Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, April 15, 2020, 6:00-7:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave., San Jose, CA 95119

Via Teleconference
(669) 900 6833
Meeting ID: 348 952 823
Password: 233367

AGENDA

1.	**Introduction**	Dr. Lin	6:00	5 min
2.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The committee reserves the right to limit the duration of public comment to 30 minutes	Dr. Lin	6:05	5 min
3.	**Meeting Minutes** Review minutes of the Q1 January 15, 2020 Utilization Management Committee (UMC) meeting **Possible Action:** Approve Q1 2020 UMC Meeting Minutes	Dr. Lin	6:10	5 min
4.	**Chief Executive Officer Update** Discuss status of current topics and initiatives	Ms. Tomcala	6:15	10 min
5.	**Chief Medical Officer Update** **a.** General Update **b.** COVID-19 update	Dr. Nakahira	6:25	10 min
6.	**Old Business/Follow-Up Items** **a.** General Old Business	Dr. Boris	6:35	10 min
7.	**UM Program Evaluation** Annual review of UM Program Evaluation **Possible Action:** Approve UM Program Evaluation	Dr. Boris	6:45	5 min
8.	**UM Work Plan** Annual review of UM Work Plan **Possible Action:** Approve UM Work Plan	Dr. Boris	6:50	5 min
9.	**Care Coordinator Guidelines** Annual review of Care Coordinator guidelines **Possible Action:** Approve Annual Care Coordinator guidelines	Mr. Perez	6:55	10 min

10. Reports **a.** Membership **b.** Over/Under Utilization by Procedure Type/Standard UM Metrics **c.** Dashboard Metrics • Turn-Around Time – Q1 2020 • Call Center – Q1 2020 **d.** Cal MediConnect and MediCal Quarterly Referral Tracking - Q1 2020 **e.** Quality Monitoring of Plan Authorizations and Denials Letters (HS.04.01) – Q1 2020 **f.** Inter-Rater Reliability (IRR) Report – Q2 2020 Delayed **g.** Behavioral Health UM Reports	Dr. Boris Ms. McKelvey	7:05 7:20	15 min 10 min
11. Adjournment Next meeting: Wednesday, July 15, 2020 at 6:00 p.m.	Dr. Lin	7:30	

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™

Meeting Minutes

Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Thursday, January 15, 2020 6:30 PM - 8:00 PM
Santa Clara Family Health Plan, Redwood
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES - Draft

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

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

Members Absent
Laurie Nakahira, DO, Chief Medical Officer

Staff Absent
Christine Tomcala, Chief Executive Officer

1. Introduction

Dr. Jimmy Lin, Chair, called the meeting to order at 6:30 p.m. Roll call was taken, and a quorum was established. Absent this evening were Laurie Nakahira, DO, Chief Medical Officer, and Christine Tomcala, Chief Executive Officer.

2. Public Comment

There were no public comments.

3. Review and Approval of October 16, 2019 Meeting Minutes

The minutes of the October 16, 2019 Utilization Management Committee meeting were reviewed.

> Dr. Lin called for a motion to approve the October 16, 2019 Utilization Management Committee meeting minutes. Dr. Alkoraishi moved to approve the October 16, 2019 Utilization Management Committee meeting minutes. Dr. Van Cai seconded the motion. The motion passed 6-6.

4. CEO and CMO Update

Dr. Boris gave the CEO and CMO updates on behalf of Ms. Tomcala and Dr. Nakahira. The governor of California has proposed a Medi-Cal Healthier California for all, formerly known as CalAim (California Advancing and Innovating Medi-Cal). This is a set of proposals that uses Medi-Cal as a tool to address some of California's biggest challenges, such as homelessness, insufficient access to behavioral health care,

children with complex medical needs, the clinical needs of the justice system population, and the medical needs of the elderly. The governor has identified three (3) goals: (1) Identify and manage member risk and need through whole person care approaches, while addressing the social determinants of health; (2) move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and (3) improve quality outcomes and drive delivery system transformation through value-based initiatives, the modernization of systems and payment reform. At present, the Plan's Cal MediConnect plan has attained NCQA accreditation. The Plan is now working towards NCQA accreditation for its Medi-Cal line of business.

5. Old Business/Follow-Up Items

a. General Old Business

There is no old business to discuss this evening.

b. Medical Covered Services Prior Authorization Grid

Dr. Boris reviewed the updated Medical Covered Services Prior Authorization Grid, which is included in the agenda packet materials. The biggest change to the Grid refers to Podiatry services. The Plan removed the need for general authorization for podiatric office visits. Members still need a referral for office visits, but not a prior authorization. Only podiatric surgery will require a prior authorization. Medi-Cal dictates the number of office visits; as such, the Plan will follow the Medi-Cal rules.

6. UMC Meeting Calendar - 2020

Dr. Boris presented the UMC Calendar for 2020 to the Committee. Dr. Boris summarized the dates of the UMC meetings for 2020.

> Dr. Lin called for a motion to approve the UMC Meeting Calendar for 2020. Dr. Van Cai moved to approve the UMC Meeting Calendar for 2020. Dr. Alkoraishi seconded the motion. The motion passed 6-6.
>
> Dr. Lin next called for a motion to change the UMC meeting start time from 6:30 p.m. to 6:00 p.m. Dr. Alkoraishi moved to approve the UMC meeting start time of 6:00 p.m. Dr. Van Cai seconded the motion. The motion passed 6-6.

7. UMC Program Description - 2020

Dr. Boris presented the UMC Program Description for 2020, as a redline version, to the Committee. Dr. Boris highlighted various changes to the UM Program Description included in the agenda packet materials.

> Dr. Lin called for a motion to approve the UMC Program Description – 2020. Dr. Vemuri moved to approve the UMC Program Description – 2020. Dr. Alkoraishi seconded the motion. The motion passed 6-6.

8. Annual Review of UM Policies

Dr. Boris presented the UM policies for 2020, as redline versions, to the Committee.

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
i. HS.10 Financial Incentive
j. HS.11 Informed Consent
k. HS.12 Preventive Health Guidelines
l. HS.13 Transportation Services
m. HS.14 System Controls – **New policy**

Dr. Lin called for a motion to approve the Annual Review of UM Policies and the new policy HS.14 System Controls. Dr. Van Cai moved to approve the Annual Review of UM Policies. Dr. Dinh seconded the motion. The motion passed 6-6.

9. Reports

a. Membership

Dr. Boris presented the membership report for December 2019. The Plan has 233,995 Medi-Cal members. The Cal MediConnect line-of-business continues to grow from 8,076 members in July 2019 to 8,428 members in December 2019. As of January 1, 2020 the Plan no longer has Healthy Kids members. All former Healthy Kids members have been successfully transitioned into other plans, mostly Medi-Cal.

b. Standard Utilization Metrics

Dr. Boris briefly summarized the Standard Utilization Metrics for the Committee. The purpose is to measure and compare the Plan's utilization levels against relevant industry benchmarks, as well as monitor utilization trends amongst the Plan's membership. From January 2019 through December 2019, the average length of stay for Medi-Cal members is 3.99. For Medi-Cal non-SPD the average length of stay is 3.79, with the Medi-Cal-SPD population slightly higher at a 4.62 average length of stay. From January 1, 2019 through December 5, 2019 the discharge rate per every 1,000 members is 2.50 for the non-SPD population. The discharge rate per every 1,000 members for the SPD population is higher at 8.92. The SPD population is smaller than the non-SPD population. As a result, the Medi-Cal total numbers per 1,000 members comes down to approximately 3 discharges per every 1,000 members. Dr. Boris discussed the Plan's ranking for Medi-Cal inpatient utilization in comparison to the NCQA Medicaid Percentile Rank, and the Plan's average for the non-SPD population, per every 1,000 members, is less than 5%. Dr. Boris next discussed the rate of inpatient readmissions for both the Medi-Cal and Cal MediConnect populations. For the MediCal SPD population, our readmission rate is 21.03% which is considered high. Dr. Lin and Dr. Boris discussed the fact this is likely due to patients diagnosed with Sepsis. Dr. Boris outlined the readmission rates for the Cal MediConnect population. The over 65 age group actually has a lower readmission rate than the 18-64 age group, as the 18-64 age group are generally on MediCare and/or receiving disability. Dr. Boris then discussed the Medi-Cal Frequency of Selected procedures from January 1, 2019 through December 5, 2019. There are no significant changes since the last Committee meeting. The trends are generally down on an overall basis. A discussion ensued between Dr. Boris and Dr. Alkoraishi as to why the numbers trend downward. Dr. Boris stated she can review the numbers from the last Committee meeting and compare them to the current data to see if there is an explanation. Dr. Alkoraishi provided a possible rationale from the clinical point-of-view, but it could also be due to the fact that the numbers are so small it does not take much change to see a downward trend. Dr. Boris next discussed the rate of anti-depressant medications for acute phase treatment and continuation phase treatment, and there is no significant change from the last Committee meeting.

c. Dashboard Metrics

- Turn-Around Time – Q4 2019 – Dr. Boris next reviewed the Turn-Around time report for Medi-Cal from October 2019 through December 2019. The Plan met its' goals for December, with the percentage of timely decisions made within 5 business days at 100%. Dr. Boris also presented the

Committee with the Plan's timeliness of decisions for the urgent, concurrent, retro, and standard authorizations. Dr. Lin asked Dr. Boris for the Medi-Care guidelines for turn-around time. Dr. Boris replied that the Medi-Care guidelines are 100% on all decisions. During the CMS audit, however, CMS did not issue any corrective action for the current numbers due to the significant improvement the Plan made since the last audit.

