-pays~~ due by the member~~, if any~~.

~~H.~~G. The Plan shall notify the member and provider of any denial for a second opinion in writing within the appropriate timeframe. ~~If an expedited request, the member will be notified in alignment with established UM procedures. When the request is denied, notifications are made to the member and provider with an explanation of the reason of the decision, a description of the criteria or guidelines used and clinical reason for the decision regarding medical necessity denials. Any written communication to a physician or other health care provider of a denial, delay or modification of a request includes the name of the deciding Medical Director or CMO along with contact information.~~ Information on how to file a grievance or appeal is included.

III. Responsibilities

Health Services follows the Second Opinion policy and procedure as directed and reviewed on an annual basis. ~~works collaboratively with internal and external departments including Quality, Benefits, IT, Providers and community services.~~

POLICY

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 Lily Boris, MD	Signature Laurie Nakahira, DO
Name Medical Director	Name Chief Medical Officer
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 01/18/2017**	
~~V~~v1	**Reviewed**	**Utilization Management**	**Approve 01/17/2018**	
~~V~~v1	**Reviewed**	**Utilization Management**	**Approve 01/16/2019**	
v2	Revised	Utilization Management		

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Santa Clara Family Health Plan

POLICY

Policy Title:	**Inter-Rater Reliability**	**Policy No.:**	HS.09
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~Healthy~~ CMC ~~Kids~~	~~☒ CMC~~

I. Purpose

To ~~standardize~~ outline Santa Clara Family Health Plan (SCFHP)'s process for Inter-Rater Reliability (IRR) testing to ensure accurate and consistent application of medical necessity criteria and guidelines.

II. Policy

SCFHP evaluates the consistency with which clinical and non-clinical staff involved with any level of applying Utilization Management (UM) criteria in decision making at least bi-annually. When a staff member is found to not be proficient, corrective measures will be pursued.

A. IRR testing will include Medical~~,~~ and~~-~~ Behavioral Health~~, and Pharmacy Cases~~

1. At least 10 hypothetical cases are presented to include a combination of:
   a. Approved and denied Prior Authorization requests
   b. Requiring non-clinician and/or clinician review
   c. Outpatient and Inpatient services
2. Reviewers will include all temp, interim, and permanent UM staff and any Health Services staff that are involved in prior authorization decision making: care coordinators, personal care coordinators and licensed nurses, social workers, pharmacists and medical directors.

B. Review

1. Identical cases are distributed to each reviewer
2. The reviewer completes the review individually on paper as if it was a real-time review
3. All cases will be reviewed by ~~Health Services leadership~~UM Management for a consensus decision-making within 1 week following due date.
4. Each item is worth one point.
5. 80% is considered a passing score.
   a. Below Proficient (<80%)
      i. A corrective action plan will be implemented by UM Management. The plan includes the following:
         a) Training in the area identified to be deficient
         b) Re-testing after training complete to ensure compliance

c) Oversight of employee determinations, including coaching and observation, as appropriate
d) Repeat of process as needed
e) Possible escalation to individualized Performance Improvement Plan which will be part of employee's personnel file.

III. Records

All results and internal Corrective Action Plans (CAPS) remain confidential and are maintained within Health Services and are reported to the UMC.

IV. Responsibilities

Health Services coordinates with both internal and external stakeholders in development and administration of IRR testing at least bi-annually in an effort to ensure consistency amongst staff for UM criteria. ~~, execution, maintenance and revisions to Denial Notifications. This includes but is not limited to collaboration with Quality, Benefits, IT, UM Committee, QIC, providers and community resources~~

V. Reference

National Committee for Quality Assurance. 2020 HP Standards and Guidelines - UM 2: Clinical Criteria for UM Decision, Element C.

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

~~VII.~~VI. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Lily Boris, MD Name	Laurie Nakahira, DO Name
Medical Director Title	Chief Medical Officer Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Utilization Management	Approve/01/18/2017	
v1	Reviewed	Utilization Management	Approve 01/17/2018	
v1	Reviewed	Utilization Management	Approve 01/16/2019	
v2	Revised	Utilization Management		

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Santa Clara Family Health Plan

POLICY

Policy Title:	~~UM~~ **Financial Incentives (Prohibition of)**	**Policy No.:**	HS.10
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~Healthy~~ CMC~~Kids~~	☒ ~~CMC~~

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I. Purpose

To provide clear directives prohibiting financial incentives for Utilization Management (UM) decisions.

II. Policy

~~1.~~ ~~A.~~ Santa Clara Family Health Plan (SCFHP) does not reward decision makers or other individuals for UM decisions. Providers, practitioners and members are notified of this policy through the Member Handbook and Provider Manual, which are also available on the website.

A.

~~2.~~ The Plan, at no time, provides financial or other incentives for UM decisions. UM approvals and denial decisions are based strictly on the appropriateness of care or service and existence of coverage.

B.

~~3.~~ The Plan never specifically rewards practitioners or other individuals to deny, limit, or discontinue medically necessary covered services.

C.

~~4.~~ The Plan does not encourage decisions that result in underutilization of care or services.

D.

~~5.~~ E. SCFHP Staff and Providers are notified annually of the Plan policy of prohibition for financial or other incentives for UM decisions.

