Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, June 10, 2020, 6:00 PM – 8:00 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference
(669) 900-6833
Meeting ID: 916 6195 6091
Password: 0Y=Bg=V=

AGENDA

1.	**Roll Call**	Dr. Paul	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 Quality Improvement Committee reserves the right to limit the duration of the public comment period to 30 minutes	Dr. Paul	6:05	5 min
3.	**Meeting Minutes** Review minutes of the April 8, 2020 Quality Improvement Committee meeting **Possible Action:** Approve minutes of the April 8, 2020 Quality Improvement Committee meeting	Dr. Paul	6:10	5 min
4.	**CEO Update** Discuss status of current topics and initiatives	Ms. Tomcala	6:15	10 min
5.	**Follow-Up/Old Business**			
	a. SCFHP Access Interventions Progress Report – MY 2019	Ms. Switzer	6:25	5 min
6.	**Review of Population Health Management Strategy 2020** Review of the Population Health Management Strategy 2020 **Possible Action:** Approve the Population Health Management Strategy 2020	Ms. Andersen & Ms. Cagel	6:30	15 min
7.	**Assessment of Cal MediConnect (CMC) Members Understanding of Marketing Information** Review the Assessment of CMC Members Understanding of Marketing Information **Possible Action:** Approve the Assessment of CMC Members Understanding of Marketing Information	Ms. Zhang	6:45	10 min

8.	**VHP Provider Satisfaction Survey (PSS) Report** Review the VHP PSS report MY 2019 **Possible Action:** Approve the VHP PSS Report MY 2019	Ms. Switzer	6:55	10 min
9.	**Annual Review of QI Policies** **a.** QI.13 Comprehensive Case Management **b.** QI.15 Transitions of Care **c.** QI.17 Behavioral Health Care Coordination **d.** QI.18 Sensitive Services, Confidentiality, Rights of Adults and Minors **e.** QI.19 Care Coordination Staff Training **f.** QI.20 Information Sharing with San Andreas Regional Center (SARC) **g.** QI.21 Information Exchange Between SCFHP & Health Services Department **h.** QI.22 Early Start Program (Early Intervention Services) **i.** QI.23 Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care **j.** QI.24 Outpatient Mental Health Services: Mental Health Parity **k.** QI.25 Intensive Outpatient Palliative Care **l.** QI.27 Informing Members of Behavioral Health Services **Possible Action:** Approve QI Policies as presented	Dr. Liu	7:05	10 min
10.	**Grievances and Appeals Report** Review of the Q1 2020 Grievance and Appeals Report	Mr. Breakbill	7:15	10 min
11.	**Quality Dashboard** Review of the Quality Dashboard	Dr. Liu	7:25	10 min
12.	**Compliance Report** Review of the Compliance Report	Ms. Yamashita	7:35	10 min
13.	**Pharmacy and Therapeutics Committee** Review minutes of the December 19, 2019 Pharmacy and Therapeutics Committee meeting **Possible Action:** Approve the December 19, 2019 Pharmacy and Therapeutics Committee meeting	Dr. Lin	7:45	5 min
14.	**Utilization Management Committee** Review minutes of the January 15, 2020 Utilization Management Committee meeting **Possible Action:** Approve the January 15, 2020 Utilization Management Committee meeting	Dr. Lin	7:50	5 min
15.	**Credentialing Committee Report** Review April 1, 2020 Credentialing Committee Meeting Report **Possible Action:** Approve the April 1, 2020 Credentialing Committee Meeting Report	Dr. Nakahira	7:55	5 min
16.	**Adjournment** The next QIC meeting will be held on August 12, 2020	Dr. Paul	8:00	

Notice to the Public—Meeting Procedures

- Persons wishing to address the Quality Improvement 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 Nancy Aguirre 48 hours prior to the meeting at (408) 874-1835.
- To obtain a copy of any supporting document that is available, contact Nancy Aguirre at (408) 874-1835. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave, San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com.

Santa Clara Family Health Plan™

Quality Improvement Committee

Meeting Minutes

April 8, 2020

Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, April 8, 2020, 6:00 PM – 8:00 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Minutes

Members Present
Ria Paul, MD, Chair
Ali Alkoraishi, MD
Nayyara Dawood, MD
Jennifer Foreman, MD
Jimmy Lin, MD
Laurie Nakahira, D.O., Chief Medical Officer
Christine Tomcala, Chief Executive Officer

Members Absent
Jeffrey Arnold, MD

Staff Present
Darryl Breakbill, Director, Grievance & Appeals
Johanna Liu, PharmD, Director, Quality & Process Improvement
Mai Chang, Manager, Quality Improvement
Jamie Enke, Manager, Process Improvement
Mai Phuong Nguyen, Manager, Compliance
Carmen Switzer, Manager, Provider Network Access
Jordan Yamashita, Director, Compliance
Theresa Zhang, Manager, Marketing

1. Roll Call

Ria Paul, MD, Chair, called the meeting to order at 6:00 pm. Roll call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Meeting Minutes

Minutes of the February 12, 2020 Quality Improvement Committee (QIC) meeting were reviewed.

It was moved, seconded and the minutes of the February 12, 2020 QIC meeting were **unanimously approved**.

Motion: Dr. Lin
Second: Dr. Alkoraishi
Ayes: Dr. Dawood, Dr. Foreman, Dr. Nakahira, Dr. Paul, Ms. Tomcala

4. CEO Update

Christine Tomcala, Chief Executive Officer, reported there are currently 235,000 Medi-Cal members and 8,700 Cal MediConnect (CMC) members, reflecting a total of 3,700 new members since February 2020.

Ms. Tomcala explained that over the last two weeks, SCFHP has redesigned the way business is operated in response to the pandemic. As of now, 96% of staff have shifted to work remotely, while an estimated 12 individuals remain at the office, primarily for mailroom needs and other functions which cannot be done remotely.

SCFHP does not have an accurate number of members diagnosed with COVID-19, as lab results aren't shared with SCFHP. However, the data available reflects a total of 41 members hospitalized with COVID-19, two members deceased, and 17 members diagnosed with COVID-19 isolating at home.

In response to the pandemic, SCFHP has suspended Prior Authorizations (PAs), as well as expended the pharmacy refill parameters. A new telehealth capability connected to SCFHP's Nurse Advice Line (NAL) has been recently implemented. Vulnerable populations have been identified and SCFHP continues to do outreach to them, such as robo-calls or direct mail.

Ali Alkoraishi, MD, asked if prescriptions writtenfor 90 days would be authorized. Laurie Nakahira, D.O., Chief Medical Officer, indicated they would, and explained early prescription refills do not require a PA and are being passed directly to the pharmacy, coded as "State of Emergency" (code 13). Disinfectants and gloves have been added to the Medi-Cal line of business, as available per supply.

5. Follow-Up / Old Business

a. CalAIM Overview
Dr. Nakahira reported Healthier California for All has changed their name back to CalAIM. Due to the current state of emergency, future plans for CalAIM are unsure. SCFHP continues their efforts toward the given CalAIM timeline while awaiting further instruction.

b. Out of Network Requests for Ambulatory Surgical Centers (ASC)
Carmen Switzer, Manager, Provider Network Access, SCFHP, confirmed SCFHP is actively in contract negotiations with Peninsula Eye Surgery Center and Tri-County Vascular Care (now named Satellite Dialysis).

c. Grievance and Appeals Report Q3
The Grievance and Appeals Report Q3 was deferred to Agenda item 10.

d. Compliance Report Q1
The Compliance Report Q1 was deferred to Agenda item 13.

6. Review of Quality Improvement (QI) Program Evaluation 2019

Mai Chang, Manager, Quality Improvement, SCFHP, reviewed the Clinical Improvement Activities for 2019 and reported the results of the HEDIS and Administrative measures for 2018. In the Medi-Cal line of business, there was a significant improvement in the Cervical Cancer Screenings (>5%) from 2018 to 2019. In the CMC line of business, there was a significant improvement (>10%) in the 30 Day Follow-Up after Hospitalization for Mental Illness measure from 2018 to 2019.

Dr. Paul asked which hospital has the highest readmission rate. This information was not readily available, but will be addressed at the following QIC meeting.

It was moved, seconded and the QI Program Evaluation 2019 was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Dawood
Ayes: Dr. Alkoraishi, Dr. Foreman, Dr. Nakahira, Dr. Paul, Ms. Tomcala

7. Review of QI Work Plan 2020

Ms. Chang reviewed the following additions to the QI Work Plan for 2020:

1. Two state-wide Performance Improvement Projects (PIPs) relating to adolescent and child welfare: Adolescent Well Care visits and Well Child visits for children turning 15 months.
2. Internal Performance Improvement Project – Comprehensive Diabetes Care.

It was moved, seconded and the QI Work Plan 2020 was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Alkoraishi
Ayes: Dr. Dawood, Dr. Foreman, Dr. Nakahira, Dr. Paul, Ms. Tomcala

8. Assessment of Member Cultural and Linguistic Needs and Preferences

Ms. Switzer reviewed the Assessment of Member Cultural and Linguistic Needs and Preferences.

It was moved, seconded and the Assessment of Member Cultural and Linguistic Needs and Preferences was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Dawood
Ayes: Dr. Alkoraishi, Dr. Foreman, Dr. Nakahira, Dr. Paul, Ms. Tomcala

9. Annual Review of QI Policies

Johanna Liu, PharmD, Director, Quality and Process Improvement, SCFHP, reported the following changes to the policies during their annual review:

a. QI.03 Distribution of QI Information – *No change*
b. QI.04 Peer Review Process – *No change*
c. QI.06 QI Study Design/Performance Improvement Program Reporting – *No change*
d. QI.08 Cultural and Linguistically Competent Services – *Healthy Kids was removed as a line of business and CMC was applied. A Population Needs Assessment requirement has been added.*
e. QI.09 Health Education Program and Delivery System – *Healthy Kids was removed as a line of business and a line item was added as a 2020 NCQA requirement.*
f. QI.11 Member Non-Monetary Incentives – *No change*
g. QI.12 Screening, Brief Intervention, and Referral to Treatment (BIRT) for Misuse of Alcohol – *No change*
h. QI.16 Managed Long Term Services and Support Care Coordination – *No change*
i. QI.28 Health Homes Program – *No change*

It was moved, seconded and the annual review of QI policies QI.03, QI.04, QI.06, QI.08, QI.09, QI.11, QI.12, QI.16, and QI.28 were **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Foreman
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Nakahira, Dr. Paul, Ms. Tomcala

10. Grievances and Appeals Report

Darryl Breakbill, Director, Grievance & Appeals reviewed the Grievances and Appeals Report for Q3 and Q4. Balance Billing and Transportation Grievances are the primary focus for the remainder of 2020.

Mr. Breakbill reported a total of 8 Grievances received related to COVID-19. Some of which were questions and others were resolved by connecting the member with the correct provider/resource.

11. Quality Dashboard

Dr. Liu reviewed the Quality Dashboard for December, 2019 through February, 2020. Dr. Liu explained only 20% of the Facility Site Reviews (FSR) were completed due to staffing changes, the HEDIS audit, and COVID-19. DHCS has granted SCFHP an extension on the FSRs that have been delayed.

Dr. Dawood suggested completing a portion of the FSR virtually, rather than in-person, if appropriate. Dr. Liu will present this suggestion to the Provider Advisory Council.

12. Compliance Report

Jordan Yamashita, Director, Compliance, SCFHP, noted SCFHP is currently in the revalidation phase of the CMS program audit. Revalidation audit activities for Coverage Determinations and Appeals and Grievances (CDAG) Conditions have begun.

Ms. Yamashita highlighted the 2019 DHCS audit. Although the final report has not been received, DHCS anticipates fewer findings for 2019, than 2018.

13. Credentialing Committee Report

Dr. Nakahira reviewed the details of the Credentialing Committee Report for February 5, 2020. There were no comments made.

It was moved, seconded and the Credentialing Committee Report was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Foreman
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Nakahira, Dr. Paul, Ms. Tomcala

14. Adjournment

The next QIC meeting will be on June 10, 2020. The meeting was adjourned at 7:42 pm.

_____ _____

Ria Paul, MD, Chair Date

Santa Clara Family Health Plan™

Timely Access Interventions MY2019

Prepared by: Carmen Switzer, Provider Network Access Manager

Quality Improvement Committee

June 10, 2020

Introduction

- Plans are required to provide or arrange for covered health care services in a timely manner appropriate for the members condition.
- Plans are required to maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with clinical appropriateness standards.
- Plans are required to implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is non-compliant with timely access, including but not limited to –
  - Taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies.
  - Bringing its network into compliance.
- Plans are required to give advance written notice to all contracted providers affected by a corrective action, to include:
  - A description of the identified deficiencies.
  - The rationale for the corrective action.
  - The name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

Timely Access Appointment Standards

In addition to ensuring compliance with the clinical appropriateness standards, Plans are required to ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer member appointments that meet the following timeframes:

- PCP Urgent Care Appointments: 48 hours of the request for appointment
- SPC Urgent Care Appointments: 96 hours of the request for appointment
- PCP Non-Urgent Appointments: Ten (10) business days of the request for appointment
- SPC Non-Urgent Appointments: Fifteen (15) business days of the request for appointment
- MH (NPMH) Non-Urgent Appointments: Ten (10) business days of the request for appointment
- Ancillary Non-Urgent Appointments: Fifteen (15) business days of the request for appointment

Monitoring Provider Accessibility and Availability

Plans should have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services --

- Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers.
- Tracking and documenting network capacity and availability with respect to DMHC and DHCS standards and requirements.
- Conducting annual enrollee and provider experience surveys.
- Reviewing and evaluating, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care, including but not limited to information obtained through—

  - Enrollee and provider surveys
  - Enrollee grievances and appeals
  - Triage or screening services

Corrective Action

- Plan's are required to implement a prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access, including but not limited to –

  - taking all necessary and appropriate action to identify the cause(s)
  - underlying identified timely access deficiencies *and*
  - bring its network into compliance

- Plans are required to give advance written notice to all contracted providers affected by a corrective action, and should include –

  - a description of the identified deficiencies,
  - the rationale for the corrective action, and
  - the name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

Interventions MY2019:

Barrier	Opportunity	Intervention	Selected for 2019	Date Initiated
1. Timely access— Urgent appointments within PCP-48hrs, SPC-96hrs and BH-6hrs	Improve access to urgent care appointments	Following CAP, resurvey non-complaint providers	Yes	Completed
2. Providers unaware of appointment access standards	Educate providers on access standards	Require providers who show continued non-compliance through resurveys to complete SCFHP's access training and submit an attestation.	Yes	In Process
3. Shortage of BH providers	BH network development	Continue to seek contracting opportunities with behavioral health providers	Yes	In Process
4. PCP and BH Providers are unaware of after-hours messaging requirements- • Calls are required to be returned within 30-minutes.	Educate providers on after-hours access	Following CAP, conduct provider outreach (Training) Submit SCFHP's access matrix via fax blast to network providers.	Yes Yes	Completed Completed
5. In-office wait times exceed 15 minutes	Educate providers on in-office wait times	Submit SCFHP's access matrix via fax blast to network providers.	Yes	Completed

Intervention Progress Report

Santa Clara Family Health Plan

Table I: PAMF

A. PAAS

Interventions 1 and 2

Standard	# Resurveyed	# Responded	# Compliant	% Compliant
PCP Urgent	97	73	41	56%
Non-Urgent	97	84	75	89%
SPC Urgent	45	31	10	32%
Non-Urgent	45	32	14	44%
Psych Urgent	2	1	0	0%
Non-Urgent	2	1	1	50%
NPMH Urgent	4	2	1	50%
Non-Urgent	4	2	1	50%

B. Training Attestation Record

# Required	PCP	SPC	BH	TTL	% Submitted
96	56	35	5	96	100%

Intervention Progress Report

Santa Clara Family Health Plan

C. After Hours Survey

Interventions 1, 2, 4

Standard	# Surveyed	# Responded	# Compliant	% Compliant
PCP 911	181	169	102	67%
30-min	181	169	67	40%
BH 911	6	6	1	17%
30-min	6	6	1	17%