- Call Center – Q4 2019 – Mr. Perez presented the Utilization Management Call Center metrics to the Committee, beginning with Medi-Cal. There has been less call volume in December, compared to October and November. The statistics show that the UM department has been able to increase the number of calls they take, with a higher rate of response and a lower rate of call abandonment. For the Cal MediConnect line of business, the volume of calls also dropped in December, as compared to October and November, and the abandonment rate is lower, so the UM department is able to answer a higher rate of calls with more efficiency. Dr. Lin inquired as to which language is the most prevalent for the calls received in the UM Call Center. Mr. Perez advised that, as the UM Call Center answers calls from providers, the language spoken is normally English. Dr. Lin also inquired as to why the call volume is so much lower in December, which Dr. Boris attributes to the holidays. Dr. Lin further inquired as to the average length of the calls, and Dr. Boris advised the average talk time is 2 minutes. Dr. Tobbagi inquired as to reason behind Provider call frequency. Dr. Boris replied that Stanford accounts for a large number of the calls taken by the UM department.

d. Quarterly Referral Tracking – Q4 2019

Dr. Boris next discussed the 'Referral Tracking Report'. The Plan does an annual report to the committee. This report is specific to the number of authorizations, and whether or not service was rendered and the Claim was paid within 90 days; or after 90 days; and what percentage of the authorizations approved had no Claim paid. The UM team also completed review of the Annual Referral Tracking report for calendar year 2019, which is included in this packet under Agenda item f. No additional clarification was needed. Dr. Lin asked if CBAS falls under the Plan's budget, not the State's budget. A discussion ensued as to the scope of services provided by CBAS centers, contracted with and paid for, by the Plan, versus a Senior Activity Center which is provided by the City.

e. Quality Monitoring of Denial Letters (HS.04.01) – Q4 2019

Dr. Boris reviewed the results of the standard quarterly report on Quality Monitoring of Denial Letters for the 4th quarter of 2019. Dr. Boris explained that the Plan analyzes a random sample of 30 total denial letters per quarter, which includes examination of all the elements the Plan is audited on. During this review process, half of the letters are for the Medi-Cal line of business, the other half are for the Cal Medi-Connect line of business, and 100% are denials. Dr. Boris reported that the results show the Plan rated 100% in each of the quality measurement benchmarks.

f. Referral Tracking System (HS.04.02) - 2019

Dr. Boris reviewed the Referral Tracking System report for the calendar year 2019. Normally, there is a rolling 12 month lookback period; however, due to issues with the new system, Dr. Boris only pulled data from January 1, 2019 through October 1, 2019. The purpose of this report is to comply with policy HS.02.Medical Necessity Criteria. The UM department conducts a random sample of 50 or more files, and the department then makes outbound calls to determine why members failed to get approved services, and connect them with a Case Manager to assist them with getting covered services. The findings show that there were 24,000 unique authorizations, which is approximately 2,400 authorizations per month. Of those, 9,170 were for Cal MediConnect and 15,000 were for Medi-Cal. It was identified that there was an average of 3 months claims lag-time. Dr. Boris examined the percentage of authorizations rendered with a claim paid within 90 days, and this showed that 74% of the Plan's authorized services were rendered with a claim paid within 90 days of authorization; 1% of authorized services were rendered with a claim paid after 90 days of authorization; and 28% of authorized services did not yet have a claim paid. Dr. Boris reviewed the most

common high volume authorizations comprised of CBAS, DME, Home Health and Hospice, and Outpatient Hospital. For example, our CBAS providers had a low rate of only 5% of claims paid; DME was 20%; Home Health was 30%; Outpatient Hospital was 43%; Continuity-of-Care was 58%; dental anesthesia was 16%; and transportation was the highest category of unpaid claims at 69%. Dr. Boris explained that out of 4,752 authorizations, only 5.2% had no claims paid on an Inpatient scale. The UM department follows up with members who have not had a claim paid to ascertain the reasons why they did not receive an authorized service or file a claim. There were no high risk areas that necessitated Case Management. Please see complete report in the packet.

g. Physician Peer-to-Peer (HS.02.02) - 2019

Dr. Boris next presented the Physician Peer-to-Peer report for calendar year 2019. The purpose of this report is to ensure the peer-to-peer process is on-track, and the needs of the Provider are addressed by the Plan. Typically how this works is the Provider calls in and requests to speak to the doctor who rendered the denial. For calendar year 2019, there were 27 total scheduled requests for peer-to-peer reviews. These were reviewed for compliance. 26 out of 27 denials were completed with the Plan physician and requesting physician; 26 out of the 27 had the appropriate documentation in our call tracking system. The current findings are that 96% of peer-to-peer calls occurred and no corrective action is required. Stanford, El Camino Hospital, and a few private physicians comprise most of the peer-to-peer review cases.

h. Behavioral Health UM

Ms. McKelvey presented the Behavioral Health UM PowerPoint to the Committee. Ms. McKelvey began with the Developmental Screening numbers for calendar year 2019. She explained that the goal is to hit 5,000 screenings for the year; however, in 2019 the number of screenings was 3,476. She anticipates this number will increase as more claims come in. For BHT, the average for Q4 was 185 receiving ABA services each month. There are 26 children on the waitlist with ABA authorizations approved, however, they are not yet receiving services due to the fact that the families and the providers have yet to agree on a time. Dr. Alkoraishi asked about the average age of these members, and Ms. McKelvey advised they are typically less than 10 years old, ranging from as young as 2 years old, up to age 17. Treatment is provided by a physician or a licensed Psychologist. Dr. Lin wanted to know why a 2 year old would need behavioral health services, and Ms. McKelvey clarified that if they have an autism diagnosis, or it is proven to be medically necessary, they can receive behavioral health services. Dr. Vemuri inquired about the waitlist. Ms. McKelvey advised it varies by family, and it is usually because they are waiting for a spot to open up that does not conflict with their child's school schedule. Children can receive services for years, so the Plan reviews cases every 6 months to ensure progress. The ABA providers meet with the Plan on a quarterly basis, and they all request more feedback from the Pediatricians. Ms. McKelvey advised she will facilitate this open communication. Ms. McKelvey gave a breakdown of the number of Cal MediConnect psychiatric admissions for Q3 and Q4. The team completed 8 transition of care calls to patients who were discharged to home. For the Medi-Cal mild to moderate referrals, 7 members were connected to services. Dr. Vemuri asked how many child Psychiatrists are in our network. Ms. McKelvey advised it is a little misleading to try to determine that number. They are all connected to the BHT. A discussion ensued as to the difficulty of the process to refer a patient to a psychiatrist. The BH team provided case management to 248 Cal MediConnect members; and case management to 65 Medi-Cal SPD members.

15. Adjournment

The meeting adjourned at 6:04 p.m. The next UMC meeting is scheduled for Wednesday, April 15, 2020 at 6:00 p.m.