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III. Responsibilities

All internal, contracted staff and vendors involved with UM activities are notified of the policy prohibiting financial incentives for UM decisions. IT and Benefits ensure the appropriate criteria/benefits are in place for appropriate decision making. ~~Compliance/QA activities monitor.~~

IV. References

3 Way Contract. ~~(2014)~~ *Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services*.

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POLICY

~~NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A. UM4;Elemement G~~
~~Technical Assistance Guide; Utilization Management; Routine Medical Survey UM 001. (2015, October 27).~~
~~*Department of Managed Healthcare; Division of Plan Surveys.* California, United States: California~~
~~Department of Health Care Services.~~

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V. Approval/Revision History

First Level Approval	Second Level Approval
Signature Lily Boris, MD	Signature Laurie Nakahira, DO
Name Medical Director	Name Chief Medical Officer
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v-1	Original	Utilization Management	Approve 01/18/2017	
v~~V~~1	Reviewed	Utilization Management	Approve 01/17/2018	
v~~V~~1	Reviewed	Utilization Management	Approve 01/16/2019	
~~V~~v2	Revised	Utilization Management		

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Santa Clara Family Health Plan

POLICY

Policy Title:	Informed Consent	**Policy No.:**	HS.11
Replaces Policy Title (if applicable):	Informed Consent Policy	**Replaces Policy No. (if applicable):**	PPQI-04C
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~Healthy~~ CMC~~Kids~~	☒ ~~CMC~~

I. Purpose

To standardize Santa Clara Family Health Plan's (SCFHP) provider requirements for obtaining, documenting and storing informed member consent.

II. Policy

SCFHP recognizes that it is necessary for members to be aware of risks and benefits of treatment and options available. It is Plan policy that members be well informed and that consent for certain high risk procedures/services as well as reproductive health services be obtained and properly recorded and stored in the member medical record.

III. Responsibilities

Health Services developed and maintains the policy on Informed Consent. The Utilization Management Committee adopts and reviews the policy. Provider Relations and Marketing provide information to members and providers via the web site. Quality Improvement reviews medical records for necessary documentation.

IV. References

DHCS Renewed Contract; Exhibit A, Attachment 4, Medical Records, 6)
Knox Keene**§ 1363.02.** Reproductive health services information; statement

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature Lily Boris, MD	Signature Laurie Nakahira, DO
Name Medical Director	Name Chief Medical Officer
Title	Title
Date	Date

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

POLICY

v1	Original	Utilization Management	Approve 01/18/2017	
v~~V~~1	Reviewed	Utilization Management	Approve 01/17/2018	
v~~V~~1	Reviewed	Utilization Management	Approve 01/16/2019	
V1	Reviewed	Utilization Management		

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POLICY

Policy Title:	**Preventive Health Guidelines**	**Policy No.:**	HS.12
Replaces Policy Title (if applicable):	Pediatric Preventive Health Services Adult Preventive Health Services	**Replaces Policy No. (if applicable):**	QM003_02 QM004_02
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~Healthy Kids~~CMC	☒ ~~CMC~~

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I. Purpose

To standardize Santa Clara Family Health Plan's (SCFHP) Preventive Health Guideline adoption, promotion and management.

II. Policy

SCFHP guidelines are intended to help clinicians, practitioners and members make informed decisions about appropriate preventive health care. This includes guidelines for perinatal care, children up to 24 months, 2-19 years, adults 20-64 years, or 65 or more years old.

The Utilization Management Committee (UMC) reviews and adopts preventive health guidelines that define standards of practice as they pertain to promoting preventive health services. Whenever possible, guidelines are derived from nationally recognized sources. They are based on scientific evidence, professional standards or in the absence of the availability of professional standards, an expert opinion. The preventive health guidelines are reviewed and updated ~~at least every two years and more frequently~~ when updates are released by the issuing entity. The Plan expects its practitioners to utilize the adopted guidelines in their practices, and recognizes the inability of the guidelines to address all individual member circumstances.

III. Responsibilities

~~The Preventive Health Guidelines are developed by health services utilizing nationally recognized sources~~
~~The~~ Preventive health ~~G~~guidelines are reviewed ~~at least bi-annually~~periodically. Guidelines are available to providers and members on the Plan's website.

IV. References

~~28 CCR 1300.70(b) (2) (G) (5)~~
~~28 CCR 1300.70(b) (2) (H)~~
~~NCQAStandardsQI7ElementB~~

V. Approval/Revision History

POLICY

First Level Approval	Second Level Approval
Signature Lily Boris, MD	Signature Laurie Nakahira, DO
Name Director of Medical Management	Name Chief Medical Officer
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Utilization Management	Approve 01/18/2017	
v~~1~~1	Reviewed	Utilization Management	Approve 01/17/2018	
v~~1~~1	Reviewed	Utilization Management	Approve 01/16/2019	
v2	Revised	Utilization Management		

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Santa Clara Family Health Plan

POLICY

Policy Title:	**Transportation Services**	**Policy No.:**	HS.13
Replaces Policy Title (if applicable):	Non-Emergency Medical and Non-Medical Transportation Services	**Replaces Policy No. (if applicable):**	HS.14
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC~~Healthy Kids~~	~~☒ CMC~~

I. Purpose

To define Santa Clara Family Health Plan's (SCFHP) coverage for emergency, non-emergency medical (NEMT) and non-medical transportation services (NMT).