D. Training Attestation Record

# Required	PCP	BH	TTL	% Submitted
84	79	5	84	100%

Intervention Progress Report

Santa Clara Family Health Plan

E. Third Next Available Appointment Interventions 1, 2, 5

Standard	# Surveyed	# Responded	# Compliant	% Compliant
PCP Urgent	10	10	8	80%
Return Call T/S	10	10	8	80%
Return Call Non-Med	10	10	8	80%
OBGYN 1st Prenatal	10	10	8	80%
SPC Call Pick Up	10	10	9	90%
Return Call T/S	10	10	9	90%

F. Training Attestation Record

# Required	PCP	OBGYN	BH	TTL	% Submitted
5	2	2	1	5	100%

Intervention Progress Report

Santa Clara Family Health Plan

Table II: PMG

A. PAAS

Interventions 1 and 2

Standard	# Resurveyed	# Responded	# Compliant	% Compliant
PCP Urgent	15	9	8	89%
Non-Urgent	15	9	8	89%
SPC Urgent	12	11	6	55%
Non-Urgent	12	12	11	92%
Psych Urgent	1	0	0	0%
Non-Urgent	2	1	1	50%

B. Training Attestation Record

# Required	PCP	SPC	BH	TTL	% Submitted
14	7	6	1	14	100%

Intervention Progress Report

Santa Clara Family Health Plan

Table II: PMG

C. After Hours Survey

Interventions 1, 2, 4

Standard	# Surveyed	# Responded	# Compliant	% Compliant
PCP 911	42	38	31	82%
30-min	42	38	35	92%
BH 911	1	1	1	100%
30-min	1	1	0	0%

D. Training Attestation Record

# Required	PCP	BH	TTL	% Submitted
12	11	1	12	100%

Intervention Progress Report

Santa Clara Family Health Plan

Table II: PMG

E. Third Next Available Appointment

Interventions 1, 2, 5

Standard	# Surveyed	# Responded	# Compliant	% Compliant
SPC Return Call T/S	10	10	9	90%

F. Training Attestation Record

# Required	SPC	TTL	% Submitted
# Attestations	1	1	100%

Intervention Progress Report

Santa Clara Family Health Plan

Table III: Premier Care

A. PAAS

Interventions 1 and 2

Standard	# Resurveyed	# Responded	# Compliant	% Compliant
PCP Urgent	9	1	0	0%
Non-Urgent	9	1	1	100%
SPC Urgent	16	11	9	82%
Non-Urgent	16	11	10	91%
Psych 6hrs	1	1	0	0%

B. Training Attestation Record

# Required	PCP	SPC	BH	TTL	% Submitted
15	9	5	1	15	100%

Intervention Progress Report

Santa Clara Family Health Plan

Table III: Premier Care

C. After Hours Survey

Interventions 1, 2, 4

Standard	# Surveyed	# Responded	# Compliant	% Compliant
PCP 911	42	38	31	82%
30-min	42	38	35	92%
BH 911	1	1	1	100%
30-min	1	1	0	0%

D. Training Attestation Record

# Required	PCP	BH	TTL	% Submitted
12	11	1	12	100%

Intervention Progress Report

Santa Clara Family Health Plan

Table III: Premier Care

E. Third Next Available Appointment

Interventions 1, 2, 5

Standard	# Surveyed	# Responded	# Compliant	% Compliant
SPC Return Call T/S	10	10	9	90%

F. Training Attestation Record

# Required	SPC	TTL	% Submitted
1	1	1	100%

Intervention Progress Report

Santa Clara Family Health Plan

Table IV: Direct

A. PAAS

Interventions 1, 2

Standard	# Resurveyed	# Responded	# Compliant	% Compliant
PCP Urgent	1	0	0	0%
Non-Urgent	1	0	0	0%
SPC Urgent	13	8	2	25%
Non-Urgent	13	8	0	0%
NPMH Urgent	3	1	0	0%
Non-Urgent	3	1	0	0%

B. Training Attestation Record

# Required	PCP	SPC	BH	TTL	% Submitted
15	1	11	3	3	20%

Intervention Progress Report

Santa Clara Family Health Plan

Table V.

A. BH Network Development

Intervention 3

Provider Type	Provider/Group	Status	Effective
ABA	Autism Interventionists	In process	Pending
Therapy	ACT for Mental Health	Contracted	12/1/2019
ABA	AGES Learning Solutions	In process	Pending
ABA	Behavior Treatment Analysis (BTA)	In process	Pending
ABA	CARD (Center for Autism Related Disorders)	In process	Pending
ABA	Roman Empire	In process	Pending
ABA	Maxim Healthcare Services	In process	Pending
Therapy	Diva Diversity	In process	Pending
ABA	JUVO BH	Contracted	6/1/2020

B. Fax Blast-SCFHP's Access Matrix

Intervention 4 and 5

Provider Types	Date Completed
Medical and BH Providers	May and December 2019

Intervention Progress Report

Santa Clara Family Health Plan™

Population Health Management

PHM Strategy 2020

Presentation to QIC June 11, 2020

PHM Strategy

- Basic framework for a cohesive plan of action to address member needs across the continuum of care
- Designed to address the four NCQA focus areas of population health:
  - Keeping members healthy
  - Managing members with emerging risk
  - Patient safety or outcomes across settings
  - Managing multiple chronic illnesses
- Incorporates Cal MediConnect (CMC) and/or Medi-Cal DHCS and Department of Managed Health Care (DMHC) required methods
- Segments the member population into subset targeted populations into tiers, based off the needs identified in the Population Assessment
- Specific programs and services to address the four focus areas.

Changes in Strategy from 2019

Added Medi-Cal line of business in anticipation of NCQA accreditation

Eligibility Criteria for Tiers

- Added dementia diagnosis under Tier 1 Complex Case Management
- Added homeless status:
  - Tier 2 Chronic Conditions Management Uncontrolled
  - Tier 3 Chronic Conditions Controlled
- Updated and clarified data sources for all criteria

Goals

- Clarified goal under Keeping Members Healthy for annual wellness visits
- Defined diabetes chronic condition for Managing Members With Emerging Risk
- Narrowed population targeted for Managing Multiple Chronic Illnesses & ED visits to safety net hospitals

Other Changes

- Programs and Service Table: modified to display relationship to goals and tiers
- Case Management Activities and Programs
  - Added Health Information Form/Member Evaluation Tool (HIF/MET) and LTSS Assessment
  - Removed Multipurpose Senior Services Program (MSSP) description
- Indirect Interventions
  - Added Aunt Bertha platform
  - Combined Population Health Delivery system Supports section with Indirect Interventions to remove redundancy
- Added Activities and Resources Table

Santa Clara Family Health Plan

Questions?

Santa Clara Family Health Plan™

Assessment of CMC Members Understanding of Marketing Information

Presented by Theresa Zhang, Manager, Communications

Assessment of Member Understanding of Policies & Procedures: Call Code Analysis

Date Analysis Conducted: 4/14/20

By: Theresa Zhang, Manager, Communications, and Chelsea Byom, Director, Marketing & Communications

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Process:

A call report was generated from the internal call reporting system for calls received between January 1, 2019 and July 1, 2019.The report contains the following fields:

Call_Date1
Create_User_ID1
Caller_ID
Type_Issue1
Relvnt Issue Tag
Within 90 day tag
LOB
Member_Full_Name
Member_HPID
Eff Date
dob
Provider_Name
Provider_ID
Status
ClosedDate
TAT
Resolution
Resolnotes
CallNotes
Assigned_To

The records in the call report were filtered by specific call codes reported under the [Type_Issue1] field to focus theassessment. The following list contains the types of issues and their descriptions:

Type_Issue1	Description
Administrative	Materials Request
Administrative	Positive Feedback
Administrative	PQI
Inquiry Auth	INQ Auth Member Call Pharmacy
Inquiry Auth	INQ Auth Provider Call Pharmacy
Inquiry Auth	INQ Auth Provider Call Medical
Inquiry Benefit	INQ Benefit Behavioral Health Therapy (BHT)
Inquiry Benefit	INQ Benefit Case Management Support
Inquiry Benefit	INQ Benefit Continuity of Care

Type_Issue1	Description
Inquiry Benefit	INQ Benefit Dental Service
Inquiry Benefit	INQ Benefit DME, Enteral and Parenteral Service
Inquiry Benefit	INQ Benefit Mental Health Service
Inquiry Benefit	INQ Benefit MLTSS Support: CBAS, IHSS, LTC, MSSP
Inquiry Benefit	INQ Benefit Other (need to specify)
Inquiry Benefit	INQ Benefit Pharmacy
Inquiry Benefit	INQ Benefit Reimbursement
Inquiry Benefit	INQ Benefit Specialist
Inquiry Benefit	INQ Benefit Vision Service
Inquiry Billing	INQ Billing Statement
Inquiry Claim	INQ Adminstrative Error
Inquiry Claim	INQ Claim Status
Inquiry General	INQ General Assistance with obtaining appointment
Inquiry General	INQ General HK Renewal Question
Inquiry General	INQ General HRA
Inquiry General	INQ General Medi-Care/CMC Inquiry
Inquiry General	INQ General Provider/Network Information Inquiry
Quality of Serv	GRV Adminstrative Issues
Quality of Serv	GRV ID Card
Quality of Serv	GRV Transportation Services (NEMT)
Quality of Serv	GRV Transportation Services (NMT)
Referral Grv	GRV Prior Auth/Appeal Process
Transportation	Member Communications Notice

Next, the report was narrowed to include members that called within 90 days of their enrollment date with the Santa Clara Family Health Plan Cal MediConnect plan.

Member health plan IDs (HPID) were included in the call report. HPID was used to source the member's enrollment date from the internal enrollment data tables. The member's enrollment date was measured against the call date to identify if the member called within 90 days of his or her enrollment. The following pivot table outlines the volume of calls members made by the type of issue (call code) within 90 days of member's enrollment.

Row Labels	Count of Member_HPID	Count of Member_HPID2
Administrative-Materials Request	250	14.16%
Administrative-Positive Feedback	2	0.11%
Administrative-PQI	20	1.13%
Inquiry Auth-INQ Auth Member Call Pharmacy	30	1.70%
Inquiry Auth-INQ Auth Provider Call Medical	10	0.57%
Inquiry Auth-INQ Auth Provider Call Pharmacy	1	0.06%
Inquiry Benefit-INQ Benefit Behavioral Health Therapy (BHT)	3	0.17%
Inquiry Benefit-INQ Benefit Case Management Support	131	7.42%
Inquiry Benefit-INQ Benefit Continuity of Care	4	0.23%
Inquiry Benefit-INQ Benefit Dental Service	62	3.51%
Inquiry Benefit-INQ Benefit DME, Enteral and Parenteral Service	53	3.00%
Inquiry Benefit-INQ Benefit Mental Health Service	13	0.74%
Inquiry Benefit-INQ Benefit MLTSS Support: CBAS, IHSS, LTC, MSSP	27	1.53%
Inquiry Benefit-INQ Benefit Other (need to specify)	222	12.57%
Inquiry Benefit-INQ Benefit Pharmacy	228	12.91%
Inquiry Benefit-INQ Benefit Reimbursement	8	0.45%
Inquiry Benefit-INQ Benefit Specialist	51	2.89%
Inquiry Benefit-INQ Benefit Vision Service	83	4.70%
Inquiry Billing-INQ Billing Statement	38	2.15%
Inquiry Claim-INQ Administrative Error	3	0.17%
Inquiry Claim-INQ Claim Status	55	3.11%
Inquiry General-INQ General Assistance with obtaining appointment	37	2.10%
Inquiry General-INQ General HK Renewal Question	1	0.06%
Inquiry General-INQ General HRA	90	5.10%
Inquiry General-INQ General Medi-Care/CMC Inquiry	113	6.40%
Inquiry General-INQ General Provider/Network Information Inquiry	183	10.36%
Quality of Serv-GRV-Administrative Issues	4	0.23%
Quality of Serv-GRV-ID Card	8	0.45%
Quality of Serv-GRV-Transportation Services (NEMT)	2	0.11%
Quality of Serv-GRV-Transportation Services (NMT)	9	0.51%
Referral Grv-GRV-Prior Auth/Appeal Process	8	0.45%
Transportation-Member Communications Notice	17	0.96%
Grand Total	**1766**	**100.00%**

Individual call records were grouped and assessed by issue type and description. The top four highest occurrence call types in individual call records were:

1. Materials Request	14.16%
2. INQ Benefit Pharmacy	12.91%
3. Other (need to specify)	12.57%
4. General Provider/Network Information Inquiry	10.36%

A sample of call notes were reviewed within these categories to identify noticeable trends and opportunities for improvement. Themes identified in the call notes are summarized in the table below.

Themes Identified in Top Call Types:

Materials Request	Mail AOR (Appointment of Representative) form
Pharmacy Benefit Inquiry	Trouble getting prescription drugs
	Status of coverage determination

Other (need to specify)	Inquiry on prescription refill
	Inquiry on transportation benefit
General Provider/Network Information Inquiry	Confirming provider
	Inquiring for case management

Conclusion:

Upon detailed review of the call notes, the Appointment of Representative process has been identified as an actionable opportunity for improvement. Member education via a mass communication vehicle would be an effective way to improve new member understanding of the form's purpose, how to find the form, and how to submit it to the Plan. Possible interventions include:

- Publishing an educational member newsletter article.
- Include instructions on appointing a representative in the new member orientation under development.
- Allowing members to access and submit the AOR form via the member portal.

Santa Clara Family Health Plan™

Valley Health Plan – MY2019
Provider Satisfaction Survey

Prepared by: Carmen Switzer, Provider Network Access Manager

Introduction

The survey tool for MY2019 was revised with new and different survey questions for MY2019 to fulfill the requirement from Department of Managed Health Care (DMHC).

The authorization/referral process was the only measure with two years of comparative data.

Standards and Thresholds

- Eighty percent (80%) of practitioners will be satisfied.
- Seventy percent (70%) of primary care physicians (PCP) will be satisfied with the authorization/referral process.