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Jimmy Lin, MD, Utilization Management Committee Chairperson

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CEO Update

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CMO Update

SCFHP's COVID-19 Responses – April 9, 2020

Group	Focus Area	Activities and Metrics
Members	Statistics	Data as of 4/6/2020; note that SCFHP does not have complete information about members tested, diagnosed, hospitalized, deceased • 41 hospitalized, including 2 deceased • 17 members diagnosed and isolating at home
	Call Center	• Call volume down 42% week of March 30 vs prior year average • Average wait time of 13 seconds
	Nurse Advice Line	• 62 calls regarding coronavirus March 6th – April 5th - 30
	Grievance and Appeals	• Eight COVID-19 related grievances (Rx access due to provider office closed; transportation safety concerns, employment concerns) as of 4/6/2020
	Outreach to Vulnerable Populations	• Specific vulnerable populations have been identified for targeted outreach methods, which may include outbound calls, robo-calls, and/or direct mail. Includes coordinated outreach efforts with community-based case management or providers including LTSS and Behavioral health. • Implementing telehealth application that integrates with nurse advice line
	Pharmacy	• Refills available via mail-order for 90 day fills; pharmacy overrides to allow early refills • Formulary expanded to include disinfectant and gloves
	Communications to Members	• Developed new webpage; published 15 member news updates • April newsletter to include infographics for coronavirus precautions and hand washing • Facebook posts in April to include more information on coronavirus precautions • Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey has been discontinued for 2020. Surveys have already been mailed out but no additional phone outreach will be conducted by the vendor.

	Eligibility Redetermination	• State and counties have paused redeterminations for March, April, May for beneficiaries with a change in status (affects approximately 3-5k SCFHP members each month who otherwise would have lost their eligibility), so these members will not lose eligibility • SCFHP temporarily-elevated enrollment will likely fall effective July 1, or whenever the pause is lifted
Providers	Prior Authorizations	• Suspended requirement for all prior authorizations to decrease burden on providers; extended suspension through 4/30/2020 • Volume of PAs has now dropped slightly
	Telehealth	• Regulations during state of emergency allow provider reimbursement, with specific coding and documentation requirements • SCFHP adding capability for Nurse Advice Line to offer members telephonic physician consultation • Communication sent to BHT providers with guidelines
	CBAS centers	• Notified of APL with guidance for continued per diem payment to CBAS Centers for services provided off site. Provider Memo expected to go out to CBAS Centers this week and contract amendments will be completed once we have final details from California Dept. of Aging.
	Skilled Nursing Facilities	• Continued outreach to SNFs regarding diagnosed residents; four SNFs reporting positive COVID cases: total of six including one SNF staff and three additional under observation. • Public Health Dept. now saying SNFs cannot unilaterally refuse to admit patients who test positive for COVID-19

	Clinics/Providers	• By measure of outreach completed so far:
		  ○ PCPs:
		  ▪ 17 of 162 locations contacted are closed.
		  ▪ 57 of 128 of the open locations have modified hours.
		  ▪ 95 of the 128 open are offering and/or exclusive to telehealth.
		  ○ Specialists:
		  ▪ 18 of 213 locations contacted are closed.
		  ▪ 26 locations are open with modified hours.
		  ▪ 150 locations are open with regular hours.
		  ▪ 137 locations are offering and/or exclusive to telehealth.
		• Concerns about equipment/supplies/staffing/financials

		• HEDIS Medical Record Review outreach has stopped for the Cal MediConnect line of business. The vendor will no longer call/fax/email/visit providers to obtain medical records. For Medi-Cal line of business, vendor is only reviewing records they can access electronically.
Staff	Working from home	• 96% of staff working remotely, up from 92% in prior week • Implemented relaxed telecommuting agreement • Staff onsite only for work that cannot be performed remotely • PTO/leave emergency policies to be implemented consistent with pending federal legislation
Community	Communications	• Informed CBOs and general community of SCFHP operational status via email and social media posts: still working and providing services for members and providers, most staff remote, lobby closed to visitors, how to contact us

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Old Business and Follow Up Items

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UM Program Evaluation/ Work Plan

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UTILIZATION MANAGEMENT WORK PLAN AND PROGRAM EVALUATION 2020

	WORK PLAN							EVALUATION	
	SCOPE	OBJECTIVE	ACTION STEPS	GOAL	RESPONSIBLE PARTY	REPORT FREQUENCY	TARGET DATE OF COMPLETION	DATE OF COMPLETION	FINDINGS/COMMENTS
1	Quality of Clinical Care	Expand on Current reporting and present findings to UMC	Review Medi-Cal Inpatient Admissions/1000	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4		
2	Quality of Clinical Care	Monitor appropriate inpatient admissions	Review CMC Inpatient Admissions/1000	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4		
3	Quality of Clinical Care	Monitor appropriateness of inpatient stays to assess proper level of care	Review Medi-Cal Inpatient ALOS	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4		
4	Quality of Clinical Care	Monitor appropriateness of inpatient stays to assess proper level of care	Review CMC Inpatient ALOS	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4		
5	Quality of Clinical Care	Monitor Readmissions, all cause to minimize unnecessary premature discharge and applicable post discharge follow up and care.	Medi-Cal Inpatient Readmissions	HEDIS goal	Medical Director	Quarterly	Q1, Q2, Q3, Q4		
6	Quality of Clinical Care	Monitor Readmissions, all cause to minimize unnecessary premature discharge and applicable post discharge follow up and care.	CMC Inpatient Readmissions	HEDIS goal	Medical Director	Quarterly	Q1, Q2, Q3, Q4		
7	Quality of Service	Assess Medi-Cal denial rates on PARs; provide benchmarks and compare to CA specific plans	Measure and act on denial rates on Outpatient PARs	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4		
8	Quality of Service	Assess CMC denial rates on PARs; provide benchmarks and compare to CA specific plans	Measure and act on denial rates on Inpatient PARs	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4		
9	Quality of Service	Track and monitor denial rates on PARs; provide benchmarks and compare to CA specific plans	Track and monitor BH IP Stays for CMC	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4		
10	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	Medi-Cal ADD Follow-up Care for Children with ADD	HEDIS Benchmarks	Manager of Behavioral Health	Quarterly	Q1, Q2, Q3, Q4		
11	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	Medi-Cal AMM Antidepressant Medication Management	HEDIS Benchmarks	Manager of Behavioral Health	Quarterly	Q1, Q2, Q3, Q4		
12	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	CMC SMC Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	HEDIS Benchmarks	Manager of Behavioral Health	Quarterly	Q1, Q2, Q3, Q4		
13	Quality of Service	Internal audit process and corrective action as necessary	Report Turn Around Times (TAT) for Prior Authorizations for Medi-Cal and CMC LOB	DHCS and CMS regulatory TAT	Manager of Utilization Management	Quarterly	Q1, Q2, Q3, Q4		
14	Quality of Service	Internal audit process and corrective action as necessary	Report TAT based on priority for Medi-Cal and CMC	DHCS and CMS regulatory TAT	Manager of Utilization Management	Quarterly	Q1, Q2, Q3, Q4		
15	Quality of Service	Annual IRR will be presented to the UMC	Assess and measure consistency of applying medical necessity criteria	80% passing rate	Manager of Utilization Management	Bi-Annually	Q2, Q4		
16	Quality of Service	Monitor Member and Provider experience	Conduct Member & Provider satisfaction survey	90% Satisfaction	Manager of Utilization Management	Annually	Q4		
17	Quality of Clinical Care	UM Program Description	UM Program Description will be adopted on an annual basis	Adoption	Health Services Director	Annually	Q1		
18	Quality of Clinical Care	Annual Evaluation of Utilization Management Program will be reviewed and updated	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis	Revisions/Adoption	Manager of Utilization Management	Annually	Q2		
19	Quality of Clinical Care	Implement a UM program which utilizes medical necessity decisions consistently, are objective and based upon evidence based criteria	Annually review and approve Medical Necessity Criteria policy	Review and Adoption	Manager of Utilization Management	Annually	Q1		
20	Quality of Service	Implement a UM program which provides access to staff for members and practitioners seeking information about the UM process and authorization of care	Annually review and approve Communication with Health Services Procedure	Review and Adoption	Manager of Utilization Management	Annually	Q1		
21	Quality of Clinical Care	Implement a UM program which utilizes qualified health professionals to assess clinical information to support UM decisions	Annually review and approve Appropriate Use of Professionals policy	Review and Adoption	Manager of Utilization Management	Annually	Q1		
22	Quality of Clinical Care	Implement a UM program which determines coverage based on medical necessity.	Annually review and approve Prior Authorization Procedure for clinical information	Review and Adoption	Manager of Utilization Management	Annually	Q1		
23	Quality of Service	Implement a UM program which documents and communicates reason for a denial with information on appeal process.	Annually review and approve Denial of Services Notification policy.	Review and Adoption	Manager of Utilization Management	Annually	Q1		
24	Quality of Clinical Care	Implement a UM program which evaluates inclusion of new technology and new application of existing technology to ensure that members have equitable access to safe and effective care	Annually review and approve Evaluation of New Technology Policy	Review and Adoption	Manager of Utilization Management	Annually	Q1		
25	Quality of Clinical Care	Annual Adoption of Clinical Practice Guidelines and Preventive Guidelines (Medical and Behavioral)	Annually review and approve Clinical practice guidelines policy	Review and Adoption	Manager of Utilization Management	Annually	Q1		

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Care Coordinator Guidelines

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

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Utilization Management Care Coordinator Guidelines

OVERVIEW

In meeting the requirements of the SCFHP Utilization Management Program, a Care Coordinator may review a select number of prior authorization requests based upon clinical review criteria set forth in these guidelines and applicable to only these type of services.