II. Policy

Emergency m~~M~~edical ~~T~~transportation

~~A.~~ ~~Emergency medical transportation~~ does not require prior authorization. ~~Detailed information regarding emergency services is available in Policy and Procedures HS.06 Emergency Services - Medical and HS.06.01 Emergency and Post-Stabilization Services~~

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Non-Emergency Medical Transportation (NEMT) Services

A. NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist or mental health or substance use disorder provider. NEMT services are subject to prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of car~~s~~e, to a skilled nursing facility or an intermediate care facility. SCFHP will make our best effort to refer for and coordinate NEMT for carved out services.
B. Medical professional's decisions regarding NEMT will be unhindered by fiscal and administrative management. SCFHP will authorize, at a minimum, the lowest cost type of NEMT transportation that is adequate for the member's medical needs. There are no limits to receiving NEMT as long as the member's medical services are medically necessary and the NEMT has a prior authorization.
C. SCFHP will provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. The plan will provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The plan will ensure door-to-door assistance for all members receiving NEMT services.
D. SCFHP will provide transportation for a parent or a guardian when the member is a minor. With written consent of a parent or guardian, SCFHP will arrange NEMT for a minor who is

unaccompanied by a parent or guardian. SCHFP will provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service.

E. SCFHP will provide the following four available modalities of NEMT when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care:
    a. Ambulance services
    b. Litter van services
    c. Wheelchair van services
    d. Air
F. SCFHP will use a DHCS approved physician certification statement (PCS) form to determine the appropriate level of service. Once the member's treating physician prescribes the form of transportation, SCFHP will not modify the authorization. PCS form must be completed before NEMT can be prescribed and provided.
G. SCFHP will capture and submit data from the PCS form to DHCS.

Non-Medical Transportation (NMT) Services

A. SCFHP will provide NMT for members to obtain medically necessary services like primary care and specialty appointments, mental health, substance use disorder, dental and other services covered by SCFHP. In addition, SCFHP will also provide NMT for any other benefits delivered through the Medi-Cal FFS delivery system.
B. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter ~~e~~vans, or wheelchair vans.
C. SCFHP will provide round trip-transportation for a member to obtain covered and carved out Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance.
D. The NMT approved must be the least costly method of transportation that meets the member's needs.
E. As a Member Services Guide, SCFHP will include information in the Evidence of Coverage on the procedures for obtaining NMT services, a description of NMT services and the conditions under which NMT is available.
F. NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation.
G. SCFHP will provide transportation for a parent or a guardian when the member is a minor. With written consent of a parent or guardian, SCFHP will arrange NMT for a minor who is unaccompanied by a parent or guardian. SCHFP will provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service.
H. SCFHP will provide mileage reimbursement consistent with the IRS rate for medical purposes when conveyance is in a private vehicle arranged by the member. The member must attest in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. In order to receive gas mileage reimbursement for use of a private vehicle, the driver must have a valid driver's license, valid vehicle registration, and valid vehicle insurance.

POLICY

I. NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.

J. SCFHP will meet DHCS contractually required timely access standards for NEMT and NMT.

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III. Responsibilities

Health Services will review prior authorization for NEMT.
Customer Services will coordinate NMT and NEMT.
Provider Network Management will educate the provider network on NEMT and NMT benefits and requirements.
~~Health Services, Claims, Grievances & Appeals, and Customer Service will gather data for submission.~~

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IV. References

APL 17-010 Non-Emergency Medical and Non-Medical Transportation Services

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature Lily Boris, MD	Signature Laurie Nakahira, DO
Name Director of Medical Management	Name Chief Medical Officer
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	~~01/16/2019~~Utilization Management	**Approve 01/16~~3~~/2019**	
~~V2~~v2	Revised			

POLICY

Santa Clara Family Health Plan

Policy Title:	**System Controls**	**Policy No.:**	HS.15
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To describe Santa Clara Family Health Plan's (SCFHP) system controls specific to Utilization Management (UM) denial and appeal notification and receipt dates.

II. Policy

A. Turn-around-times (TAT) for requests are based on the date and time of receipt
    1. Due date and time of reviews, depending on the type of request, is calculated from the date and time the request was received by the UM department

B. Written notification of decisions will be sent to the member and provider within the appropriate turn around timeframe of the type of request based on the receipt date and time of the faxed request

C. The UM department only uses the date and time stamp found on the bottom of the faxed document when it is received by UM as the receipt date and time. The receipt date and time is not to be modified.
    1. At the time of data-entry, the UM staff will enter the receipt date and time of the request into the UM platform, QNXT, to automatically calculate the due date and time based on type of request and line of business

D. Quality Assurance reports are run monthly and as needed to cross check accuracy of data entry from the receipt date to the recorded information in the UM platform.

III. Responsibilities

Health Services collaborates with IT to ensure the information received on the faxed document is accurately reflected in the UM platform

IV. References

National Committee for Quality Assurance. 2020 HP Standards and Guidelines: UM 12: UM System Controls

V. Approval/Revision History

POLICY

First Level Approval	Second Level Approval
Signature Lily Boris, MD	Signature Laurie Nakahira, DO
Name Medical Director	Name Chief Medical Officer
Title	Title
Date	Date

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

Santa Clara Family Health Plan™

Utilization Management Committee Membership

Membership

Source: iCat (1/3/2020)

Year-Month	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12
Healthy Kids	3,501	3,509	3,512	2	2	2
Medi-Cal	236,578	235,389	234,478	237,095	235,350	233,995
Cal MediConnect	8,076	8,134	8,194	8,233	8,289	8,428
Total	**248,155**	**247,032**	**246,184**	**245,330**	**243,641**	**242,425**

Santa Clara Family Health Plan™

Utilization Management Committee

Standard Utilization Metrics

UMC Goals and Objectives

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

Inpatient Utilization: Medi-Cal 1/1/2019 – 12/5/2019

Source: HEDIS Inpatient Utilization (IPU) data for measurement period ending 12/5/2019