Provider Satisfaction Survey

Santa Clara Family Health Plan

Table I: Response Rates

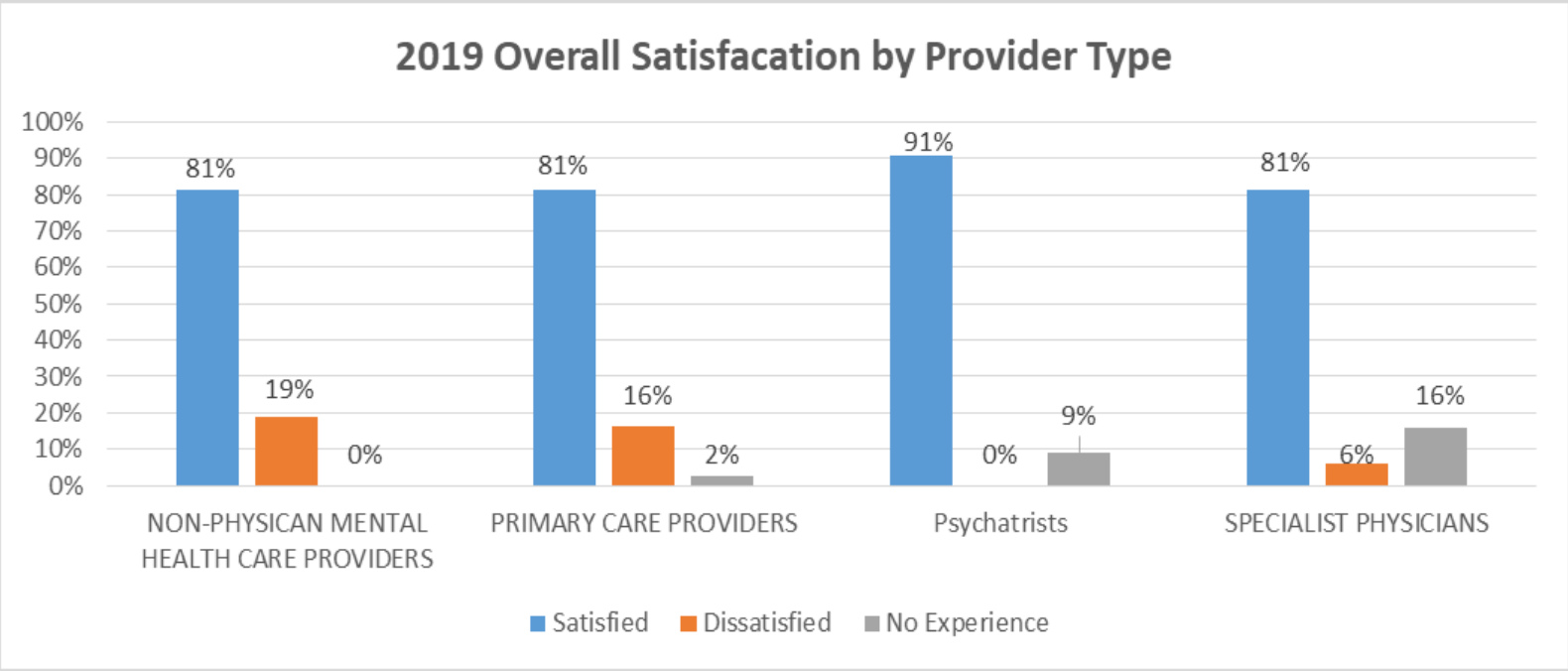
Measurement Year	Completed Surveys	Ineligible	Non-respondents	Response Rate
2019 (2,595)	260	385	1,950	12%
2018 (1,457)	253	237	967	20%

- Table shows comparison in respondents for two (2) consecutive years.
- While respondents show an increase by 8 percentage points in 2019, the provider sample increased by 56%.

Provider Satisfaction Survey

Santa Clara Family Health Plan

Table II: Overall Satisfaction by Provider Type



- Psychiatrists experienced the highest rate of satisfaction exceeding the goal by 21 percentage points at 91%.
- The NPMH, PCP and SPECS resulted in the same rate of satisfaction and exceeded the goal by 11 percentage points at 81%.

Provider Satisfaction Survey

Table IV. Results by Department (MY2018 and MY2019)

Rate Scores by Departments	MY 2019 260 Total Respondents (all Provider Types)			MY 2018			Change
	Satisfied	Dissatisfied	No Experience	Satisfied	Dissatisfied	No Experience	↓↑
Referral/Authorization Process							
Referral Process	82%	10%	8%	82%	NA	NA	--
Timeliness of Referrals	76%	15%	8%	Baseline			N/A
Access to Care							
Access to Urgent Care Services	64%	4%	31%	Baseline			N/A
Access to Non-Urgent Primary Care	64%	7%	29%	Baseline			N/A
Access to Non-Urgent Specialty Services	67%	14%	19%	Baseline			N/A
Access to Non-Urgent Ancillary Services	50%	10%	40%	Baseline			N/A
Access to Non-Urgent Behavioral Care	44%	12%	44%	Baseline			N/A
Access to Timely Appointment Scheduling	72%	10%	18%	Baseline			N/A
Access to Continuity of Care	76%	8%	15%	Baseline			N/A
Language Assistance Program							
Coordination of Appointments with an Interpreter	26%	7%	67%	Baseline			N/A
Availability of Interpreters	26%	7%	67%	Baseline			N/A
Training of Interpreters	22%	6%	72%	Baseline			N/A

Opportunities for Improvement

Santa Clara Family Health Plan

Table V. Interventions

Description of Intervention for My2020	Barrier Addressed	Time Frame	Expected Outcome
Dedicated staff focused on Developing, implementing, and monitoring improvement plan.	Low response rate to Provider Satisfaction Survey	12 months	Improve response rate by 10%
Gather information related to provider dissatisfaction regarding patients' access to care, then develop and implement work plans	Low response rate to Provider Satisfaction Survey	12 months	Improve response rate by 10%
Develop strategy aimed at Language Assistance Program to determine more targeted approach	Overall Low Satisfaction with LAP	12 months	Improve satisfaction with LAP by 10%
Provider Relations Department to utilize proactive outreach between surveys to address Physician concerns.	Low response rate to Provider Satisfaction Survey	12 months	Improve response rate by 5%
Investigate incentives for surveys	Low response rate to Provider Satisfaction Survey	12 months	Improve response rate by 5%

- The interventions outlined above will be the focus for MY2019.

Conclusion

- VHP met and exceeded the goals for Physician Overall Satisfaction and for Authorization/Referral Process.

- The survey results reveal some opportunities for improvement. VHP will collaborate with VHP's operational departments (e.g., Quality, Utilization Management, Member Services, etc.) to improve provider's satisfaction.

- VHP values its providers and wants to create a positive, collegial working relationship with them.

Santa Clara Family Health Plan™

Review of Quality Improvement Policies

QI.13 Comprehensive Case Management

QI.15 Transitions of Care

QI.17 Behavioral Health Care Coodination

QI.18 Sensitive Services, Confidentiality, Rights of Adults and Minors

QI.19 Care Coordination Staff Training

QI.20 Information Sharing and San Andreas Regional Center (SARC)

QI.21 Information Exchange Between SCFHP & Health Services Dept.

QI.22 Early Start Program (Early Intervention Services)

QI.23 Alcohol Misuse: Screening and Behaviroal Counseling Interventions in Primary Care

QI.24 Outpatient Mental Health Services: Mental Health Parity

QI.25 Intensive Outpatient Palliative Care

QI.27 Informing Members of Behavioral Health Services

POLICY

Policy Title:	**Comprehensive Case Management**	**Policy No.:**	QI.13
Replaces Policy Title (if applicable):	Case Management	**Replaces Policy No. (if applicable):**	CM030_05
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

To promote access to appropriate, coordinated services with the intent that members with case management needs may achieve optimal health and functionality.

II. Policy

A. The comprehensive case management program is established to provide case management processes and procedures that helps members with multiple or complex conditions to obtain access to care and services, and the coordination of appropriate care and resources. The structure of comprehensive case management is organized to promote quality case management, client satisfaction and cost efficiency through the use of collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

B. To define the fundamental components of SCFHP case management services which when appropriate for any given member, include:
   1. Initial assessment of members' health status, including condition specific issues
   2. Documentation of clinical history, including medications
   3. Initial assessment of the activities of daily living;
   4. Initial assessment of behavioral health status, including cognitive functions
   5. Initial assessment of social determinants of health
   6. Initial assessment of life-planning activities
   7. Evaluation of cultural and linguistic needs, preferences or limitations
   8. Evaluation of visual and hearing need, preferences or limitations
   9. Evaluation of caregiver resources and involvement
   10. Evaluation of available benefits
   11. Evaluation of community resources

C. Referrals to SCFHP's case management team are accepted from members or their caregivers, practitioner's or other external providers, hospital discharge planners, SCFHP internal staff (including customer service and utilization management) and/or community partners. All referrals will initially be assessed by case management staff for the appropriate level of case management support needed to coordinate care and services for medical, behavioral health and other non-medical risk factors. Successful completion of an initial assessment will determine member's placement in the most appropriate Population Health case management tier for ongoing support.

D. A Case Management referral form is available on SCFHP's public website and all completed forms and supporting documentation may be submitted directly to the Case Management department by USPS mail delivery or by secure email to: CaseManagementHelpDesk@scfhp.com. Case Management referrals may also be requested verbally thru telephonic interaction by calling SCFHP's Customer Service department at 1-877-

723-4795 (Medicare members) of 1-800-260-2055 (Medi-Cal members) and requesting case management support. All Case Management referrals will receive an initial review within 72 business hours of receipt.

E. SCFHP's 2018 Complex Case Management program description defines the process of how SCFHP coordinates services for the highest risk members with complex conditions and helps them access needed resources thru intensive and comprehensive interactions.

III. Responsibilities

A. Health Services collaborates with other SCFHP departments (IT, claims, benefits, provider services) as well as providers and community services to identify, coordinate services, coordinate benefits and provide members with complex case management.

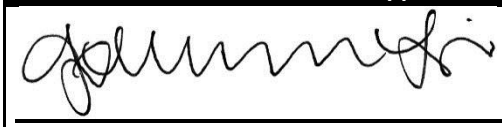
IV. References

3 Way Contract. (2017). Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services.

Cal MediConnect Continuity of Care Technical Assistance Guide (TAG). (2015, October 27). California, USA. NCQA Health Plan Accreditation Guidelines 2018 - Population Health (PHM) Element 5

DPL 17-001 and DPL 17-002

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, DO
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title 08/14/19	Title 08/14/19
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 08/05/16; Reviewed 08/09/17; Reviewed 06/06/18; Reviewed 06/12/19	Quality Improvement	Approve 08/19/17; 06/06/18; 06/12/19	
V2	Revised 7/22/19	Quality Improvement	8/14/19	
V2	Review	Quality improvement		

POLICY

Policy Title:	**Transitions of Care**	**Policy No.:**	QI.15
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		☒ CMC

I. Purpose

To define the process the Plan adopts to monitor and take action to improve continuity and coordination of care across the health care network, including medical care settings, medical with behavioral health care settings, and for transitioning members between levels of care.

II. Policy

A. The Plan supports and promotes appropriate transitions between care settings which is critical to improving member quality of care and health outcomes. The Plan's Care Transitions Program goal is to improve transitions between settings to the most appropriate and safe level of care for that member. Objectives include:
   1. Curtail medical errors
   2. Identify issues for early intervention
   3. Minimize unnecessary hospitalizations and readmissions
   4. Support member preferences and choices
   5. Reduce duplication of processes and efforts to more effectively utilize resources
   6. Promote the exchange of information
   7. Support appropriate use of medications
   8. Meet special needs of members with behavioral disorders commonly seen in primary care

B. The Plan implements processes that arrange for/ authorize and coordinate services and care needed for members after inpatient discharge, nursing facility residents or at other levels of care into the community or to the least restrictive setting possible. This includes ensuring access to necessary medical/behavioral health care, medications, durable medical equipment, supplies, transportation, and integration of Long Term Support Services (LTSS) benefits and community based resources.

C. The Plan uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system
   1. Between medical care settings
   2. Between medical and behavioral health care settings

Process is detailed in the associated Procedure document Transitions of Care.

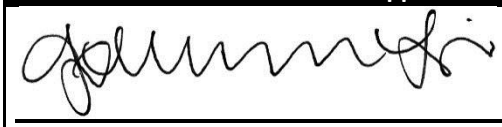
III. Responsibilities

A. Health Services works with internal departments, providers and community resources for referrals and to transition members to appropriate levels of care.

IV. References

WIC section 14182.17(d)(4)(H).
NCQA, 2016
87890 2016 SCFHP Model of Care
DHCS/Plan Renewed Contract 2013
DHCS/CMS/Plan 3-Way Contract

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, DO
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title 06/12/19	Title 06/12/19
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 08/05/16 Reviewed 08/09/17; Reviewed 06/06/18; Reviewed 06/12/19; Review 06/10/20	Quality Improvement	Approve: 08/09/17; 06/06/18; 06/12/19	

POLICY

Policy Title:	**Behavioral Health Care Coordination**	**Policy No.:**	QI.17
Replaces Policy Title (if applicable):	**Cal MediConnect Behavioral Health Coordination Of Care Policy and Procedure**	**Replaces Policy No. (if applicable):**	**CM106_1**
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

Santa Clara Family Health Plan (SCFHP) promotes and coordinates seamless access and availability to appropriate behavioral health providers, community services and support for members identified with behavioral/mental health and substance use needs so that member may achieve optimal health and functionality.

II. Policy

A. To complement the Comprehensive Case Management policy, SCFHP optimizes access to services for members by coordinating care and facilitating referrals to Behavioral Health (Mental Health and Substance Use Disorders) services for Medi-Cal and Cal MediConnect (CMC) members. This includes emergent, non-emergent, in-patient or outpatient referrals. Referrals may encompass community services, a community triage service, a community crisis line, contracted plan providers.

B. SCFHP promotes continuity and coordination of care between behavioral healthcare providers and medical providers. Information is gathered regarding exchange of information, appropriate diagnoses, treatment, referrals, medications and follow-up. Successful collaboration is monitored and improvement plans implemented as appropriate.

C. SCFHP defines processes for the provision of Early, Periodic Screening, Diagnostic and Treatment (EPSDT) services for members 0 to 21 years of age which includes medically necessary Behavioral Health Treatment (BHT) services with or without an Autism diagnosis and other evidence based behavioral intervention services that develop or restore functioning. SCFHP provides BHT for members who are under 21, have a recommendation from a licensed physician, surgeon or psychologist that evidence-based BHT services are medically necessary and that the member is medically stable without the need for 24 hour medical nursing monitoring. SCFHP requires Primary Care Physicians (PCP) to administer the Department of Health Services approved assessment tool as detailed in the procedure.

D. To define how SCFHP provides guidelines to PCPs regarding management and treatment for members with Behavioral Health conditions as outlined in the procedure Mental Health Services Provided by PCPs.

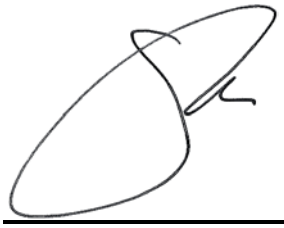
III. Responsibilities

Behavioral Health Services collaborates with other Health Services areas to coordinate care, and with QI to monitor coordination of care, for under/over utilization.

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.*
NCQA Guidelines 2016
WIC Sections 14182.17(d)(4) and 14186(b)
28 CCR 1300.74.72(g)(3) through (5)
DHCS All Plan Letter 18-006, Responsibilities For Behavioral Health Treatment Coverage For Members Under The Age Of 21, 03/02/2018

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Jeff Robertson, MD	Signature Laurie Nakahira, MD
Name Medical Director	Name Chief Medical Officer
Title 6/12/19	Title 6/12/19
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; Review 06/10/20	QIC	Approve;	

POLICY

Policy Title:	**Sensitive Services, Confidentiality, Rights of Adults and Minors**	**Policy No.:**	QI.18
Replaces Policy Title (if applicable):	Sensitive Services, Confidentiality, Rights of Adults and Minors	**Replaces Policy No. (if applicable):**	CM036_04
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

To promote timely access to sensitive, confidential medical services for adult and minor children when needed and/or requested.

II. Policy

A. Santa Clara Family Health Plan (SCFHP) allows minor children and adult members to have access to sensitive, confidential medical services without the need for prior authorization.
   1. The following services are considered confidential and sensitive services for adult and minor children aged 12 and older without parental consent:
      a. Sexually transmitted diseases
      b. Family planning
      c. Sexual assault
      d. Pregnancy testing
      e. HIV testing and counseling
      f. Abortion
      g. Drug and alcohol abuse
      h. Outpatient mental health care

B. Requirements for consent, confidentiality and rights for these sensitive services are defined in the associated procedure CM.06.01.

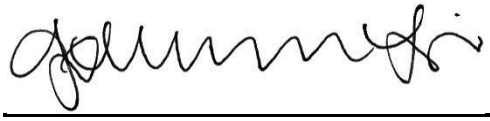
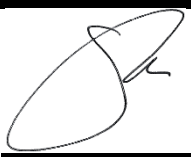
III. Responsibilities

A. Health Services works with IT, Provider and Customer Services, providers and community services to provide sensitive and confidential services to members without requiring prior authorization.