Care Coordinators may approve covered medical service when criteria are met. The Care Coordinator is responsible to document all pertinent information within the approved authorization. This includes, but is not limited to, accurately and fully completing authorization entry in QNXT and the Care Coordinator Guideline section and page used to base the approval. All reviews must be completed within the regulatory timeframes for making the determination.

The Care Coordinator must refer requests for medical service requiring authorization that do not meet the criteria within these guidelines to a licensed nurse, licensed Behavioral Health clinician or Medical Director within the regulatory timeframes for making the determination.

All Care Coordinator Guidelines are reviewed and approved by the SCFHP Utilization Management Committee at least annually.

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

INPATIENT ACUTE HOSPITALIZATION

1. Emergency and observation stay (not inpatient admission) - do not require Prior Authorization.

2. Inpatient Admission via Emergency room:
    a. Medi-Cal
        - Independent Physician's - approve 1 day
        - Palo Alto Medical Foundation
        - Out-of-area emergency admission - all networks
          In-area emergency admission for Kaiser, PMG, and Premier Care - Redirect to the delegated group
        - VHP - fully delegated
        - Kaiser - fully delegated
    b. CMC - All emergency admissions, in and out of area - approve 1 day

3. Inpatient Admission Elective/Scheduled admission: (in area and out of area)
    a. Medi-Cal - Send to Nurse for review if no PA in system
        - Independent Physician's
        - VHP - fully delegated
        - Palo Alto Medical Foundation
        - PMG and Premier care - possible LOA needed
        - Kaiser - redirect to group

4. Acute Rehab - send to nurse for review

5. Long Term Acute Care (LTAC) - send to nurse for review

6. Maternity – Approve 2 days for vaginal delivery, 4 days for C-Section delivery
    a. Approval date starts from the date of baby's birth/date of delivery.
    b. Exceeding days must be send to Nurse for review.
    c. Admission date different from Baby's date of birth must be forwarded to Nurse for review.
    d. Maternity Kick-follow maternity kick entry process for QNXT for Medicare primary without part A, Independent network and for PAMF.

Valley Health Plan is fully delegated for all inpatient admission for in area and out of area admissions.

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

SKILLED LEVEL OF CARE (SNF)

1. Member must be CMC or Medi-Cal assigned to network:
    a. Independent Physician's
    b. Palo Alto Medical Foundation
    c. VHP - fully delegated
    d. Kaiser, PMG, and Premier Care – redirect to the network if within month of admission and month after admission. SCFHP will be financially responsible beginning 3rd month of admission
    e. Medicare Primary
        - Without Medicare A - Apply CCG pre-approval of 7 days and forward to nurse review for additional days
            - Skilled days exhausted (100 days per benefit period). SNF must provide NOMNC or proof of exhausted Medicare Skilled Days

2. SNF sends skilled level of care request to SCFHP UM.

3. Coordinator will approve initial 7 days.

4. Coordinator will forward this request to UM nurse for additional days and concurrent review.

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

LONG TERM CARE

1. Member must be CMC or Medi-Cal assigned to network
    a. Independent Physician's
    b. Palo Alto Medical Foundation
    c. VHP Long Term Custodial Care services become the financial responsibility of SCFHP on the 1st day of the month following admission if VHP submits the Enrollee reassignment request to SCFHP before that date.
    d. Kaiser, PMG, and Premier Care - redirect to network if within month of admission and month after admission.
        - If member is LTC during the time of eligibility, network must be changed to Independent Provider (except for PAMF and Kaiser).
2. SNF sends LTC request (PAR) to SCFHP UM

3. Coordinator will approve initial authorization for 6 months with receipt of completed required LTC PART documentation from the provider

4. Authorization will remain "in process" status and will be assigned to LTC nurse for further review. Send Authorization letter.

5. Nurse may recommend Last Covered Day to MD if LTC criteria is not met.

6. Coordinator will approve 1 year LTC Re-Authorizations with complete LTC PAR documentation and attachments for members that have been in LTC for 2 years or more. These re-authorizations will remain "in process" status and will be assigned to the LTC UM RN for further review. Send re-authorization letter.

7. Re-authorizations for members residing in LTC less than 2 years will be forwarded to nurse for review.

8. All LTC out of area requests will be forwarded to nurse for review for denial as non- covered benefit.

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

BED HOLD

1. For members who are at a SNF for LTC or skilled, member must be CMC or Medi-Cal assigned to network -
    a. Independent Physician's
    b. Palo Alto Medical Foundation
    c. VHP will be responsible for Bed Hold during the time that member is delegated to them
    d. Kaiser, PMG, Premier Care redirect to Network if within month of admission and month after admission except OOA

2. Bed Hold Notification Form is received from Facility

3. Coordinator will enter and approve up to 7 days max per Medi-Cal benefit.
    a. A separate authorization will be created for Bed Hold.

4. If bed hold request if over 7 days, or if member is out of SNF bed over 7 days, existing LTC or skilled auth will be updated with correct DC date and a new skilled or LTC auth will be created for the days following the bed hold to continue auth for the level of care.

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

HOME HEALTH

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

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

3. Approve initial request ordered by contracted hospital or physician up to total of 18 visits (Combination of services: PT, OT, ST, Nurse, SW, HHA)

4. Initial request exceeding 18 visits must be forwarded to nurse for review.

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

HOSPICE ROOM AND BOARD FOR NON-CONTRACTED PROVIDERS

1. Member must be Medi-Cal with Medicare primary (Medicare does not cover room and board) assigned to:
    a. Independent Physician's
    b. Palo Alto Medical Foundation
    c. VHP-fully delegated for hospice services
    d. Any other network (Kaiser, PMG, Premier Care) redirect to delegated network for authorization if within the month of and the month after admission date.

2. Covered benefit for all LOB's when medically indicated. Must include:
    a. Hospice admission notification

3. This applies to non-contracted Hospice Providers. Contracted hospice providers do not require authorization and can bill directly through claims.

4. Room and board authorization must be requested by Hospice agency and not by SNF.

5. Care coordinator may approve up to 90 days.

6. Additional days beyond 90 days must come with new hospice certification order, then can be approved by care coordinator.

7. Authorizations are reimbursed with Medi-Cal rates. No Letter of agreement (LOA) will be processed.

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

HEARING AID

1. Member must be CMC or Medi-Cal assigned to:
    a. Medicare Primary
    b. Independent Physician's
    c. Palo Alto Medical Foundation
    d. Any other network redirect to group

2. Covered benefit for all LOB's when medically indicated

3. Current Audiology exam done by an Audiologist

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

HEARING AID REPAIR

1. Member must be CMC or Medi-Cal assigned to:
    a. Medicare Primary
    b. Independent Physician's
    c. Palo Alto Medical Foundation
    d. Any other network redirect to group

2. Covered benefit for all LOB's when medically indicated

3. Need information of current hearing aids and reason for repair
    a. Purchase date
    b. Serial number

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

OUTPATIENT PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

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

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

3. Approve initial request ordered by contracted hospital or physician up to total of 18 visits (Combination of services: PT, OT, ST,)

4. Initial request exceeding 18 visits must be forwarded to nurse for review.

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

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

WHEELCHAIR REPAIR

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

2. Wheelchair must be 3 year old or less.

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

NON-EMERGENCY TRANSPORTATION

1. Member can be assigned to Independent Providers, VHP, PAMF, PMG, Premier Care and Medicare Primary.
    a. Medicare part B covers ambulance transportation for Facility to Facility.
    b. Kaiser is fully delegated for NEMT benefit

2. Provider must sent authorization request for and PCS form including start and end date of NEMT/gurney ambulance services.