LOB	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
MC – Non-SPD	5,784	2.50	21,909	3.79
MC – SPD	1,853	8.92	8,570	4.62
MC – Total	7,637	3.03	30,479	3.99

Inpatient Utilization: Cal MediConnect (CMC) 7/1/2018 – 6/30/2019

Source: CMC Enrollment & QNXT Claims Data (UAT Metrics Dashboard)

Quarter	Discharges	Discharges / 1,000 Members per Year	Days	Average Length of Stay
2018 Q3	438	242.5	2,478	5.7
2018 Q4	428	233.3	2,545	5.9
2019 Q1	479	255.7	2,625	5.5
2019 Q2	428	225.5	2,332	5.4

Medi-Cal Inpatient Utilization NCQA Medicaid Benchmark Comparisons 1/1/2019 – 12/5/2019

	Medi-Cal Population		
Measure	**Non-SPD**	**SPD**	**Total**
Discharges / 1,000 Member Months	2.50	8.92	3.03
NCQA Medicaid Percentile Rank[1]	<5th	>75th	<5th
ALOS	3.79	4.62	3.99
NCQA Medicaid Percentile Rank[2]	<10th	>75th	<50th

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

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

Inpatient Readmissions: Medi-Cal

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 1/1/2019 – 12/5/2019 measurement period

LOB	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1,2]
MC – SPD	1,032	217	21.03%
MC – Non-SPD	2,512	369	14.69%
MC - All	3,544	586	15.92%

[1] A lower rate indicates better performance.
[2] Only for members aged 18-64 in Medi-Cal.

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

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 1/1/2019 – 12/5/2019 measurement period

Rate Description	Ages 18 – 64 (PCR-A)	Ages 65+ (PCR-B)
Count of Index Hospital Stays	313	920
Count of 30-Day Readmissions	55	121
Actual Readmission Rate	17.57%	13.15%
NCQA Medicare 50th Percentile	16.39%	12.08%
SCFHP Percentile Ranking	>75th	>50th

[1] A lower rate indicates better performance.

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

Frequency of Selected Procedures: Medi-Cal

Source: HEDIS data for 1/1/2019 – 12/5/2019 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	125	0.22	0.59	↓
Male & Female, Age 10-19	72	0.11	0.27	↓
Hysterectomy, abdominal				
Female, Age 15-44	22	0.04	0.08	↓
Female, Age 45-64	29	0.10	0.19	↓
Hysterectomy, vaginal				
Female, Age 15-44	10	0.02	0.08	↓
Female, Age 45-64	19	0.07	0.13	↓

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	6	0.02	0.02	↓
Female, Age 15-44	3	0.01	0.01	↓
Female, Age 45-64	0	0.00	0.02	↓
Cholecystectomy, closed (laparoscopic)				
Male, Age 30-64	44	0.12	0.23	↓
Female, Age 15-44	163	0.30	0.54	↓
Female, Age 45-64	78	0.28	0.54	↓

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	6	0.02	0.16	↓
Female, Age 20-44	5	0.01	0.14	↓
Male, Age 45-64	44	0.19	0.53	↓
Female, Age 45-64	33	0.12	0.48	↓
Mastectomy				
Female, Age 15-44	23	0.04	0.03	↑
Female, Age 45-64	29	0.10	0.13	↓
Lumpectomy				
Female, Age 15-44	29	0.05	0.10	↓
Female, Age 45-64	72	0.26	0.31	↓

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	1	0.00	0.00	↔
Female, Age 0-19	1	0.00	0.00	↔
Male, Age 20-44	4	0.01	0.03	↓
Female, Age 20-44	29	0.07	0.15	↓
Male, Age 45-64	5	0.02	0.04	↓
Female, Age 45-64	18	0.06	0.15	↓

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%	43.41%	>95th
Continuation & Maintenance Phase	75.76%	55.5%	>95th
Antidepressant Medication Management			
Acute Phase Treatment	58.77%	52.35%	>75th
Continuation Phase Treatment	43.86%	36.51%	>75th
Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia	53.85%	77.63%	<10th

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Utilization Management Committee

Turn-Around Time

Santa Clara Family Health Plan

Turnaround Time – Q4 2019

MEDI-CAL	Oct	Nov	Dec
MEDICAL AUTHORIZATIONS - HS COMBINED			
Routine Authorizations			
# of Routine Prior Authorization Requests Received	695	695	413
# of Routine Prior Authorization Requests Completed within 5 Business Days	668	692	413
% of Timely Decisions made within 5 Business Days of request	96.1%	99.6%	100.0%
# of Prior Authorization Notification Sent	695	695	413
# of Prior Authorization Notification Sent Within 2 Business Days of Decision Date	684	686	403
% timely notification of HS decision	98.4%	98.7%	97.6%
Expedited Authorizations			
# of Expedited Prior Authorization Requests Received	152	152	162
# of Expedited Prior Authorization Requests Completed within 72 Hours	150	151	162
% of Timely Decisions made within 72 Hours of request	98.7%	99.3%	100.0%
# of Prior Authorization Notification Sent	152	152	162
# of Prior Authorization Notification Sent Within 2 Business Days of Decision Date	145	146	159
% timely notification of HS decision	95.4%	96.1%	98.1%
Urgent Concurrent Review			
# of Urgent Concurrent Requests Received	1	4	3
# of Urgent Concurrent Requests Completed within 72 Hours of request	1	4	3
% of Timely Decisions made within 72 Hours of request	100.0%	100.0%	100.0%
# of Prior Authorization Notification Sent	1	4	3
# of Prior Authorization Notification Sent Within 2 Business Days of Decision Date	1	4	3
% timely notification of HS decision	100.0%	100.0%	100.0%