IV. References

Fed. Law 1987 OBRA, Sec. 4113 (c)(1)(B), 1905 (a)(4)(c); BBA
DHS Contract A-12, Exhibit A, Attachments 5, et. seq, 9, Items 1, 3, 8, 2. C
MMCD Pol. Letter #s: 94-13, 96-09, 97-08, 98-11
T22, CCR, 50063.5, 51009, 50063.5; Family Code §6925 et. seq., W & I Code §14132. et seq., 14451 et. seq. ; T28, CCR

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, D.O.
Name Director of Quality and Process Improvement	Name Chief Medical Officer
Title 06/12/2019	Title 06/12/2019
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original 08/05/16 Reviewed 08/09/17 Reviewed 06/12/19; Review 06/10/20	Quality Improvement	Approve: 08/09/17; 06/06/18; 06/12/19	

POLICY

Policy Title:	**Care Coordination Staff Training**	**Policy No.:**	QI.19
Replaces Policy Title (if applicable):	Long Term Support Services and Social Services Training	**Replaces Policy No. (if applicable):**	112_01
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

To provide staff the skills to meet member needs related to care coordination principals.

II. Policy

A. Care Coordination Staff training includes but is not limited to the following:
   1. Overview of regulatory / contractual requirements including ICP and ICT training
   2. Accessibility and accommodations; independent living
   3. Wellness principles
   4. Criteria for safe transitions, transition planning, care plans after transitioning
   5. Along with other required training as specified by DHCS—both initially and on an annual basis
   6. Dementia care management for specially designated care coordination
   7. LTSS operations including:
      a. LTSS benefits
      b. Eligibility and Service Authorization process
      c. Program limitations
      d. Referrals
      e. Interface with Case Management
      f. Overview of characteristics and needs of LTSS target population
   8. Self-direction
   9. Behavioral Health coordination
   10. Community Services
   11. Model of Care
   12. Cultural and Linguistic Services
   13. Care Plan Options
   14. Person centered planning process
   15. Home and Community Based Services

B. Training content is reviewed and updated as needed in regards to state and federal regulations as well as other best practices. Staff training is completed upon hire, reviewed annually and additional reviewed as needed.

III. Responsibilities

A. Health Services management works with internal departments, external partners and providers to provider staff training.

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.
Cal MediConnect Prime Contract (§2.9.10.10.)
H7890 2016 SCFHP Model of Care

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, DO
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title 06/12/19	Title 06/12/19
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 08/05/16; Reviewed 06/06/18; Reviewed 06/12/19; Review 06/10/20	Quality Improvement	Approve: 08/09/19; 06/06/18; 06/12/19	

POLICY

Policy Title:	**Information Sharing with San Andreas Regional Center (SARC): MOU**	**Policy No.:**	QI.20
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☐ CMC

I. Purpose

This policy supports the agreement between San Andreas Regional Center (SARC) and the Santa Clara Family Health Plan (SCFHP) to perform care coordination and information exchange activities when Medi-Cal beneficiaries are accessing medically necessary Behavioral Health Treatment Services (BHT) without regard to diagnosis. The agreement addresses both new referrals for BHT and clients/beneficiaries receiving BHT when funding for this service is transitioning from SARC to SCFHP.

II. Policy

SCFHP is responsible for the provision of BHT as a managed care health benefit, including the coordination of the client's care with SARC and the BHT provider(s). SARC will support SCFHP's care coordination by providing necessary client information to SCFHP and vendors in accordance with any and all privacy laws and regulations.

Santa Clara Family Health Plan

- SCFHP is responsible for coordination of services provided by SCFHP including primary care, and carve out services such as California Children's Services, Specialty Mental Health Services.
- SCFHP and/or its subcontracted providers and vendors shall arrange and pay for comprehensive diagnostic evaluations (CDE's) for members/clients who are suspected of needing BHT services.
- SCFHP and/or its subcontracted providers and vendors shall arrange and pay for BHT services for members who meet criteria as outlined in APL 18-006 or any revised version of these APL's.
- SCFHP shall provide client information to SARC to ensure appropriate care coordination, in compliance with all privacy laws.
- SCFHP and/or its subcontracted providers and vendors shall be available to assist, the SARC in the development of the Individual Program Plan (IPP) or Individualized Family Services Plan (IFSP) as necessary.

San Andreas Regional Center

- SARC shall provide client information, including comprehensive diagnostic evaluation(s), treatment plan(s), utilization data and assessment information to SCFHP upon receipt of appropriate release of information (ROI)
- SARC shall refer clients under age 21 who are diagnosed without regard to diagnosis for evaluation for medically necessary BHT services upon client/member request for BHT services.

- SARC shall provide case management & care coordination services related to SARC's Early Start Program clients to SCFHP for medically necessary BHT services.
- SARC shall provide case management and care coordination to eligible clients and assist those clients in maintaining an ongoing relationship with the SCFHP's assigned primary care provider when medical needs arise.
- SARC will identify a staff person to be the primary liaison to SCFHP. The liaison will meet not less than quarterly to ensure continuous communication and resolve any operational, administrative and policy complications.
- SARC will share information on community resources to SCFHP and/or its sub-contracted providers and vendors.
- SARC shall provide Targeted Case Management (TCM) services to eligible clients and their families to assure timely access to health, developmental, social, educational, and vocational services.

TCM includes, but is not limited to:

a. Coordination of health related services with SCFHP to avoid duplication of services; and
b. Provision of referrals to specialty centers and follow-up with schools, social workers and others involved in the IPP and IFSP

- SARC agrees to provide periodic training to SCFHP's staff as requested by the SCFHP concerning SARC services and requirements
- SARC shall work collaboratively with SCFHP to resolve timely access and coordination of care issues.

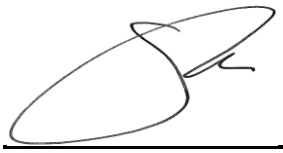
III. Responsibilities

See Memorandum of Understanding between SARC and SCFHP. Policies and Procedures to be attached. Health Services works collaboratively with plan benefits, compliance, QA , IT, plan and community providers to coordinate members' Behavioral Health Treatment services and members' Behavioral Health managed care.

IV. References

Center for Medicare & Medicaid Services approved California State Plan Amendment (SPA) 14-026
Section 1915 C waiver, CA.336 HCBS Waiver for Californians with Developmental Disabilities
DHCS All Plan Letter 18-009 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Regional Centers, 03/02/2018
DHCS All Plan Letter 18-006 Responsibilities For Behavioral Health Treatment Coverage For Members Under The Age Of 21, 03/02/2018

Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Jeff Robertson, MD	Signature Laurie Nakahira, MD
Name Medical Director	Name Chief Medical Officer
Title June 3, 2019	Title June 3, 2019
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v.1	Original 08/05/16; Reviewed 08/09/2017, 6/3/2019; Review 06/10/20	Quality Improvement	Approve 08/05/16; Reviewed 08/09/19; Reviewed 06/12/2019	

POLICY

Policy Title:	**Information Exchange Between Santa Clara Family Health Plan & County of Santa Clara Behavioral Health Services Department**	**Policy No.:**	QI.21
Replaces Policy Title (if applicable):	Information Exchange Between Santa Clara Family Health Plan & County of Santa Clara County	**Replaces Policy No. (if applicable):**	HS 409
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

This policy is to provide detailed instructions for how Santa Clara County Behavioral Health Services Department and Santa Clara Family Health Plan (SCFHP) will perform activities to support the provision of Medi-Cal Specialty Mental Health and/or drug Medi-Cal services as a managed care benefit under the Medi-Connect program. SCFHP and the County of Santa Clara Behavioral Health Services Department (formerly known as Santa Clara County Mental Health Department and Santa Clara County Department of Alcohol and Drugs) entered into a MOU effective January 1, 2014 to specify how roles and responsibilities between the two entities were to be performed.

II. Policy

It is the policy of the SCFHP to provide coordination of care for the purpose of providing services to CMC members which are coordinated with Santa Clara County BHSD, their mental health clinics and contractors. The SCFHP and the CBHSD will follow the medical necessity criteria for Medi-Cal specialty mental health 1915 (b) waiver services described in Title 9, California Code of Regulations. DHCS has developed a matrix of Roles and Responsibilities "Behavioral Health Benefits in the Duals Demonstration" which is attached to the MOU. Medical necessity for Drug Medi-Cal Substance Abuse Services will be as found in Title 22, California Code of Regulations (CCR).

III. Responsibilities

1. Assessment Process

The SCFHP and CBHSD shall develop and agree to written policies and procedures regarding screening and assessment processes that comply with all federal and state requirements. SCFHP completes a Health Risk Assessment (HRA) pursuant to the CMC three way contract guidelines. SCFHP Behavioral Health Department reviews and/or completes the HRA with special attention to the depression Indicators as well as Severe Mental Illness indicators. The HRA, in conjunction with claims and pharmacy Information, is utilized to create a preliminary interdisciplinary care plan (ICP). The ICP is reviewed with

the member and sent to the member's primary care physician and the member's Specialty Mental Health provider for their review and changes.

2. Referrals

The SCFHP and the CBHSD shall develop and agree to written policies and procedures regarding referral processes including:

a. CBHSD will accept referrals from SCFHP staff, providers, and members' self-referral for determination of medical necessity
b. SCFHP will accept referrals from CBHSD for services needed are provided by the SCFHP and not the CBHSD and the member does not meet the Medi-Cal Specialty mental health and/or Drug Medi-Cal medical necessity criteria. This will include mild to moderate levels of care needs which are the responsibility of SCFHP.

3. Information Exchange

a. CBHSD will develop and agree to information sharing policies and procedures. CBHSD Director has provided a memo to County Clinics and Sub-contractors stating that basic information may be shared in order to determine if a member is being seen and who is the provider in the agency.
b. SCFHP will create a list of members who are receiving Medi-Cal specialty mental health services, and/or Drug Medi-Cal services.
c. A signed mental health release of information is obtained from the member in order to 1. Share information with behavioral health services agencies; 2. Provide care coordination and 3. Complete and updated ICP and an interdisciplinary care team (ICT) meeting as needed.
d. The information sharing policies and procedures developed by the CBHSD and SCFHP will include milestones agreed upon for shared roles and responsibilities for sharing personal health information. Meetings with County BHSD providers and their contractors will be held to provide training to discuss the policies and procedures which have been agreed upon for sharing of personal health information.

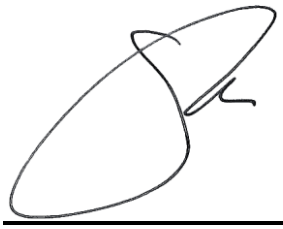
4. Care Coordination

a. The SCFHP and CBHSD will develop and agree to policies and procedures for coordinating Medical and behavioral health care for members enrolled in SCFHP and receiving Medi-Cal specialty mental health or Drug Medi-Cal services.
b. The policies and procedures will include:
    - An identified point of contact from both CBHD and SCFHP who will initiate and maintain ongoing care coordination
    - CBHSD and their contractors will participate in ICT's for members receiving County services and identified as needing an ICT.
    - At the County's request, the SCFHP will assist the CBHSD in developing behavioral health care plans
    - SCFHP will have a process for reviewing and updating the care plans as clinically indicated and following a hospitalization or significant change such as level of care.
    - SCFHP will have regular quarterly meetings to review the care coordination process
    - SCFHP will coordinate with the County to perform an annual review, analysis & evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.

IV. References

California Code of Regulations, Title 9, Division 4, Chapter 8 commencing with Section 13000
Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 11, Case Management and Coordination of Care, 5. Specialty Mental Health
DHCS Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 10, Scope of Services, 7. Services for All Enrollees, D. Mental Health Services
MMCD Policy Letter 00-01
Title 9, CCR, Chapter 11, Division 1, Section (s) 1810.231; 1810.247; 1810.350; 1810.405; 1810.415; 1820.100; 1820.205; 1820.225; 1830.205; 1830.205 (b) (1); 1830.210; 1850.210 (I); 1850.505
Title 22, CCR, Chapter 3, Article 4, Section (s) 51305; 51311; 51313; 51183
Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (1) and the State of California Alcohol and/or Other Drug Program Certification Standards Welfare and Institutions Code Section 5600.3; and 14016.5

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Jeff Robertson, MD	Signature Laurie Nakahira, MD
Name Medical Director	Name Chief Medical Officer
Title 06/03/19	Title **06/03/19**
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 06/06/2018; Reviewed 6/3/2019	Quality Improvement	Approve 06/06/2018; Reviewed 06/12/2019	

POLICY

Policy Title:	**Early Start Program (Early Intervention Services)**	**Policy No.:**	QI.22
Replaces Policy Title (if applicable):	Early Start Program (Early Intervention Services): Developmental Delay Identification, Referral and Care Coordination	**Replaces Policy No. (if applicable):**	CM.005_03
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☐ CMC

I. Purpose

Santa Clara Family Health Plan (SCFHP) ensures that eligible members receive early screening, counseling and treatment for developmental delay or disabilities.

II. Policy

Santa Clara Family Health Plan (SCFHP) identifies members (aged 0 to 2.9 years) who have, or are at risk of acquiring developmental delays or disabilities and need early intervention services. SCFHP will coordinate the referral of members to the Early Start Program, which is a collaborative effort between the San Andreas Regional center (SARC) and the Santa Clara County Office of Education.

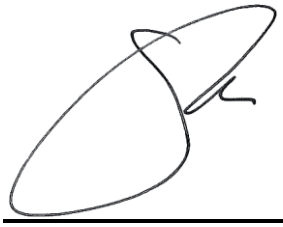
III. Responsibilities

The Health Services Department of the SCFHP is responsible for referring members to Early Start as they are identified by the primary care physicians, case managers and others. The Department is also responsible to notify SCFHOP delegates of their responsibilities to refer to Early Start.

IV. References

DHCS All Plan Letter 18-009 Memorandum of Understanding Requirements for Medi-Cal Managed Health Care Plans and Regional Centers, 03/02/2018

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Jeff Robertson, MD	Signature Laurie Nakahira, MD
Name Medical Director	Name Chief Medical Officer
Title June 3, 2019	Title June 3, 2019
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v.4	Original 06/06/2018; Reviewed 06/02/2019; Review 06/10/20		02/08/2017 Approve 06/06/2018 Approve 06/12/2019 Approve	

POLICY

Policy Title:	**Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care**	**Policy No.:**	QI.23
Replaces Policy Title (if applicable):	Screening, Brief Intervention and Referral for Treatment for Misuse of Alcohol	**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☐ CMC

I. Purpose

Santa Clara Family Health Plan (SCFHP) primary care providers will provide Alcohol Misuse: Screening and Behavioral Counseling (AMSC) Interventions in Primary Care settings for members 18 years of age and older who misuse alcohol.

II. Policy

A. SCFHP's policy is to support the contracted network in providing an expanded alcohol screening for members 18 years of age and older who answer "yes" to the alcohol question in the Individual Health Education Behavioral Assessment (IHEBA).
B. It is the policy of SCFHP to meet the Department of Health Care Services (DHCS) expanded contractual requirements for identification of potential alcohol misuse problems.
C. Providers in SCFHP primary care settings must offer and document AMSC services are offered.
D. The SCFHP will not limit behavioral counseling interventions. Beneficiaries who meet criteria for an alcohol use disorder or whose diagnosis is uncertain, are to be referred for further evaluation to the County Gateway program at 1-800-488-9419.

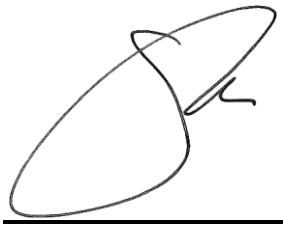
III. Responsibilities

The Quality Improvement Department is responsible for monitoring compliance with the policy and to collaborate with the assistance of the Health Education, Provider Services and Behavioral Health Departments to train/educate providers in the provision of the AMSC.