3. Non-emergency ground transportation - approve x 1.

4. Non-emergency ground transportation for dialysis - approve up to 1 year for initial and reauthorization.

5. Non-emergency air transportation - forward to nurse for review.

6. Non-medical transportation (wheelchair van, litter van, cab, etc.) are processed by Customer Service.

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

BEHAVIORAL HEALTH TREATMENT (BHT)

1. Member must be Medi-Cal and assigned to:
    a. Independent Providers
    b. Palo Alto Medical Foundation (PAMF)
    c. Physician's Medical Group (PMG)
    d. Premier Care (Conifer)
    e. Valley Health Plan (VHP) and Kaiser are delegated for BHT
2. A Prior Authorization Request (PAR) must be received by SCFHP from either a licensed physician or licensed psychologist. The appropriate ICD 10 code, must be identified on the PAR
3. Comprehensive Diagnostic Evaluations (CDEs) which are completed by a licensed physician or psychologist are also accepted with a diagnosis of Autism or any other approved diagnosis per APL 19-014.
4. The Coordinator will enter an authorization approving up to 10 hours for up to two months for a BHT assessment.
5. If there is not a specified provider identified initially, the authorization will be approved to an unspecified provider and then changed when a provider is identified.
6. Authorizations will be initiated according to UM guidelines:
    a. 72 hours for Urgent Requests
    b. 5 Business Days for Routine
    c. 30 Days for Retroactive
7. The Health Plan has 15 business days to offer a provider to complete the initial assessment.
8. Following the initial assessment where goals and treatment plans are identified, the plan will be approved for 180 days per APL 19-014
9. Any request which is greater than 25 hours per week for Direct Services will be reviewed by the Manager of Behavioral Health and may require a case conference with the provider

Santa Clara Family Health Plan™

Membership Report

Membership

Source: iCat (4/1/2020)

Mbr Ct Sum		Cap Month											
LOB	Network Name	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
CMC		**7,884**	**7,869**	**7,915**	**8,022**	**8,076**	**8,134**	**8,194**	**8,233**	**8,289**	**8,428**	**8,401**	**8,486**	**8,601**
	Santa Clara Family Health Plan	7,884	7,869	7,915	8,022	8,076	8,134	8,194	8,233	8,289	8,428	8,401	8,486	8,601
MC		**239,836**	**239,444**	**237,655**	**237,697**	**236,578**	**235,389**	**234,478**	**237,095**	**235,350**	**233,995**	**231,435**	**231,548**	**233,229**
	INDEPENDENT PHYSICIANS	15,756	15,759	15,691	15,654	15,553	15,359	15,349	15,707	15,609	15,333	15,021	14,744	14,709
	KAISER PERMANENTE	25,442	25,428	25,435	25,488	25,426	25,415	25,332	25,344	25,152	24,978	24,743	24,764	25,097
	MEDICARE PRIMARY	14,409	14,504	14,509	14,645	14,787	15,005	15,177	15,244	15,347	15,433	15,422	15,455	15,460
	PALO ALTO MEDICAL FOUNDATION	6,984	6,976	6,874	6,863	6,820	6,750	6,704	6,784	6,678	6,639	6,536	6,473	6,481
	PHYSICIANS MEDICAL GROUP	42,996	42,718	42,236	42,242	41,765	41,271	41,061	42,021	41,548	41,420	40,820	40,860	41,050
	PREMIER CARE	14,873	14,813	14,693	14,731	14,612	14,516	14,448	14,660	14,622	14,541	14,485	14,407	14,467
	VHP NETWORK	119,376	119,246	118,217	118,074	117,615	117,073	116,407	117,335	116,394	115,651	114,408	114,845	115,965
HK		**3,348**	**3,465**	**3,507**	**3,486**	**3,501**	**3,509**	**3,512**	**2**	**2**	**2**			
	INDEPENDENT PHYSICIANS	390	380	376	359	360	359	366						
	PALO ALTO MEDICAL FOUNDATION	82	92	97	94	88	86	85						
	PHYSICIANS MEDICAL GROUP	1,169	1,230	1,234	1,239	1,257	1,245	1,232	2	2	2			
	PREMIER CARE	252	265	266	270	263	268	277						
	VHP NETWORK	1,455	1,498	1,534	1,524	1,533	1,551	1,552						
Grand Total		**251,068**	**250,778**	**249,077**	**249,205**	**248,155**	**247,032**	**246,184**	**245,330**	**243,641**	**242,425**	**239,836**	**240,034**	**241,830**

Santa Clara Family Health Plan™

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

Membership

Source: iCAT (4/8/2020)

Year-Month	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04
Healthy Kids	2	2	0	0	0	0
Medi-Cal	235,350	233,995	231,435	231,548	233,229	235,049
Cal MediConnect	8,289	8,428	8,401	8,486	8,601	8,725
Total	**243,641**	**242,425**	**239,836**	**240,034**	**241,830**	**243,774**

Inpatient Utilization: Cal MediConnect (CMC) and Medi-Cal
1/1/2019 – 12/31/2019

Is getting implemented in new HEDIS system. Estimated: 4/30/2020

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 – 12/31/2019 measurement period (Citius Tech)

LOB	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1,2]
MC - All	6,086	10,92	17.94%

[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 – 12/31/2019 measurement period

Rate Description	PCR
Count of Index Hospital Stays	1,365
Count of 30-Day Readmissions	188
Actual Readmission Rate	13.77%
NCQA Medicare 50th Percentile	16.39%
SCFHP Percentile Ranking	>75th

[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

Is getting implemented in new HEDIS system. Estimated: 4/30/2020

ADHD Medi-Cal Behavioral Health Metrics

Source: HEDIS data for 1/1/2019 – 12/31/2019 measurement period

Measure	Rate	NCQA Medicaid 50th Percentile	SCFHP Percentile Rank
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	34.56%	43.41%	<50th
Continuation & Maintenance Phase	45.00%	55.5%	<50th
Antidepressant Medication Management			
Acute Phase Treatment	58.94%	52.35%	>75th
Continuation Phase Treatment	45.49%	36.51%	>75th
Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia	65.00%	77.63%	<10th

Santa Clara Family Health Plan™

Call Center Dashboard Metrics

Santa Clara Family Health Plan™

	Jan	Feb	Mar	Q1 2020
MEDI-CAL				
MEDICAL AUTHORIZATIONS - HS COMBINED				
Routine Authorizations				
# of Routine Prior Authorization Requests Received	1,070	1,004	718	**2,792**
# of Routine Prior Authorization Requests Completed within 5 Business Days	1,069	999	718	**2,786**
% of Timely Decisions made within 5 Business Days of request	99.9%	99.5%	100.0%	**99.8%**
# of Prior Authorization Notification Sent	1,070	1,004	718	**2,792**
# of Prior Authorization Notification Sent Within 2 Business Days of Decision Date	1,060	992	709	**2,761**
% timely notification of HS decision	99.1%	98.8%	98.7%	**98.9%**
Expedited Authorizations				
# of Expedited Prior Authorization Requests Received	211	139	127	**477**
# of Expedited Prior Authorization Requests Completed within 72 Hours	210	137	127	**474**
% of Timely Decisions made within 72 Hours of request	99.5%	98.6%	100.0%	**99.4%**
# of Prior Authorization Notification Sent	211	139	127	**477**
# of Prior Authorization Notification Sent Within 2 Business Days of Decision Date	211	137	125	**473**
% timely notification of HS decision	100.0%	98.6%	98.4%	**99.2%**
Urgent Concurrent Review				
# of Urgent Concurrent Requests Received	6	4	4	**14**
# of Urgent Concurrent Requests Completed within 72 Hours of request	6	4	4	**14**
% of Timely Decisions made within 72 Hours of request	100.0%	100.0%	100.0%	**100.0%**
# of Prior Authorization Notification Sent	6	4	4	**14**
# of Prior Authorization Notification Sent Within 2 Business Days of Decision Date	6	4	4	**14**
% timely notification of HS decision	100.0%	100.0%	100.0%	**100.0%**
Retrospective Review				
# of Retrospective Requests Received	359	391	327	**1,077**
# of Retrospective Requests completed within 30 Calendar Days of request	359	391	327	**1,077**
% of Retrospective Reviews completed within 30 Calendar Days of request	100.0%	100.0%	100.0%	**100.0%**
# of Prior Authorization Notification Sent	359	391	327	**327**
# of Prior Authorization Notification Sent Within 2 Business Days of Decision Date	356	375	320	**320**
% timely notification of HS decision	99.2%	95.9%	97.9%	**97.9%**