MEDI-CAL	Oct	Nov	Dec
Retrospective Review			
# of Retrospective Requests Received	364	223	1
# of Retrospective Requests completed within 30 Calendar Days of request	364	223	0
% of Retrospective Reviews completed within 30 Calendar Days of request	100.0%	100.0%	0.0%
# of Prior Authorization Notification Sent	364	223	1
# of Prior Authorization Notification Sent Within 2 Business Days of Decision Date	358	217	1
% timely notification of HS decision	98.4%	97.3%	100.0%
Denied Authorizations (Routine, Expedited, CCR, Retro)			
Total Requests Approved	1175	1,070	1,455
Total Requests Denied	37	4	3
Total Requests Pended/Extended	0	0	0
Total Requests Cancelled	0	0	0
% of Total Requests Denied	3.1%	0.4%	0.5%

CAL MEDICONNECT	Oct	Nov	Dec
PRE-SERVICE ORGANIZATION DETERMINATIONS - HS COMBINED			
Standard Part C			
# Approved	425	501	483
# Denied	27	31	25
% Approved	94.0%	94.2%	95.1%
# of Prior Authorization Requests Received	452	532	508
# of Prior Auth Requests Completed within 14 days	451	532	508
% of Timely Decisions made within 14 days	99.8%	100.0%	100.0%
# of Prior Authorization Notification Sent	452	532	508
# of Prior Authorization Notification Sent Within 14 Days	443	527	503
% Timely Notification of HS decision	98.0%	99.1%	99.0%
Expedited Part C			
# Approved	214	220	819
# Denied	9	13	35
% Approved	96.0%	94.4%	95.9%

CAL MEDICONNECT	Oct	Nov	Dec
Expedited Part C			
# of Prior Authorization Requests Received	223	233	854
# of Prior Auth Requests Completed within 72 Hours	219	228	850
% of Timely Decisions made within 72 Hours	98.2%	97.9%	99.5%
# of Prior Authorization Notification Sent	223	233	854
# of Prior Authorization Notification Sent Within 72 hours	213	221	837
% timely notification of HS decision	95.5%	94.8%	98.0%
URGENT CONCURRENT ORGANIZATION DETERMINATIONS - HS COMBINED			
# Approved	9	7	265
# Denied	0	0	10
% Approved	100.0%	100.0%	96.4%
# of Urgent Concurrent Requests Received	9	7	275
# of Urgent Concurrent Requests Completed within 72 Hours	9	7	271
% of Timely Decisions made within 72 Hours	100.0%	100.0%	98.5%
# of Prior Authorization Notification Sent	9	7	275
# of Prior Authorization Notification Sent Within 24 hours	1	5	265
% timely notification of HS decision	11.1%	71.4%	96.4%
POST SERVICE ORGANIZATION DETERMINATIONS - HS COMBINED			
# Approved	48	33	61
# Denied	4	2	0
% Approved	92.3%	94.3%	100.0%
# of Requests Received	52	35	61
# of Post Service Requests Completed within 30 Days	52	35	61
% of Timely Decisions made within 30 days	100.0%	100.0%	100.0%
# of Prior Authorization Notification Sent	52	35	61
# of Prior Authorization Notification Sent Within 30 Days	51	35	61
% timely notification of HS decision	98.1%	100.0%	100.0%

Santa Clara Family Health Plan™

Utilization Management Committee

Call Center Metrics

Santa Clara Family Health Plan™

UM Call Center Metrics – Q4 2019

MEDI-CAL	Oct	Nov	Dec
CALL STATS - UM Provider Queue			
# Calls Presented	2,418	1,465	1,631
Provider Average Speed of Answer in Seconds	51	31	25
Provider Average Hold Time in Seconds	18	16	12
# of Abandoned Provider Calls	132	46	37
Provider Abandonment Rate	5.5%	3%	2%
Provider Service Level	70.0%	81%	85%
Average Talk Time	0:02:57	0:02:56	0:02:35

CAL MEDICONNECT	Oct	Nov	Dec
CALL STATS			
Provider			
# Calls Presented	1,666	928	991
Provider Average Speed of Answer in Seconds	55	43	28
Provider Average Hold Time in Seconds	17	11	12
# of Abandoned Provider Calls	65	40	31
Provider Abandonment Rate	3.9%	4%	3%
Total Provider Calls Handled	1,596	883	951
# of Provider Calls Handled in ≤ 30 seconds	1,153	736	827
Provider Service Level	69.0%	79%	83%
Average Talk Time	0:02:55	0:02:06	0:02:35