IV. References

DHCS All Plan Letter 17-016 Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care
Title 42 CFR Requirements with the Mental Health Parity Rule

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Jeff Robertson, MD	Signature Laurie Nakahira, MD
Name Medical Director	Name Chief Medical Officer
Title June 3, 2019	Title June 3, 2019
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v.1	Original 02/21/2018 Reviewed 06/03/2019; Review 06/10/20	Quality Improvement	Approve 02/21/18; Approve 06/03/19;	

POLICY

Policy Title:	**Outpatient Mental Health Services: Mental Health Parity**	**Policy No.:**	QI.24
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

To define the contractual responsibilities of Santa Clara Family Health Plan (SCFHP) for the provision of services to adults and children with mental health disorders resulting in mild to moderate distress in the areas of mental, emotional or behavioral functioning. The responsibilities also include referring to and coordinating with the Santa Clara County Behavioral Health Services Department (CBHSD).

II. Policy

It is the policy of SCFHP to provide access to outpatient mental health services for beneficiaries who do not meet the criteria for Specialty Mental Health Services (SMHS). These mild to moderate services will be provided by licensed mental health professionals, in addition to primary care physicians within their scope of practice. The treatment limitations will not be more restrictive than the treatment limitations applied to medical or surgical benefits to ensure parity in access to mental health services. SCFHP will not restrict access to an initial mental health assessment by requiring a prior authorization. SCFHP will be responsible for the arrangement and payment of an initial mental health assessment performed by a network mental health provider unless there is no in-network provider available who can provide the necessary service.

III. Responsibilities

SCFHP will ensure that authorization determinations are based on medical necessity in a manner which is consistent with current evidence-based clinical practice guidelines.

These policies and procedures will be consistently applied to medical/surgical, mental health and substance use disorders.

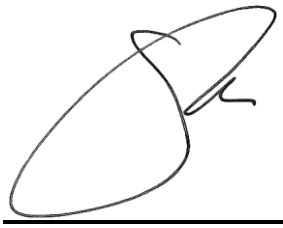
SCFHP will be responsible for outpatient mental health services as follows:

1. Individual and group mental health evaluation and treatment
2. Psychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Outpatient laboratory, drugs, supplies and supplements (excluding carded out medications)
5. Psychiatric consultation

IV. References

DHCS All Plan Letter 17-018 Medi-Cal Managed Care Health Plan Responsibilities For Outpatient Mental Health Services, 10/27/2017
Mental Health Parity Final Rule (CMS-2333-F)
Title42, CFR 438.915 (a) (b)
CA Health and Safety Code 1367.01

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Jeff Robertson, MD	Signature Laurie Nakahira, MD
Name Medical Director	Name Chief Medical Officer
Title June 3, 2019	Title June 3, 2019
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v.1	Original 02/21/2018 Reviewed 06/03/2019; Review 06/10/20	Quality Improvement	02/21/2018 Approve	

POLICY

Policy Title:	**Intensive Outpatient Palliative Care**	**Policy No.:**	QI.25
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		☐ CMC

I. Purpose

To promote access to appropriate and effective symptom management and palliative care in accordance with Final Draft All Plan Letter (APL) 17-015 and Senate Bill (SB) 1004, with the intent that members facing serious illness may achieve optimal quality of life.

II. Policy

A. The Intensive Outpatient Palliative Care (IOPC) program is established to provide processes and procedures that enable SCFHP to improve the health and health care of its members with palliative care needs

B. To define the fundamental components of SCFHP palliative care services, which include: Advance Care Planning; Palliative Care Assessment and Consultation; Plan of Care; Palliative Care Team; Care Coordination; Pain and Symptom Management; and Mental Health and Medical Social Services. The structure of the IOPC program is organized to promote quality palliative care, client satisfaction and cost efficiency through the use of collaborative patient-centered palliative care services, evidence-based guidelines and protocols, and targeted goals and outcomes.

C. SCFHP defines the process of how the plan coordinates palliative care services for members with serious illness and helps them access needed resources and care.

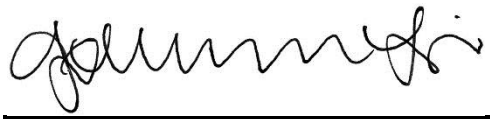
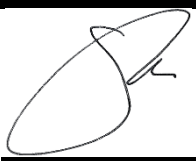
III. Responsibilities

A. Health Services collaborates with other SCFHP departments (IT, Claims, Benefits, Provider Services, and Member Services) as well as contracted IOPC providers and member providers and delegates to identify, coordinate services, coordinate benefits, and provide eligible members with IOPC palliative care services.

IV. References

California Welfare and Institutions Code (WIC) Section 14132.75
Final Draft APL 17-015, October 2017

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, D.O.
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title 6/12/19	Title 6/12/19
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; Review 06/10/20	Quality Improvement	Approve	

POLICY

Policy Title:	**Informing Members of Behavioral Health Services**	**Policy No.:**	QI.27
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

The purpose of this policy is to address how members are informed of their eligibility for services through the Santa Clara Family Health Plan (SCFHP), the Santa Clara County Behavioral Health Services Department and under the Behavioral Health (BH) Department. The information to the members includes:

A. Member eligibility to participate in the BH programs
B. How to use BH program services
C. How to opt in or out of BH program services

II. Policy

It is the policy of the SCFHP, specifically, the BH Department to offer services to those Cal Medi Connect (CMC) members who are diagnosed with a Severe Mental Illness (SMI) and/or Substance Use Disorder (SUD). Services include care coordination to ensure that the members receive the specialty mental health, substance use treatment, physical health and other psycho-social services they need to be able to live in the least restrictive environment possible and to be as healthy as possible. In addition, the BH Department will provide consultation and support to the other departments and the community to assist all those members with a behavioral health diagnosis and/ or substance use disorder to access needed services.

A. Eligible members will be identified through claims, referrals from community providers, and referrals from other departments, from the Health Risk Assessment (HRA) or through self-referral. In addition, through data-sharing agreements and MOUs, the County Behavioral Health Services Department will provide information to the SCFHP BH Department to identify the members who are eligible for Specialty Mental Health Services.
    1. Behavioral Health program services will be initiated through outreach to the member, completion of the HRA and care plan and care coordination to assist the member to meet their own goals.
    2. The BH Social Worker or Personal Care Coordinator (PCC) will explain to the member that the County Behavioral Health Services Department will provide a screening through their Call Center to determine if the member is qualified for Specialty Mental Health.
    3. The member receives information from the BH Social Worker or PCC that if the member is not eligible for Specialty Mental Health services, then the SCFHP will assist with providing services such as counseling and care coordination.
    4. The information regarding BH services is also provided on the SCFHP website www.SCFHP.com

5. Information on how to reach the County Call Center is provided on the member identification card.
6. Members may participate in the BH program as they would any of the SCFHP programs. The member may opt out of any part of the case management program including the HRA and care plan or ICP.

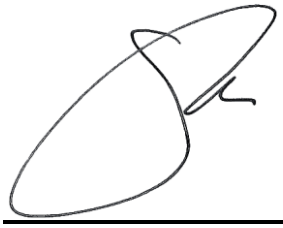
III. Responsibilities

Behavioral Health Services Department has the primary responsibility for carrying out the policy requirements. Case management and the Customer Services Department may be responsible for referring members into BH services.

IV. References

DPL # 14-003 CROSSOVER CLAIMING RESPONSIBILITY FOR MENTAL HEALTH SERVICES PROVIDED TO CAL MEDICONNECT BENEFICIARIES

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Jeff Robertson, MD	Signature Laurie Nakahira, MD
Name Medical Director	Name Chief Medical Officer
Title June 3, 2019	Title June 3, 2019
Date	Date

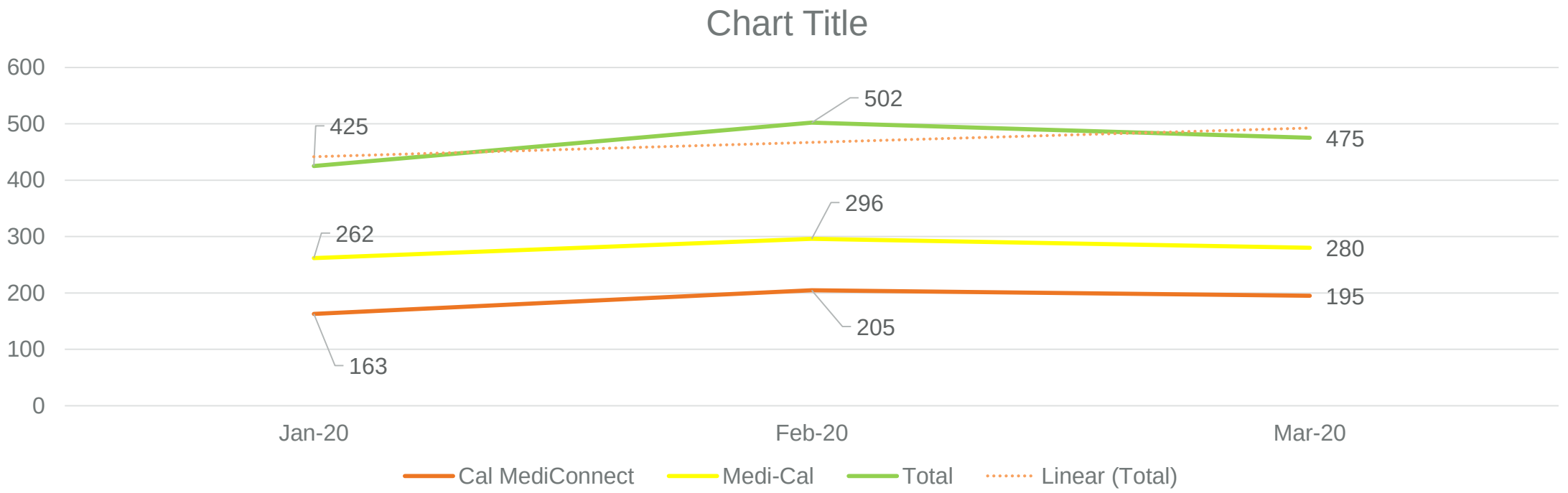
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v.1	Original 11/08/2018 Reviewed 06/03/2019	Quality Improvement	06/03/20196 Approve	

Santa Clara Family Health Plan™

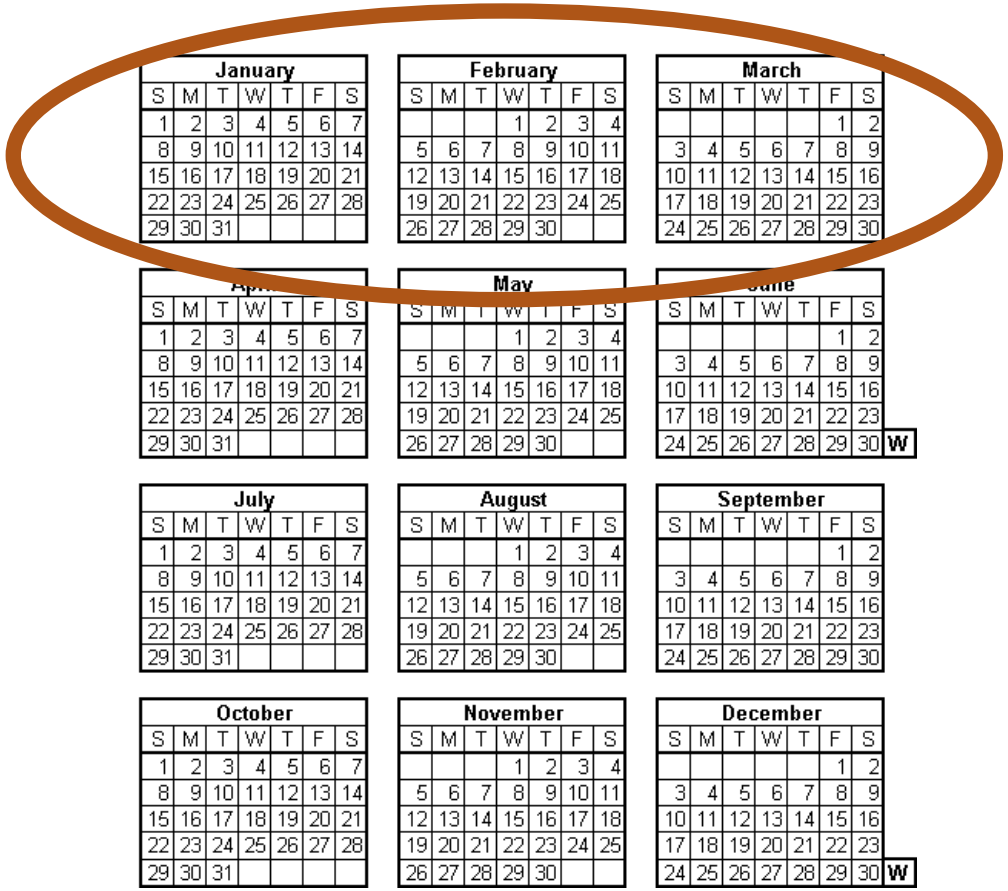
Quality Improvement Committee

Q1 2020 Review

Q1 2020 Total Cases Received



Medi-Cal & Healthy Kids



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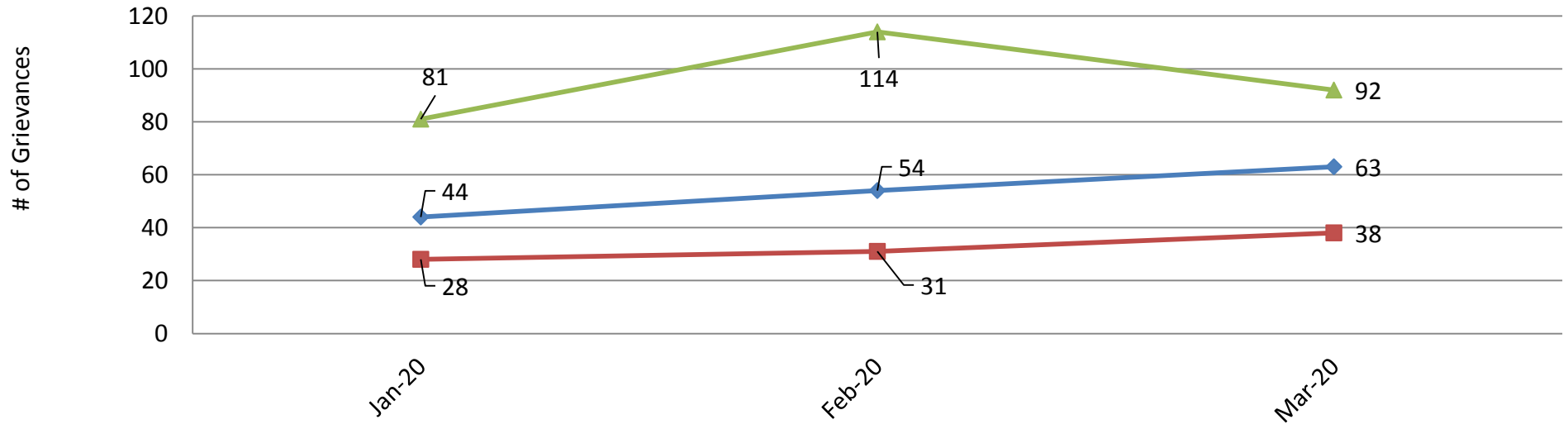
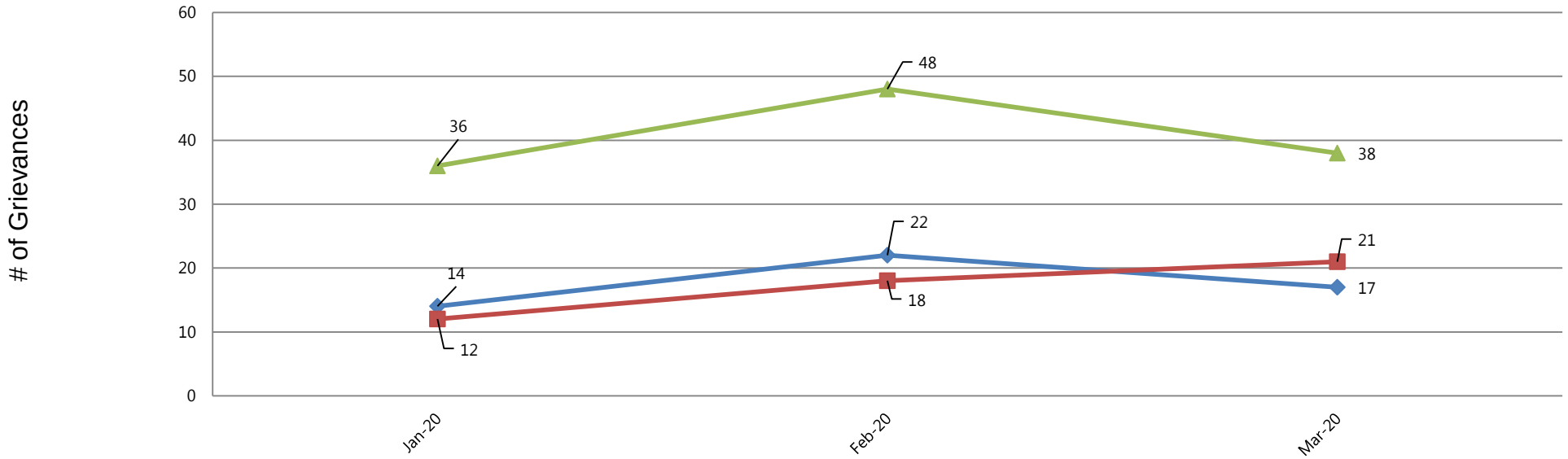
Q1 2020