Santa Clara Family Health Plan

Denied Authorizations (Routine, Expedited, CCR, Retro)				
Total Requests Approved	1,644	1,531	1,176	**4,351**
Total Requests Denied	2	7	0	**9**
Total Requests Pended/Extended	0	0	0	**0**
Total Requests Cancelled	0	0	0	**0**
% of Total Requests Denied	0.1%	0.5%	0.0%	**0.2%**
	Jan	Feb	Mar	Q1 2020
CAL MEDICONNECT				
CALL STATS				
PRE-SERVICE ORGANIZATION DETERMINATIONS - HS COMBINED				
Standard Part C				
# Approved	625	588	522	**1,735**
# Denied	27	18	26	**71**
% Approved	95.9%	97.0%	95.3%	**96.1%**
# of Prior Authorization Requests Received	652	606	548	**1,806**
# of Prior Auth Requests Completed within 14 days	652	606	546	**1,804**
% of Timely Decisions made within 14 days	100.0%	100.0%	99.6%	**99.9%**
# of Prior Authorization Notification Sent	652	606	548	**1,806**
# of Prior Authorization Notification Sent Within 14 Days	647	601	548	**1,796**
% Timely Notification of HS decision	99.2%	99.2%	100.0%	**99.4%**
Expedited Part C				
# Approved	308	272	192	**772**
# Denied	13	12	12	**37**
% Approved	96.0%	95.8%	94.1%	**95.4%**
# of Prior Authorization Requests Received	321	284	204	**809**
# of Prior Auth Requests Completed within 72 Hours	319	282	202	**803**
% of Timely Decisions made within 72 Hours	99.4%	99.3%	99.0%	**99.3%**
# of Prior Authorization Notification Sent	321	284	204	**809**
# of Prior Authorization Notification Sent Within 72 hours	314	284	195	**793**
% timely notification of HS decision	97.8%	100.0%	95.6%	**98.0%**
URGENT CONCURRENT ORGANIZATION DETERMINATIONS - HS COMBINED				
# Approved	10	4	8	**22**
# Denied	0	0	0	-
% Approved	100.0%	100.0%	100.0%	**100.0%**
# of Urgent Concurrent Requests Received	10	4	8	**22**

# of Urgent Concurrent Requests Completed within 72 Hours	10	4	8	**22**
% of Timely Decisions made within 72 Hours	100.0%	100.0%	100.0%	**100.0%**
# of Prior Authorization Notification Sent	10	4	8	**22**
# of Prior Authorization Notification Sent Within 24 hours	10	4	5	**19**
% timely notification of HS decision	100.0%	100.0%	62.5%	**86.4%**
POST SERVICE ORGANIZATION DETERMINATIONS - HS COMBINED				
# Approved	78	80	60	**218**
# Denied	1	0	1	**2**
% Approved	98.7%	100.0%	98.4%	**99.1%**
# of Requests Received	79	80	61	**220**
# of Post Service Requests Completed within 30 Days	79	80	61	**220**
% of Timely Decisions made within 30 days	100.0%	100.0%	100.0%	**100.0%**
# of Prior Authorization Notification Sent	79	80	61	**220**
# of Prior Authorization Notification Sent Within 30 Days	78	80	61	**219**
% timely notification of HS decision	98.7%	100.0%	100.0%	**99.5%**

Santa Clara Family Health Plan

	Jan	Feb	Mar	Average
CALL STATS - UM Provider Queue				
MEDI-CAL				
# Calls Presented	1,974	1,687	1,593	1,751
Provider Average Speed of Answer in Seconds	0:00:24	0:00:28	0:00:40	0:00:31
Provider Average Hold Time in Seconds	0:00:11	0:00:10	0:00:45	0:00:22
# of Abandoned Provider Calls	45	46	88	60
Provider Abandonment Rate	2%	3%	6%	4%
Provider Service Level	86%	81%	78%	82%
Average Talk Time	0:02:22	0:02:22	0:01:37	0:02:07
CAL MEDICONNECT				
# Calls Presented	1,141	1,020	1,045	1,069
Provider Average Speed of Answer in Seconds	0:00:20	0:00:33	0:00:42	0:00:32
Provider Average Hold Time in Seconds	0:00:11	0:00:10	0:00:08	0:00:10
# of Abandoned Provider Calls	34	41	63	46
Provider Abandonment Rate	3%	4%	6%	4%
Total Provider Calls Handled	1,104	978	958	1,013
# of Provider Calls Handled in ≤ 30 seconds	992	799	779	857
Provider Service Level	87%	78%	75%	80%
Average Talk Time	0:02:22	0:02:22	0:01:19	0:02:01