Santa Clara Family Health Plan™

Utilization Management Committee

Quarterly Referral Tracking

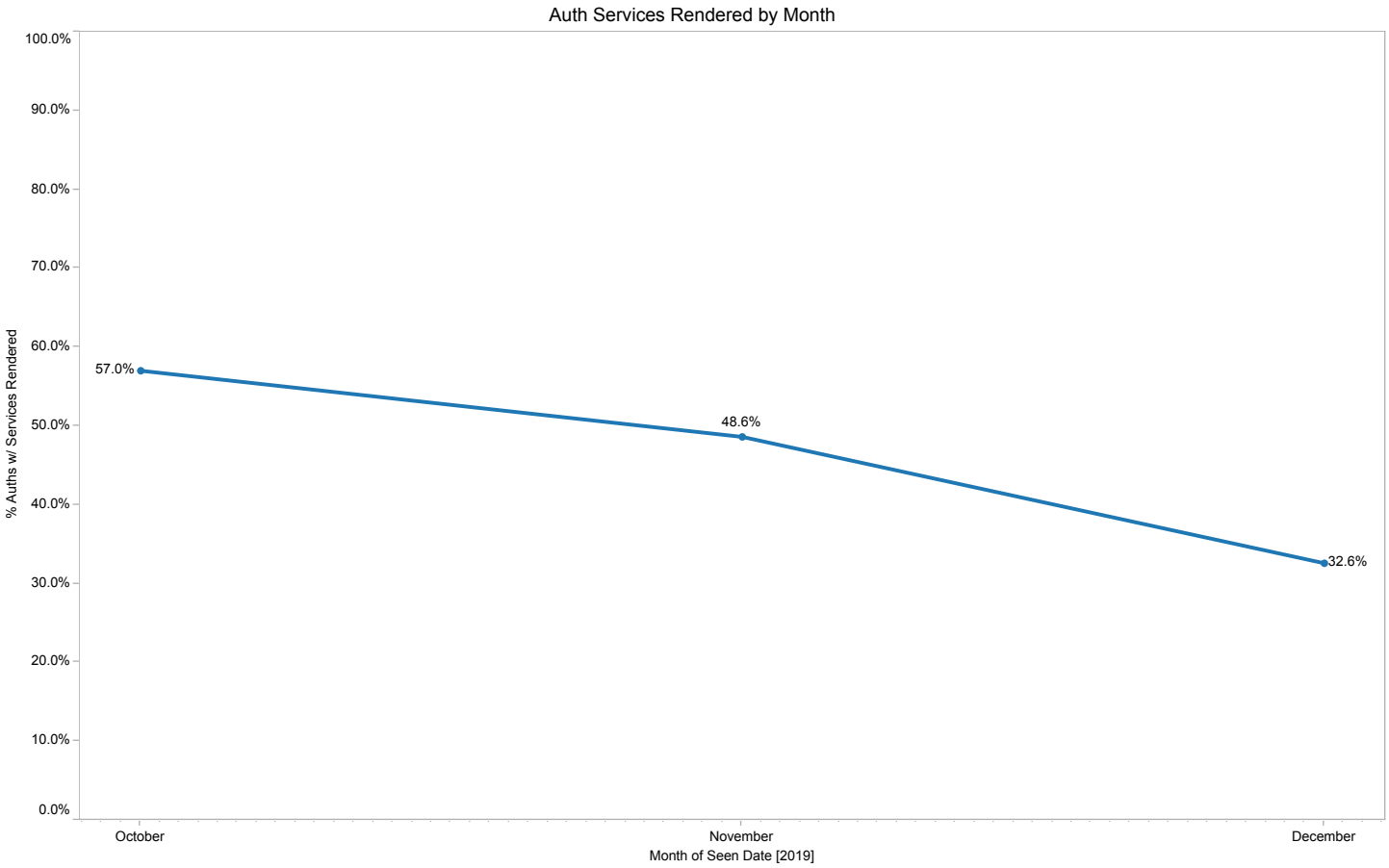
Santa Clara Family Health Plan

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Cal MediConnect	CBAS	Retro Request	23	20	0	3	13.0%
		Routine - Initial Request	3	3	0	0	0.0%
	CONT OF CARE	Member Initiated Org Determi..	1	0	0	1	100.0%
		Non Contracted Provider - Ro..	1	0	0	1	100.0%
	CONT OF CARE GR	Routine - Initial Request	1	0	0	1	100.0%
	CUSTODIAL	Member Initiated Org Determi..	1	0	0	1	100.0%
		Retro Request	85	76	0	9	10.6%
		Routine - Initial Request	27	19	0	8	29.6%
	DME		1	0	0	1	100.0%
		Member Initiated Org Determi..	4	1	0	3	75.0%
		Member Initiated Org Determi..	3	0	0	3	100.0%
		Member Rep Initiated Org Det..	1	0	0	1	100.0%
		Non Contracted Provider - Ro..	5	2	0	3	60.0%
		Non Contracted Provider - Urg..	1	1	0	0	0.0%
		Retro Request	16	6	0	10	62.5%
		Routine - Extended Service	4	0	0	4	100.0%
		Routine - Initial Request	188	97	0	91	48.4%
		Urgent - Initial Request	25	12	0	13	52.0%
	HomeHealth	Member Initiated Org Determi..	3	0	0	3	100.0%
		Non Contracted Provider - Ret..	1	0	0	1	100.0%
		Non Contracted Provider - Ro..	4	0	0	4	100.0%
		Non Contracted Provider - Urg..	46	23	0	23	50.0%
		Retro Request	10	2	0	8	80.0%
		Routine - Extended Service	14	4	0	10	71.4%
		Routine - Initial Request	2	0	0	2	100.0%
		Urgent - Extended Service	76	10	0	66	86.8%
		Urgent - Initial Request	144	46	0	98	68.1%
	HomeHealthInd	Routine - Initial Request	1	0	0	1	100.0%
	HOSPICE	Non Contracted Provider - Ret..	4	3	0	1	25.0%
		Retro Request	2	0	0	2	100.0%
		Routine - Initial Request	1	0	0	1	100.0%
		Urgent - Initial Request	1	0	0	1	100.0%
	Inpatient		4	4	0	0	0.0%
		Non Contracted Provider - Urg..	2	1	0	1	50.0%
		Retro Request	3	3	0	0	0.0%
		Routine - Extended Service	3	3	0	0	0.0%
		Routine - Initial Request	412	386	0	26	6.3%
		Urgent - Extended Service	1	0	0	1	100.0%
		Urgent - Initial Request	23	21	0	2	8.7%
	InpatientAdmin	Urgent - Initial Request	1	1	0	0	0.0%
	OP-BehavioralGr	Non Contracted Provider - Ret..	3	3	0	0	0.0%
	OP-Behavorial	Member Initiated Org Determi..	1	0	0	1	100.0%
		Non Contracted Provider - Ret..	1	1	0	0	0.0%
		Routine - Initial Request	2	0	0	2	100.0%
	OPHospital		3	1	0	2	66.7%
		Member Initiated Org Determi..	22	3	0	19	86.4%
		Member Initiated Org Determi..	3	0	0	3	100.0%
		Non Contracted Provider - Ret..	2	1	0	1	50.0%
		Non Contracted Provider - Ro..	26	3	0	23	88.5%
		Non Contracted Provider - Urg..	10	3	0	7	70.0%