Q1 2020:Top 3 Medi-Cal Grievance Categories



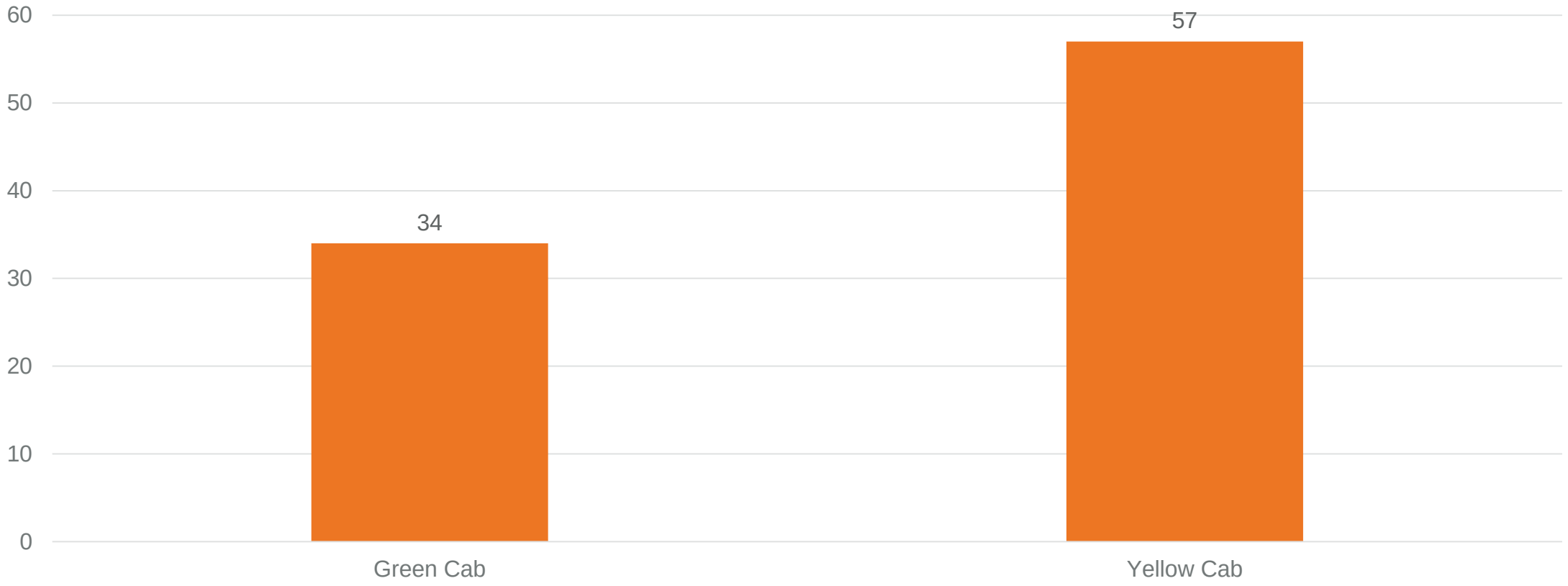
	Jan-20	Feb-20	Mar-20
Access	44	54	63
Quality of Care	28	31	38
Quality of Service	81	114	92

Q1 2020:Top 3 Medi-Cal Grievance Subcategories

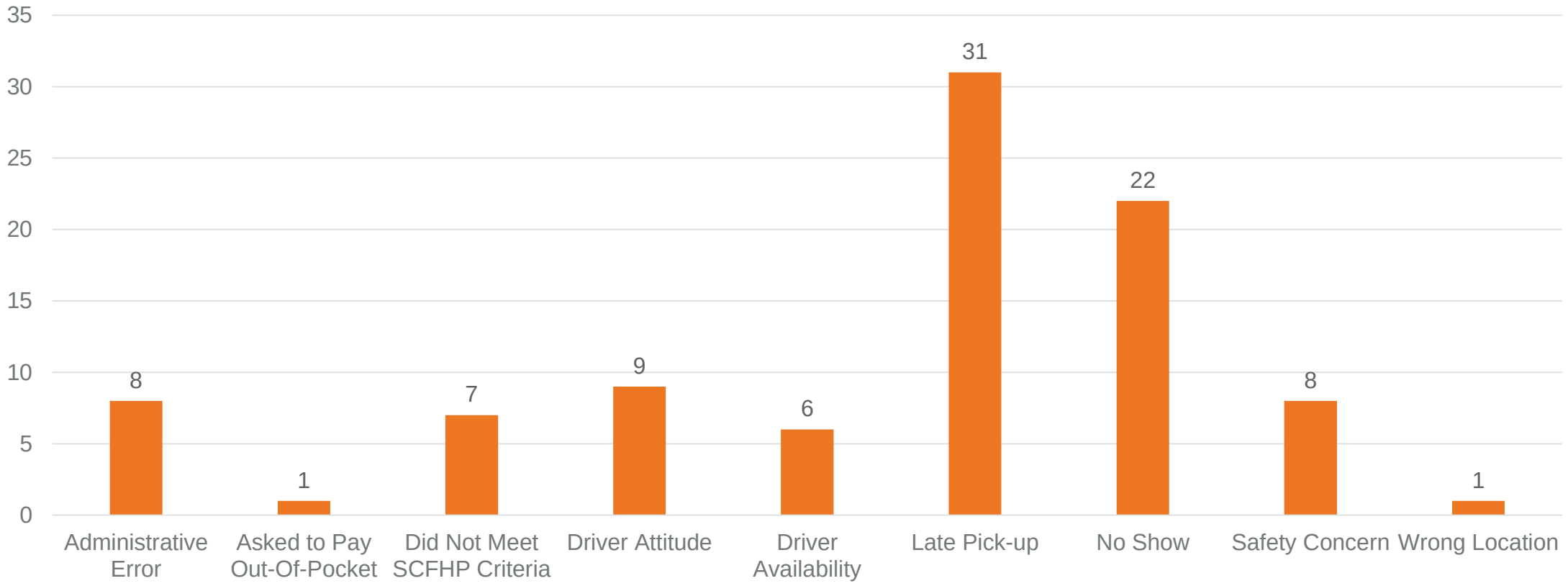


	Jan-20	Feb-20	Mar-20
QOC- Inappropriate Provider Care	14	22	17
Access-Timely Access to PCP	12	18	21
Transportation Services (NMT)	36	48	38

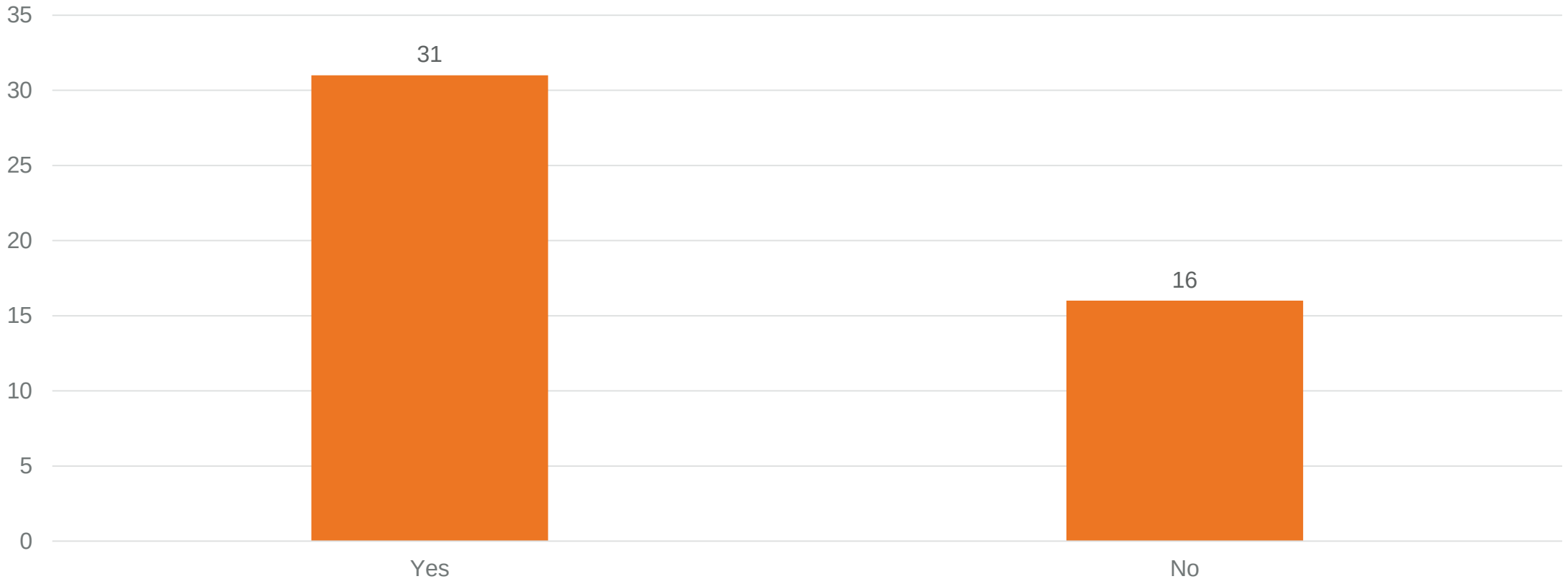
Q1 2020 MC NMT Grievances by Vendor



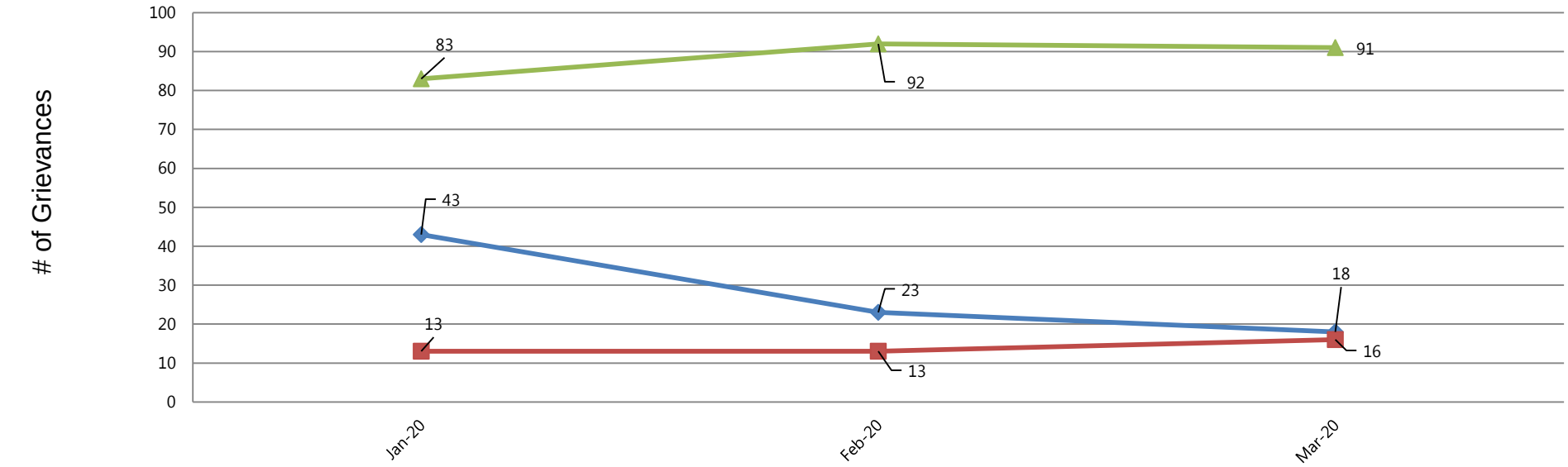
Q1 2020 MC Grievances by Reason



Q1 2020 CMC Inappropriate Provider Care PQI Issues Flag

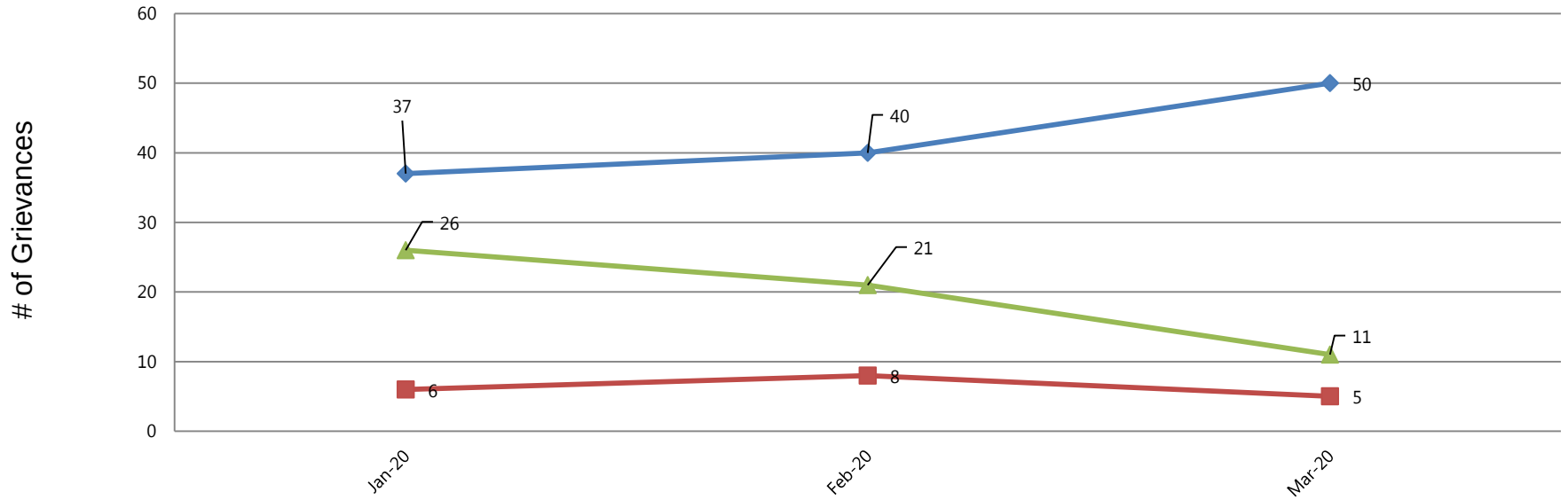


Q1 2020:Top 3 Cal MediConnect Grievance Categories



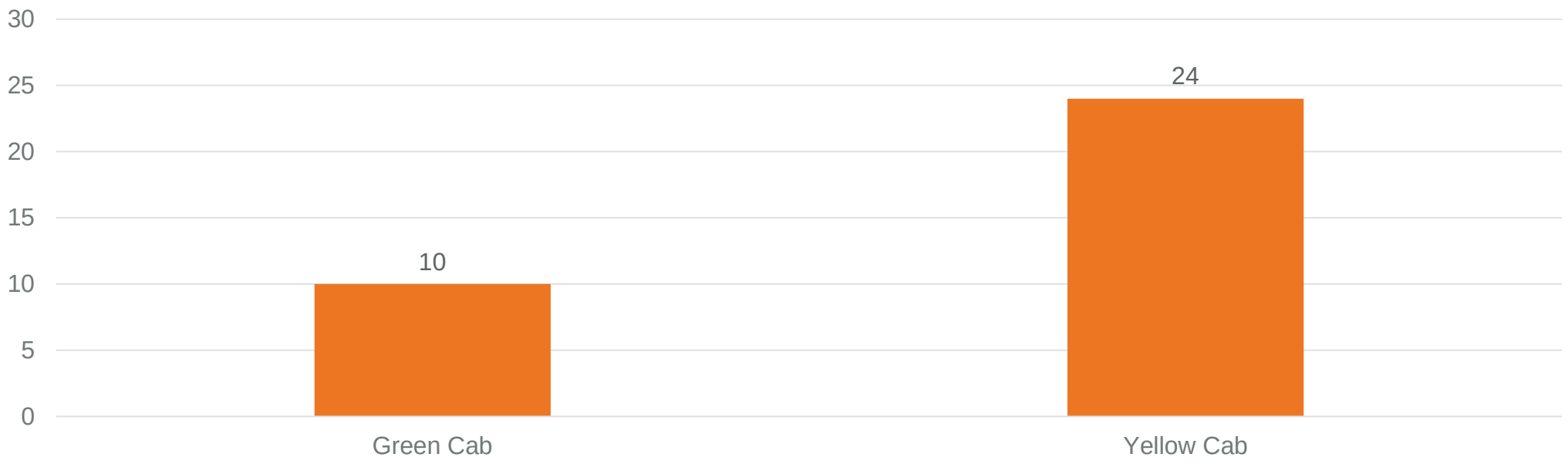
	Jan-20	Feb-20	Mar-20
Access	43	23	18
Quality of Care	13	13	16
Quality of Service	83	92	91