Santa Clara Family Health Plan™

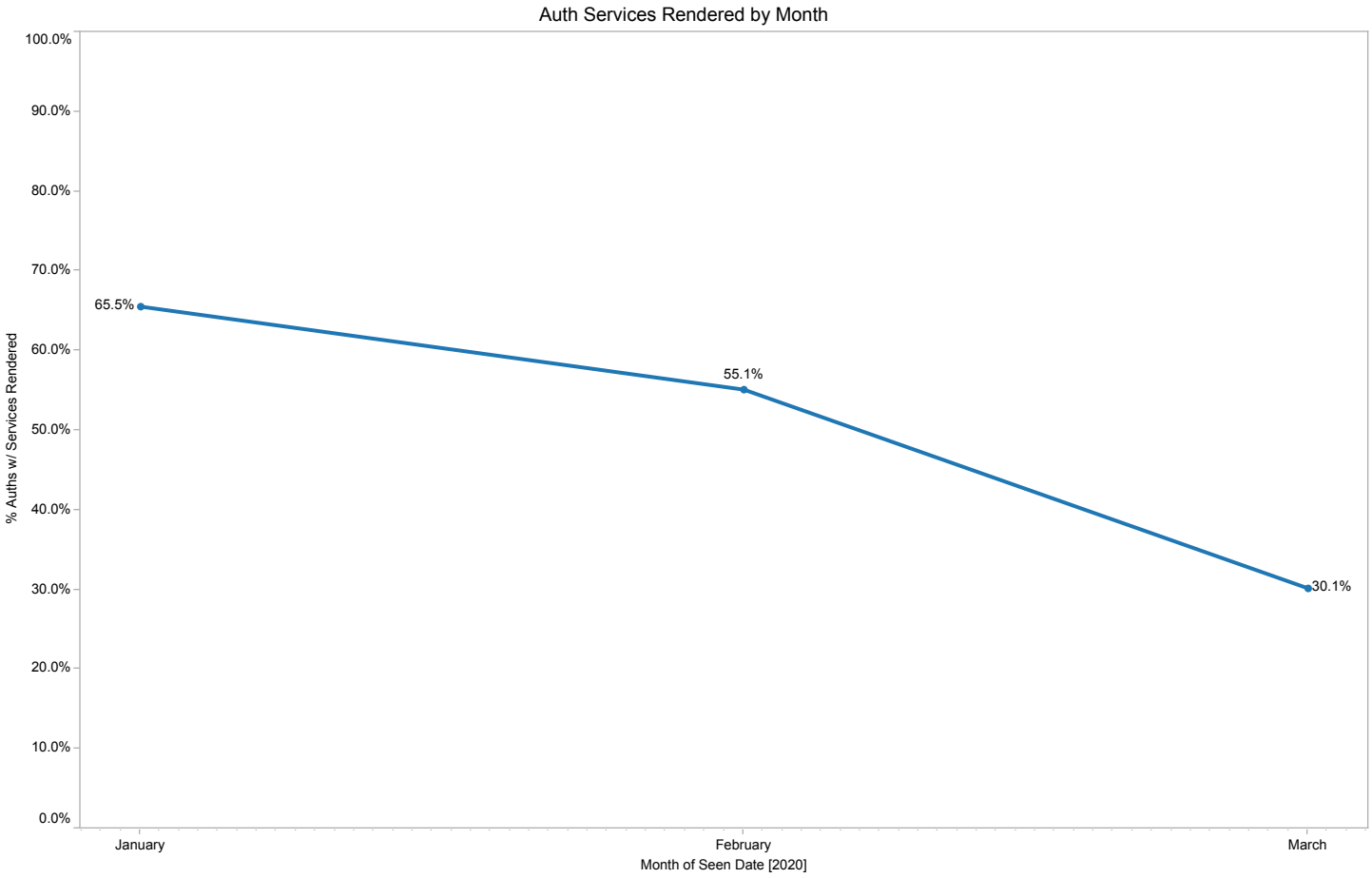
CMC and MC Quarterly Referral Tracking

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	14	11	0	3	21.4%
		Routine - Extended Service	3	2	0	1	33.3%
		Routine - Initial Request	6	6	0	0	0.0%
	CONT OF CARE	Member Initiated Org Determi..	5	1	0	4	80.0%
		Member Rep Initiated Org Det..	1	1	0	0	0.0%
		Non Contracted Provider - Ro..	2	1	0	1	50.0%
		Non Contracted Provider - Urg..	2	2	0	0	0.0%
	CUSTODIAL	Retro Request	154	122	0	32	20.8%
		Routine - Initial Request	31	20	0	11	35.5%
	Dental	Routine - Initial Request	1	0	0	1	100.0%
	DME	Member Initiated Org Determi..	7	1	0	6	85.7%
		Member Initiated Org Determi..	3	0	0	3	100.0%
		Non Contracted Provider - Ro..	4	0	0	4	100.0%
		Non Contracted Provider - Urg..	3	0	0	3	100.0%
		Retro Request	20	8	0	12	60.0%
		Routine - Extended Service	1	0	0	1	100.0%
		Routine - Initial Request	200	106	0	94	47.0%
		Urgent - Extended Service	1	1	0	0	0.0%
		Urgent - Initial Request	25	14	0	11	44.0%
	HomeHealth	Member Initiated Org Determi..	2	1	0	1	50.0%
		Member Rep Initiated Org Det..	1	0	0	1	100.0%
		Non Contracted Provider - Ro..	2	2	0	0	0.0%
		Non Contracted Provider - Urg..	61	25	0	36	59.0%
		Retro Request	10	4	0	6	60.0%
		Routine - Extended Service	11	3	0	8	72.7%
		Routine - Initial Request	7	1	0	6	85.7%
		Urgent - Extended Service	66	16	0	50	75.8%
		Urgent - Initial Request	150	54	0	96	64.0%
	HOSPICE	Non Contracted Provider - Ret..	4	1	0	3	75.0%
		Non Contracted Provider - Ro..	1	1	0	0	0.0%
		Non Contracted Provider - Urg..	4	2	0	2	50.0%
		Retro Request	1	1	0	0	0.0%
	Inpatient		1	1	0	0	0.0%
		Non Contracted Provider - Ro..	4	4	0	0	0.0%
		Retro Request	4	4	0	0	0.0%
		Routine - Initial Request	593	565	0	28	4.7%
		Urgent - Initial Request	20	19	0	1	5.0%
	InpatientAdmin	Routine - Initial Request	1	0	0	1	100.0%
		Urgent - Initial Request	1	0	0	1	100.0%
	OP-BehavioralGr	Non Contracted Provider - Ret..	4	4	0	0	0.0%
	OP-Behavorial	Care Coordinator Initiated Org..	1	0	0	1	100.0%
		Member Initiated Org Determi..	2	1	0	1	50.0%
		Non Contracted Provider - Ro..	1	0	0	1	100.0%
	OPHospital	Member Initiated Org Determi..	8	1	0	7	87.5%
		Member Initiated Org Determi..	4	0	0	4	100.0%
		Non Contracted Provider - Ret..	2	0	0	2	100.0%
		Non Contracted Provider - Ro..	36	7	0	29	80.6%
		Non Contracted Provider - Urg..	22	4	0	18	81.8%
		Retro Request	17	6	0	11	64.7%

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	Routine - Extended Service	23	5	0	18	78.3%
		Routine - Initial Request	637	141	0	496	77.9%
		Urgent - Extended Service	6	3	0	3	50.0%
		Urgent - Initial Request	273	107	0	166	60.8%
	OPHospitalGr	Member Initiated Org Determi..	9	5	0	4	44.4%
		Member Initiated Org Determi..	4	2	0	2	50.0%
		Non Contracted Provider - Ro..	1	0	0	1	100.0%
		Non Contracted Provider - Urg..	1	1	0	0	0.0%
		Retro Request	14	9	0	5	35.7%
		Routine - Extended Service	10	2	0	8	80.0%
		Routine - Initial Request	175	53	0	122	69.7%
		Urgent - Extended Service	3	1	0	2	66.7%
		Urgent - Initial Request	49	24	0	25	51.0%
	SkilledNursing		7	6	0	1	14.3%
		Non Contracted Provider - Urg..	1	1	0	0	0.0%
		Retro Request	11	9	0	2	18.2%
		Routine - Initial Request	12	11	0	1	8.3%
		Urgent - Initial Request	123	109	0	14	11.4%
	Transportation	Member Initiated Org Determi..	1	0	0	1	100.0%
		Member Initiated Org Determi..	2	0	0	2	100.0%
		Member Rep Initiated Org Det..	2	1	0	1	50.0%
		Member Rep Initiated Org Det..	1	0	0	1	100.0%
		Routine - Initial Request	66	6	0	60	90.9%
Grand Total			**2,955**	**1,519**	**0**	**1,436**	**48.6%**

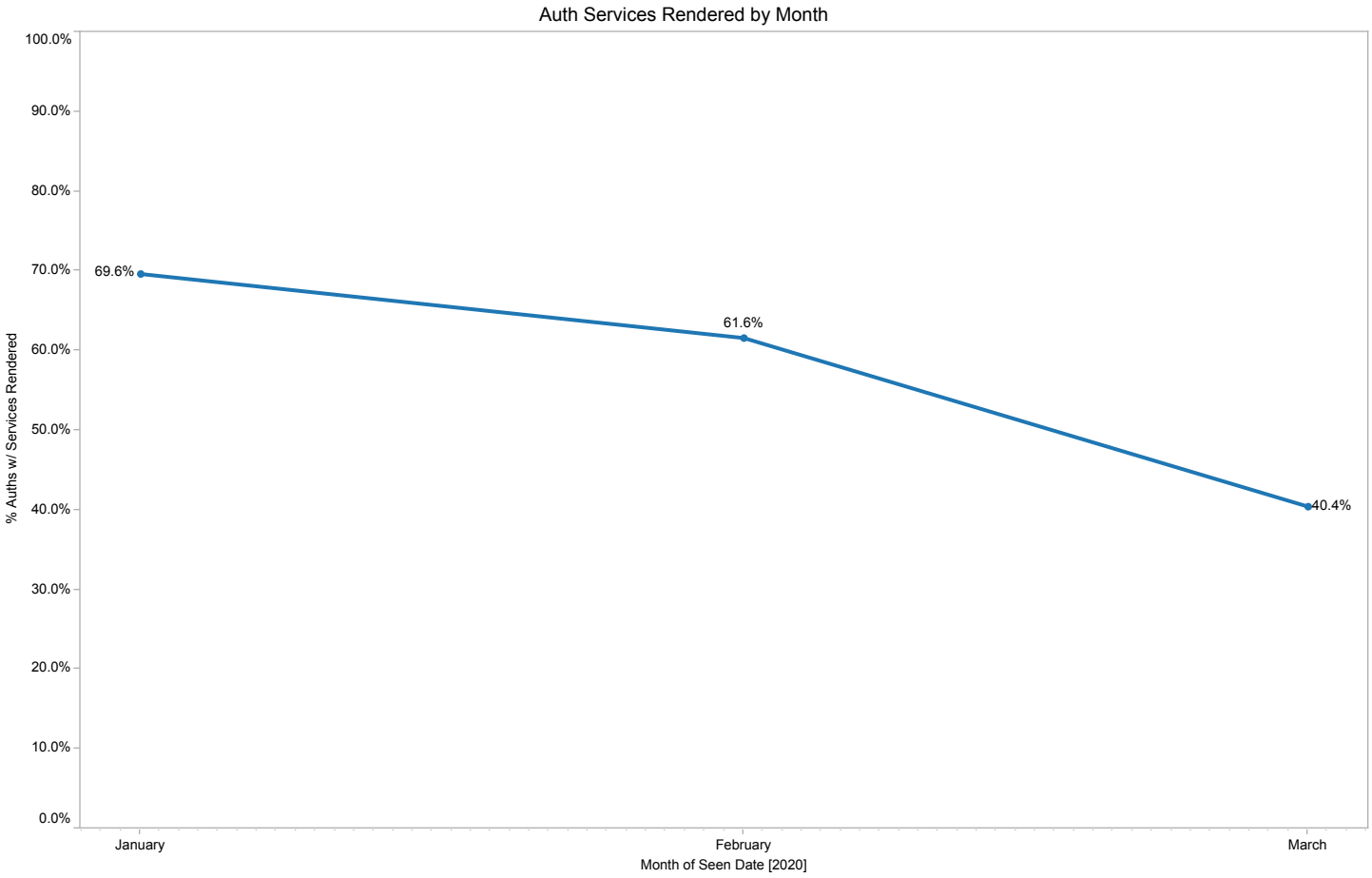

Auth Services Rendered by Month
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
% Auths w/ Services Rendered
65.5%
55.1%
30.1%
January
February
March
Month of Seen Date [2020]