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Cal MediConnect	OPHospital	Retro Request	19	5	0	14	73.7%
		Routine - Extended Service	10	1	0	9	90.0%
		Routine - Initial Request	654	136	0	518	79.2%
		Urgent - Extended Service	10	1	0	9	90.0%
		Urgent - Initial Request	309	125	0	184	59.5%
	OPHospitalGr	Member Initiated Org Determi..	1	0	0	1	100.0%
		Retro Request	15	10	0	5	33.3%
		Routine - Extended Service	9	5	0	4	44.4%
		Routine - Initial Request	178	74	0	104	58.4%
		Urgent - Extended Service	4	2	0	2	50.0%
		Urgent - Initial Request	66	36	0	30	45.5%
	SkilledNursing		2	2	0	0	0.0%
		Retro Request	9	9	0	0	0.0%
		Routine - Initial Request	8	7	0	1	12.5%
		Urgent - Initial Request	60	44	0	16	26.7%
	Transportation	Member Initiated Org Determi..	2	0	0	2	100.0%
		Retro Request	3	0	0	3	100.0%
		Routine - Extended Service	2	0	0	2	100.0%
		Routine - Initial Request	68	2	0	66	97.1%
Grand Total			**2,650**	**1,218**	**0**	**1,432**	**54.0%**


Auth Services Rendered by Month
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
% Auths w/ Services Rendered
57.0%
48.6%
32.6%
October
November
December
Month of Seen Date [2019]

Santa Clara Family Health Plan™

Utilization Management Committee

Quality Monitoring of Denial Letters

Quality Monitoring of Denial Letters for HS.04.01
4th Quarter 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 2019 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 Q4 2019, the dates of services and denials for were pulled in January 2020.
   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. 13% or 4/30 were expedited request; 87% or 26/30 were standard request.
         1. 100% or 4/4 of the expedited authorizations are compliant with regulatory turnaround time of 72 calendar hours
         2. 100% or 26/26 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 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. 100% or 1/1 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 these findings presented to UMC are as follows:

1. Quality and productivity continues to be monitored on a weekly basis. Findings are reported to the Medical Director with a plan of action to correct it.
2. The UM team continues to optimize the Quality Assurance reports with IT in an effort to monitor productivity and quality by the staff.

Santa Clara Family Health Plan™

Utilization Management Committee

Referral Tracking System

In accordance with the Santa Clara Family Health Plan (SCFHP) Referral Tracking System HS. 01.02, SCFHP tracks all authorizations, for completion of the "authorization to claims paid" cycle, to identify opportunities for improvement. By definition all authorizations are defined as: 1. Both contracted and non- contracted prior authorizations and 2. Behavioral health and non-behavioral health authorizations are tracked to completion. SCFHP (The Plan) has a referral tracking system which tracks approved, modified, deferred medical and behavioral health prior authorizations to completion on an ongoing basis.

DATA

The authorization report was completed for the rolling 12 month look back of:

- October 1, 2018 to October 1, 2019

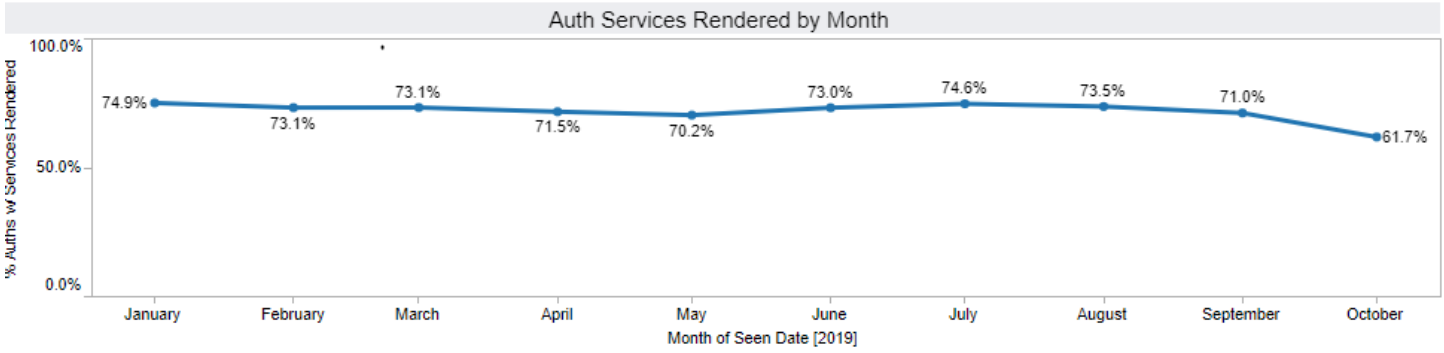
Because of system issues: the claims report could only be generated for 12 months rolling back January 2019 to October 2019.