Q1 2020:Top 3 Cal MediConnect Grievance Subcategories

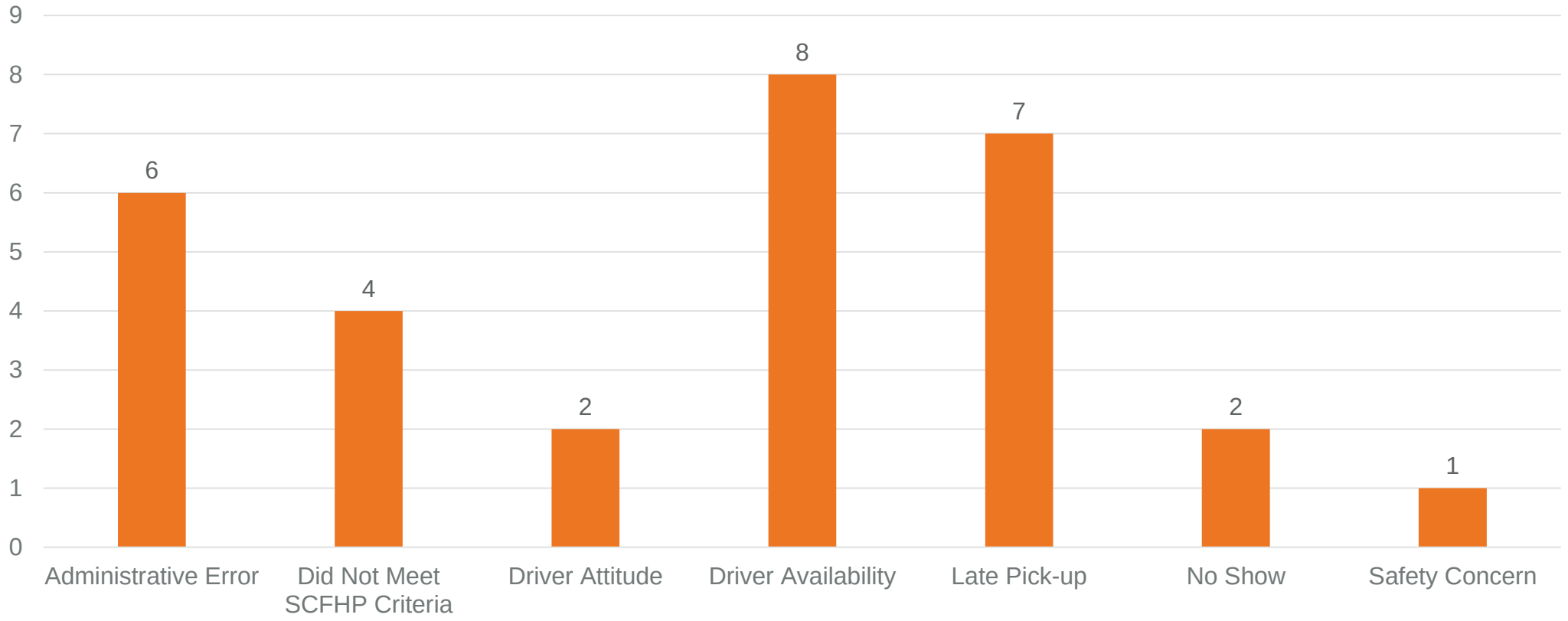


	Jan-20	Feb-20	Mar-20
QOS-Billing/Balance Billing	37	40	50
QOC-Inappropriate Provider Care	6	8	5
QOS-Transportation Services (NMT)	26	21	11

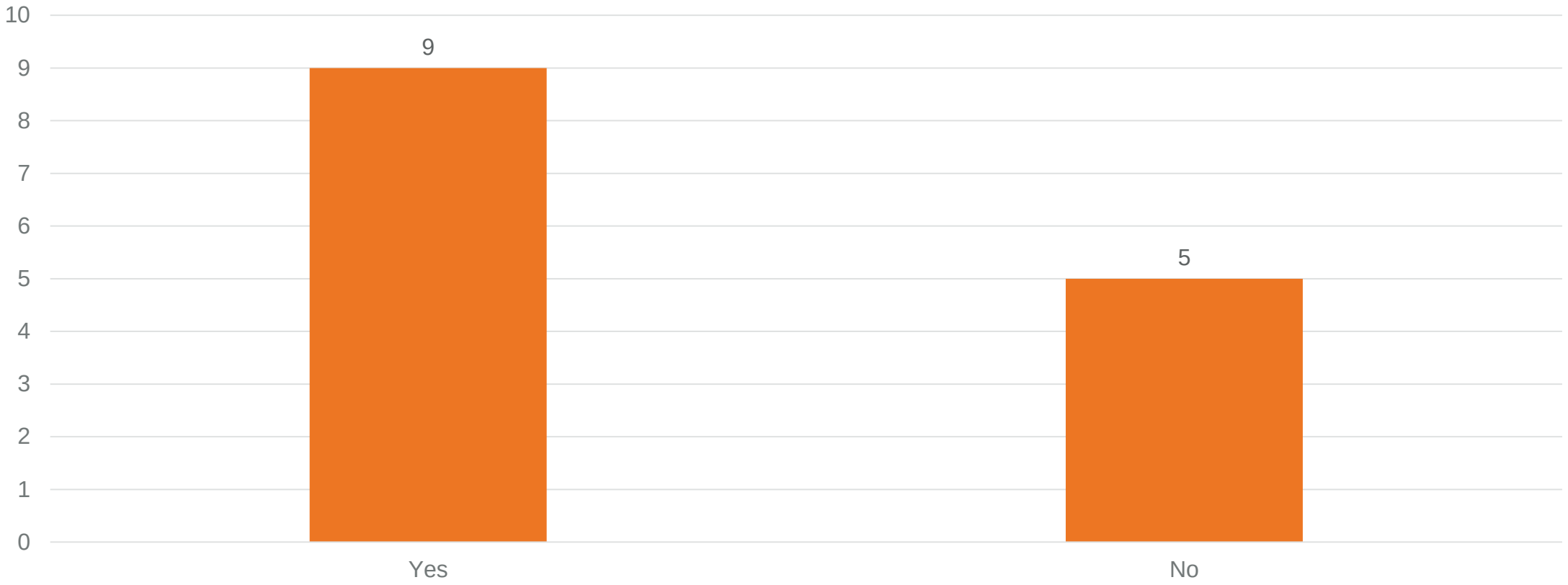
Q1 2020 CMC NMT Grievances by Vendor



Q1 2020 CMC Grievances by Reason



Q1 2020 CMC Inappropriate Provider Care PQI Issues Flag



Santa Clara Family Health Plan™

Quality Improvement Committee

June 10, 2020

Santa Clara Family Health Plan™

Quality Improvement Dashboard

March- May 2020

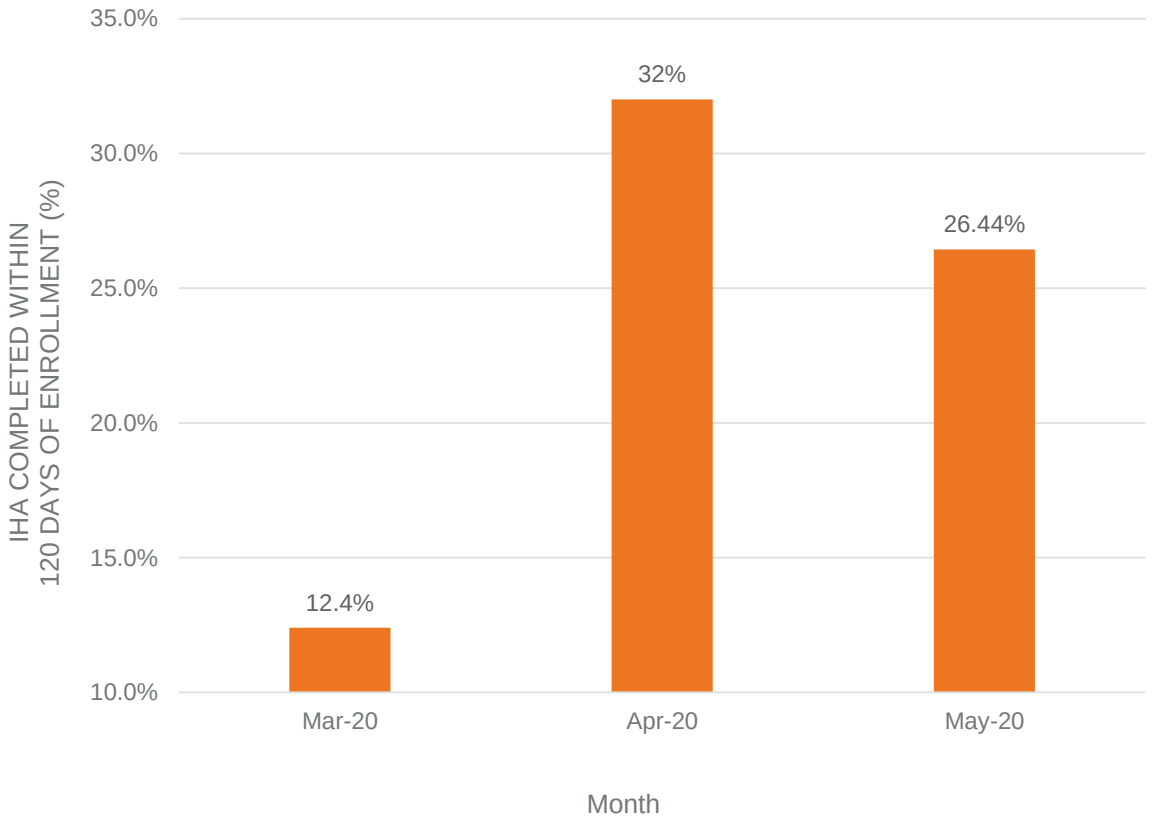
Initial Health Assessment (IHA)

Santa Clara Family Health Plan

What is an IHA?

An IHA is a comprehensive assessment completed during a new MC member's initial visit with their PCP within 120 days of joining the plan

QI currently conducts quarterly IHA audits and provider education to continually improve IHA completion rates



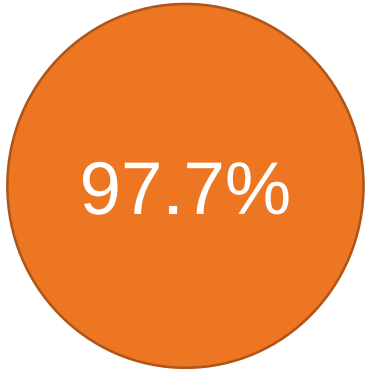
Potential Quality of Care Issues

Santa Clara Family Health Plan

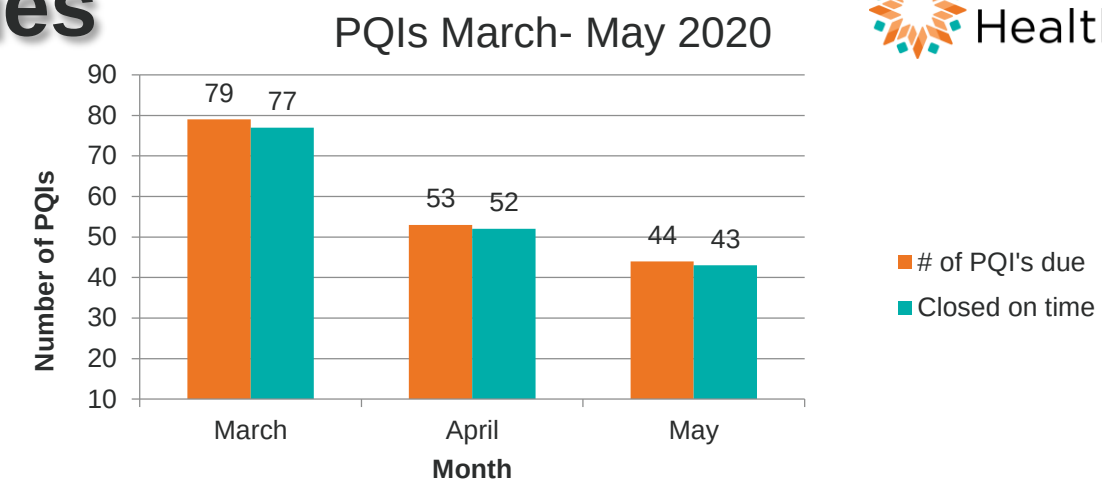
Quality helps ensure member safety by investigating all potential quality of care (PQI) issues