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Medi-Cal	CBAS		2	1	0	1	50.0%
		Retro Request	66	62	0	4	6.1%
		Routine - Extended Service	2	0	0	2	100.0%
		Routine - Initial Request	19	17	0	2	10.5%
	CONT OF CARE	Non Contracted Provider - Urg..	1	0	0	1	100.0%
		Routine - Initial Request	1	0	0	1	100.0%
	CUSTODIAL		3	2	0	1	33.3%
		Retro Request	756	628	0	128	16.9%
		Routine - Initial Request	166	113	0	53	31.9%
	Dental	Routine - Initial Request	27	15	0	12	44.4%
		Urgent - Initial Request	12	5	0	7	58.3%
	DME	Non Contracted Provider - Ret..	20	5	0	15	75.0%
		Non Contracted Provider - Ro..	5	0	0	5	100.0%
		Non Contracted Provider - Urg..	2	0	0	2	100.0%
		Retro Request	25	9	0	16	64.0%
		Routine - Extended Service	1	0	0	1	100.0%
		Routine - Initial Request	271	143	0	128	47.2%
		Urgent - Extended Service	2	0	0	2	100.0%
		Urgent - Initial Request	45	36	0	9	20.0%
	HomeHealth	Non Contracted Provider - Ro..	1	0	0	1	100.0%
		Non Contracted Provider - Urg..	5	3	0	2	40.0%
		Retro Request	5	0	0	5	100.0%
		Routine - Extended Service	1	0	0	1	100.0%
		Routine - Initial Request	2	0	0	2	100.0%
		Urgent - Extended Service	14	2	0	12	85.7%
		Urgent - Initial Request	40	19	0	21	52.5%
	HomeHealthGr	Routine - Extended Service	1	1	0	0	0.0%
	HomeHealthInd	Routine - Initial Request	1	0	0	1	100.0%
	HOSPICE	Non Contracted Provider - Ret..	17	9	0	8	47.1%
		Non Contracted Provider - Ro..	8	5	0	3	37.5%
		Non Contracted Provider - Urg..	6	1	0	5	83.3%
		Urgent - Initial Request	1	1	0	0	0.0%
	Inpatient		5	4	0	1	20.0%
		Non Contracted Provider - Ret..	2	1	0	1	50.0%
		Non Contracted Provider - Ro..	5	4	0	1	20.0%
		Retro Request	10	7	0	3	30.0%
		Routine - Initial Request	631	556	0	75	11.9%
		Urgent - Initial Request	12	9	0	3	25.0%
	InpatientAdmin	Routine - Initial Request	2	1	0	1	50.0%
	OP-BehavioralGr	Non Contracted Provider - Ret..	12	9	0	3	25.0%
		Non Contracted Provider - Ro..	41	22	0	19	46.3%
		Retro Request	21	11	0	10	47.6%
		Routine - Extended Service	106	71	0	35	33.0%
		Routine - Initial Request	12	3	0	9	75.0%
	OP-Behavorial	Delay Additional info – See N..	1	1	0	0	0.0%
		Non Contracted Provider - Ret..	3	3	0	0	0.0%
		Non Contracted Provider - Ro..	13	6	0	7	53.8%
		Retro Request	6	4	0	2	33.3%
		Routine - Extended Service	5	4	0	1	20.0%

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
Medi-Cal	OP-Behavorial	Routine - Initial Request	35	9	0	26	74.3%
		Urgent - Initial Request	6	2	0	4	66.7%
	OPHospital		4	1	0	3	75.0%
		Non Contracted Provider - Ret..	33	6	0	27	81.8%
		Non Contracted Provider - Ro..	30	8	0	22	73.3%
		Non Contracted Provider - Urg..	13	2	0	11	84.6%
		Retro Request	21	12	0	9	42.9%
		Routine - Extended Service	46	15	0	31	67.4%
		Routine - Initial Request	427	158	0	269	63.0%
		Urgent - Extended Service	14	4	0	10	71.4%
		Urgent - Initial Request	166	68	0	98	59.0%
		Urgent – RN review; Expedite..	1	0	0	1	100.0%
	OPHospitalGr	Retro Request	17	9	0	8	47.1%
		Routine - Extended Service	46	23	0	23	50.0%
		Routine - Initial Request	361	142	0	219	60.7%
		Urgent - Extended Service	11	7	0	4	36.4%
		Urgent - Initial Request	89	59	0	30	33.7%
	SkilledNursing		1	1	0	0	0.0%
		Retro Request	12	7	0	5	41.7%
		Routine - Initial Request	13	10	0	3	23.1%
		Urgent - Initial Request	52	45	0	7	13.5%
	Transportation	Non Contracted Provider - Ro..	1	0	0	1	100.0%
		Retro Request	275	194	0	81	29.5%
		Routine - Initial Request	513	120	0	393	76.6%
Grand Total			**4,602**	**2,695**	**0**	**1,907**	**41.4%**


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
69.6%
61.6%
40.4%
January
February
March
Month of Seen Date [2020]

Santa Clara Family Health Plan™

Quality Monitoringof Plan Authorizations and Denials

Quality Monitoring of Denial Letters for HS.04.01
1st Quarter 2020

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 1st 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 1st quarter of 2020 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 Q1 2020, the dates of service and denials were pulled in April 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. 23% or 7/30 were expedited requests, 77% or 23/30 were standard requests
         1. 100% or 7/7 of the expedited authorizations are compliant with regulatory turnaround time of 72 calendar hours
         2. 100% or 23/23 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. 73% or 22/30 were medical denials, 27% or 8/30 was administrative denials
      e. 97% or 29/30 of cases were denied by a Medical Director, 3% or 1/30 was denied by a Pharmacist
      f. 100% or 30/30 were provided both member and provider notification.
      g. 100% or 7/7 expedited authorizations were provided oral notifications to member.
      h. 100% or 30/30 of the member letters are of member's preferred language.
      i. 100% or 30/30 of the letters were readable and rationale for denial was provided.
      j. 100% or 30/30 of the letters included the criteria or EOC that the decision was based upon.
      k. 100% or 30/30 of the letters included interpreter rights and instructions on how to contact CMO or Medical Director.

IV. Follow-Up

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

1. Quality and productivity will continued to be monitored on a weekly basis. Findings will be reported to the Medical Director with a plan of action of how to correct it.
2. The UM leadership team will continue to optimize the Quality Assurance reports with IT to ensure that quality and productivity are monitored accurately.

Santa Clara Family Health Plan™

Inter-Rater Reliability (IRR) Report

Santa Clara Family Health Plan™

Inter-Rater Reliability (IRR) Report

The current COVID-19 pandemic and shelter in place order has delayed our Inter-Rater Reliability (IRR) testing. IRR testing will be completed in the coming quarter. These results will be presented at the next Utilization Management Committee Meeting on July 15, 2020.

Santa Clara Family Health Plan™

Behavioral Health UM Reports

DEVELOPMENTAL SCREENING (96110)

ORGANIZATIONAL GOAL: TO MEET GREATER THAN 5000 SCREENS COMPLETED

Quarter	Dev Screening
2020 Q1	941
2019 Q4	962

BHT

Currently Receiving BHT

January	February	March	WAITLIST
184	197	173	15

Utilization

Cal MediConnect Quarter 1

- Psychiatric admissions
  - Quarter 1: 8
- Transitions of Care Completed
  - Quarter 1: 8

Medi-Cal Quarter 1

- Mild to Moderate Referrals:
  - Members connected to services: 9
  - Members not connected to services: 0

Case Management

Cal MediConnect

- 102 members assigned/referred to Behavioral Health Team in Quarter 1

Medi-Cal

- 4 SPD members assigned/referred to Behavioral Health Team in Quarter 1

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Adjournment