FINDINGS:

1. There were 24,730 unique authorizations for all lines of business (roughly 2,400 auths / month).
   - Cal MediConnect: 9,173
     - 30% without claims
   - Medi-Cal 15, 557
     - 27% without claims

2. It was identified that there is an average 3 months claim lag time.

   - 71% Authorized services were rendered and a claim paid within 90 days of authorization.
   - 1% were rendered and a claim paid after 90 days of authorization.
   - 28% did not yet have a claim paid.



COMMON HIGH VOLUME SERVICES	NUMBER OF AUTHORIZATIONS WITH NO CLAIMS MATCH	% OF AUTHORIZATIONS WITH NO CLAIMS MATCH
CBAS	535	4.9%
DME	2047	21%
Home Health + Hospice	1496	34%
Outpatient Hospital	8810	43%
Continuity of Care	31	58%
Dental Anesthesia	156	16%
Transportation	2256	69%
Behavioral health	835	17%
In-Patient and Skilled	4752	5.2%

FOLLOW UP

Follow up process interventions are initiated when identified via the fore-mentioned review process. Authorizations for the current year are pulled and a sampling of 10% or up to 50 outpatient specialty authorizations annually will result in a patient phone call to assess why a service was not received / no paid claim / or service was delayed. This will include medical and behavioral health care services, contracted and non-contracted provider.

1. 55 Unique case authorizations were pulled for sample calls (5 for oversample).

    - 27 Cal MediConnect
    - 28 Medi-Cal

2. Types of services:

    - 18 Therapy Services
    - 7 MRI and PET Scan
    - 1 Sleep Studies
    - 20 Out-Patient
        - 3 DME
        - 3 Behavioral Health
        - 14 Out-Patient Hospital
    - 9 Other

3. 16 of the 55 patients were successfully contacted. Of these 9 of the 12 received the service per patient report.

4. Reasons why member did not get service:
    - Family member was in hospital -1

- Does not remember – 5
- PT not approved – However the Auth is in Approved status - 1

5. 39 member were unreachble
    - 7 had no number or the number was disconnected
    - 32 calls were unsuccessful

SUMMARY:

Data confirms that for the high volume services of outpatient hospital and transportation, the auth to claim mismatch is highest. This is also confirmed in the small sample size of the telephone calls.

Data also confirms that the highest cost services: inpatient and skilled care there is a very low auth to claim mismatch.

Santa Clara Family Health Plan is committed to working on improving the service delivery systems to our members. As such, the UM team will continue its monthly monitoring and quarterly reporting to UM Committee.

Santa Clara Family Health Plan™

Utilization Management Committee

Physician Peer-to-Peer

Peer to Peer Annual Review Calendar Year
Year to Date January 1 to November 30, 2019

In accordance with Procedure HS.02.02, the provider dispute process also includes a Peer to Peer (P2P) review with the SCFHP physician who makes the determination (in cases of denials of service). It is the goal of SCFHP medical director team to ensure quality of service and return of calls when there is a requested P2P. The telephone number to schedule those calls is sent out with each of the denied cases.

For YTD 2019, there were 27 total scheduled requests for Peer to Peer Reviews.

All cases were reviewed for compliance. This was to ensure that the Peer to Peer process is working and that community physician requests for P2P are completed and do in fact occur.

The findings are as follows:

1. 96% (26/27) calls were completed with the SCFHP physician and the requesting physician.
2. 96% (26/27 cases) had documentation of the call in our QNXT system.

SCFHP recommendation to UMC:

1. Since 6/2017, QNXT is the one system that now holds authorizations for all Lines of Business (Medi-Cal, Cal MediConnect, and Healthy Kids). As such both physician know the system and have agreed to enter their call documentation into QNXT.

   The current findings are that 96% of P2P occurred and no corrective action is needed.

2. SCFHP will continue annual monitoring.

Santa Clara Family Health Plan™

Utilization Management Committee

Behavioral Health UM Reports

Santa Clara Family Health Plan

DEVELOPMENTAL SCREENING (96110)

Quarter	Dev Screening
2019 Q1	1,023
2019 Q2	1,114
2019 Q3	905
2019 Q4	434*
Grand Total YTD	3,476

*As of 1/3/2020. Claims data lag will effect totals for quarter 4

BHT

Currently Receiving BHT

Quarter 3	July	August	September
	189	175	197
Quarter 4	**October**	**November**	**December**
	198	187	178

BHT

Waitlist (pending assessment)

August 2019	October 2019	November 2019	December 2019	January 2020
11	12	19	22	26

Utilization

Cal MediConnect

- Psychiatric admissions
  - Quarter 3: 17
  - Quarter 4: 17
- Transitions of Care Completed
  - Quarter 3: 8 (1 no TOC required and 8 UTC)
  - Quarter 4: pending

Medi-Cal July 2019 – December 2019

- Mild to Moderate Referrals:
  - Members connected to services: 7 (had first appointment)
  - Members not connected to services: 1 (psychiatry only), 14 able to locate provider but did not schedule appointment or declined

Case Management

Cal MediConnect

- 248 members assigned/referred to Behavioral Health Team in Quarters 3 and 4

Medi-Cal

- 65 SPD members assigned/referred to Behavioral Health Team in Quarters 3 and 4