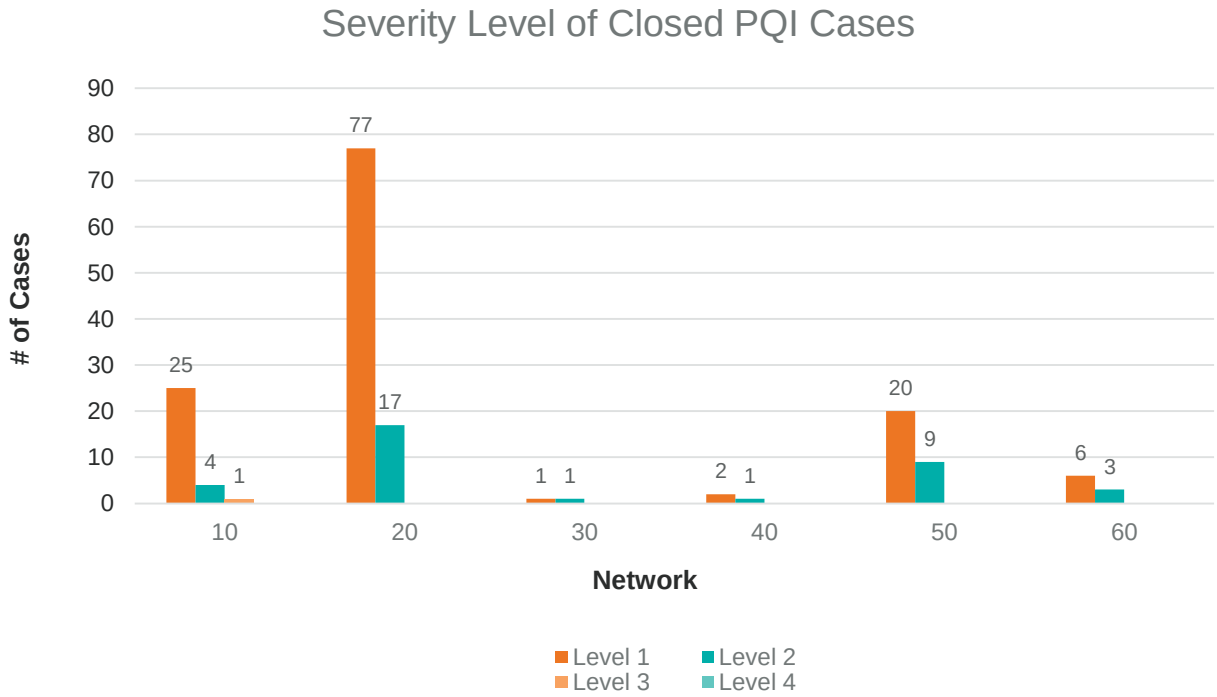
97.7%

Percentage of PQIs due from March- May, 2020 and closed on time within 60 days



Percentage of PQI cases due in May 2020 closed on time





Health Homes Program (HHP)

Santa Clara Family Health Plan

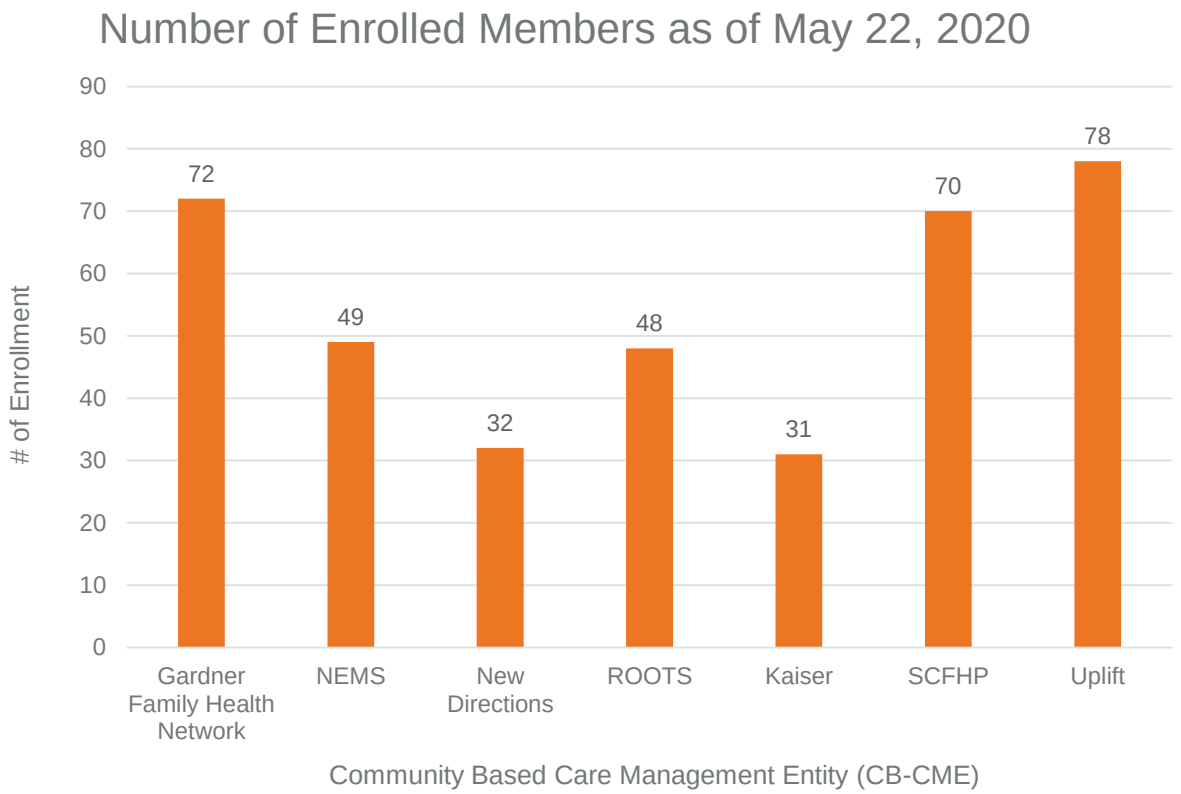
HHP launched with Community Based Care Management Entities (CB-CMEs) on July 1, 2019 for Chronic Conditions and on January 1, 2020 for Serious Mental Illness

What is the Health Homes Program?

HHP is designed to coordinate care for Medi-Cal beneficiaries with chronic conditions and/or substance use disorders

380

Members have verbally consented into Health Homes as of May 22, 2020

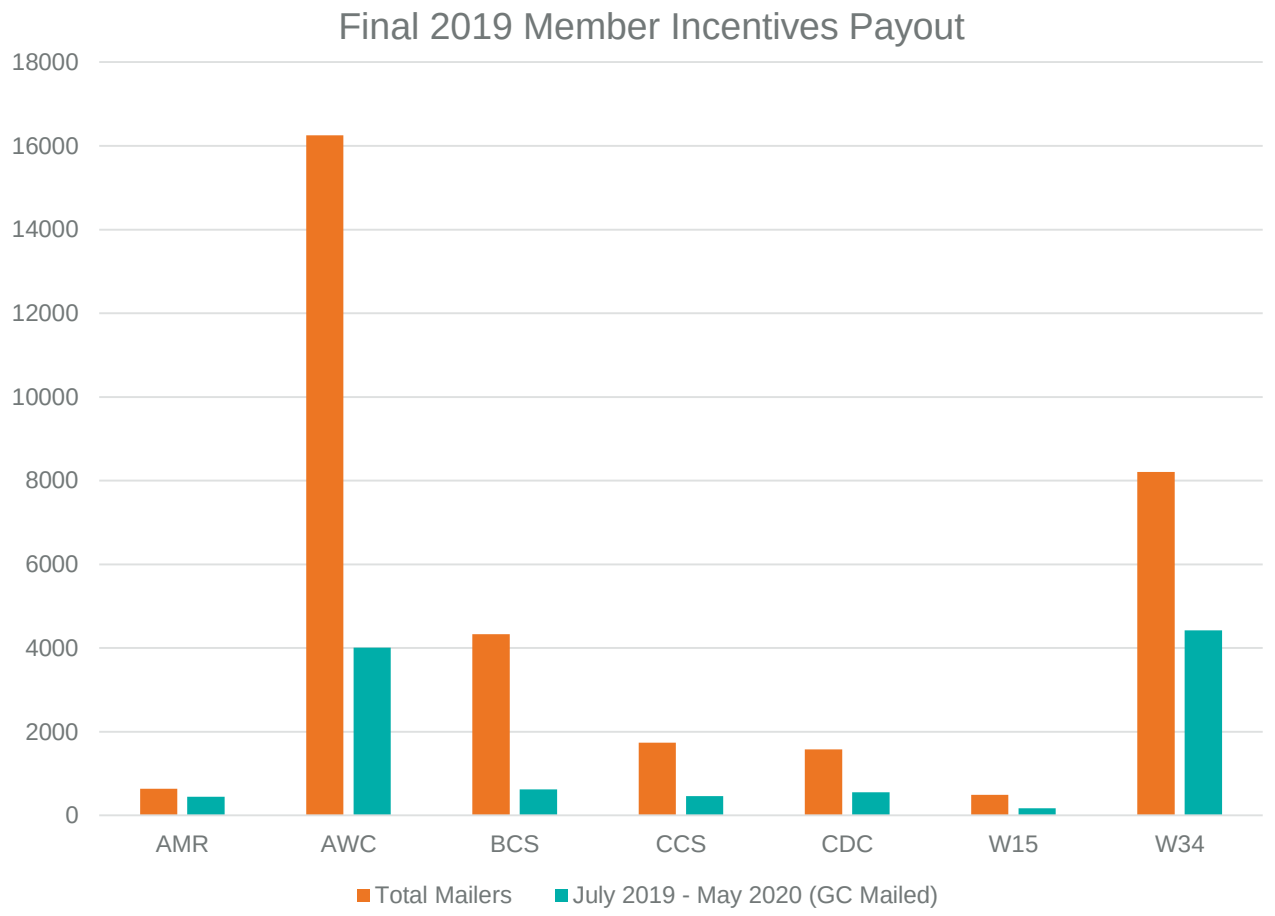


Member Incentives:
Wellness Rewards Mailing

What is the Wellness Rewards Mailing?

In July 2019, QI began mailing out letters to members who were not compliant for the measures: W15, W34, AWC, BCS, CCS and CDC

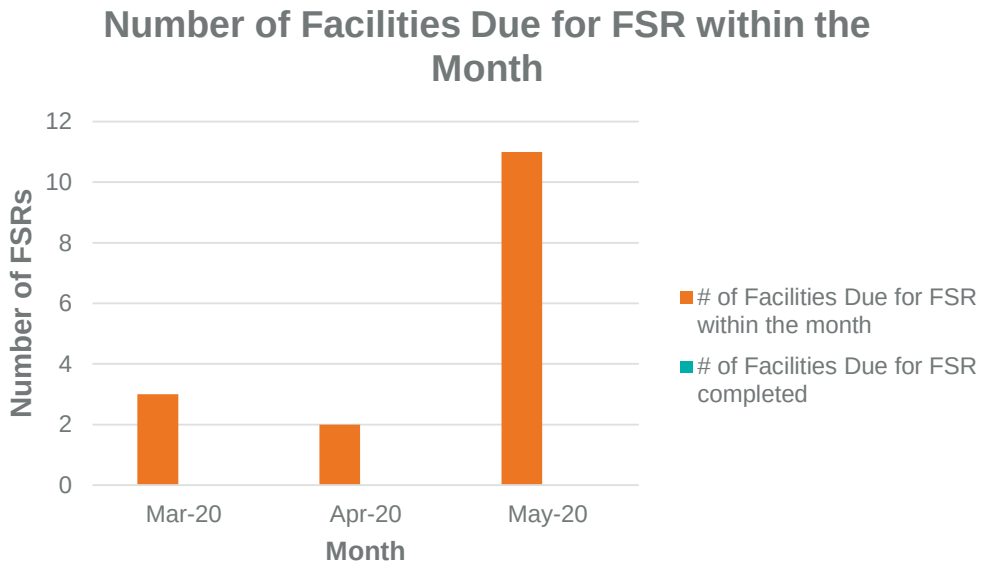
Total # of mailers sent since July '19	**33,232**
Total # of gift cards mailed (member completed visit)	**10,673**
Average Compliant Rate	**37%**



Facility Site Review (FSR)

What is a FSR?
A FSR is a 3 part evaluation of all PCPs and high volume specialists to audit provider offices for patient safety

FSRs were not conducted due to the **COVID-19 situation-** Extensions have been approved by DHCS



Compliance Report

June 10, 2020

AUDIT UPDATE

- **Centers for Medicare & Medicaid Services (CMS) Program Audit**

  The Plan is underway with activities related to our CMS Program Audit Revalidation (Revalidation Audit). All outstanding deliverables related to the Coverage Determinations, Appeals and Grievances (CDAG) portion of the Revalidation Audit have been submitted to ATTAC, the consulting firm directing the audit activities on behalf of CMS. Additionally, on 5/21/2020, ATTAC conducted the audit field work for the Compliance Program Effectiveness (CPE) portion of the Revalidation Audit. The CPE audit field work evaluated whether the Plan appropriately reviewed the Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists for all employees, temporary staff, consultants, Board Members, vendors and delegates. Information provided by the auditors at the conclusion of the CPE field work indicate that the Plan successfully passed this portion of the Revalidation Audit. The Plan anticipates receiving a draft report detailing the results of the CDAG and CPE audit field work on or before 6/15/2020.

  The third component of the Revalidation Audit is related to the Care Coordination and Quality Improvement Program Effectiveness (CCQIPE) Conditions. The Plan has been working to sustain full compliance with respect to the relevant tasks and is well situated as we enter the audit "clean period", which runs from 5/1/2020, through 7/31/2020. Audit field work for the CCQIPE Conditions will begin in August 2020, with the ATTAC's Final Report for the CCQIPE Conditions due to CMS on or before 9/25/2020.

- **Medicare Data Validation (MDV) Audit**

  CMS issued a memo reducing the scope of the 2020 MDV audit activities as a result of the COVID-19 pandemic. This reduction in scope is consistent with CMS' reprioritization of certain activities to allow organizations to focus on health and safety threats posed by the COVID-19 pandemic. Based on the new guidance, the auditors focused solely on Medicare Part D (prescription drug) Medication Therapy Management (MTM). On 5/26/2020, Advent, the organization conducting the audit on behalf of CMS, notified SCFHP that the Plan successfully passed the data validation portion of the audit. No issues or concerns were noted for the data. Advent is in process of completing its review of the MTM Source Documentation. The Plan expects to receive the preliminary results of that review by the end of May 2020.

- **Department of Health Care Services (DHCS) Medi-Cal Managed Care Audit**

  The Plan has completed all initial activities related to our 2020 annual DHCS audit for the Medi-Cal line of business. We anticipate receiving the draft report from DHCS within the next 4-6 weeks. However, due to the impact of the COVID-19 pandemic, there may be a delay in receiving the report.

- **Department of Managed Health Care (DMHC) Medi-Cal Managed Care Audit**

  The DMHC has indicated that the Plan is scheduled for a follow-up audit in March 2021.

Santa Clara Family Health Plan™

P & T Committee

Meeting Minutes

December 19, 2019

Regular Meeting of the

Santa Clara County Health Authority
Pharmacy and Therapeutics Committee

Thursday, December 19, 2019, 6:00 PM - 8:00 PM
Santa Clara Family Health Plan, Redwood Conference Room
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES (OPEN)

Members Present
Ali Alkoraishi, MD
Dang Huynh, PharmD, Director of Pharmacy
Jesse Parashar-Rokicki, MD
Jimmy Lin, MD, Chair
Laurie Nakahira, DO, Chief Medical Officer
Peter Nguyen, DO
Xuan Cung, PharmD

Members Absent
Amara Balakrishnan, MD
Dolly Goel, MD
Hao Bui, BS, RPh
Minh Thai, MD
Narinder Singh, PharmD

Staff Present
Duyen Nguyen, PharmD
Nancy Aguirre, Administrative Assistant
Tami Otomo, PharmD

Others Present
Alan Kaska, Abbott Labs, Public
Amy McCarty, PharmD, MedImpact

1. Roll Call

Jimmy Lin, MD, Chair, called the meeting to order at 6:06pm. Roll call was taken and a quorum was not established.

2. Public Comment

Alan Kaska, Abbott Labs, talked about continuous glucose monitoring (CGM) devices for diabetes care. Abbott's CGM product, FreeStyle Libre, involves reading a person's blood glucose level with a reader and sensor instead of using the traditional fingerstick method. Mr. Kaska shared that Abbott Labs introduced the FreeStyle Libre CGM products at a lower cost than competitors.

3. Open Meeting Minutes

The review of the 3Q2019 Pharmacy and Therapeutics Committee open meeting minutes was deferred until a quorum was established.

4. Standing Agenda Items

a. Chief Medical Officer Health Plan Updates

Laurie Nakahira, DO, Chief Medical Officer, Santa Clara Family Health Plan (SCFHP), reviewed the following Health Plan updates:

I. The Healthy Kids line of business has ended. The children who were enrolled in Healthy Kids were transitioned into the Medi-Cal line of business, which offers more benefits. All but two of the 3,500 children were transitioned into Medi-Cal on October 1, 2019. The two children (siblings) who did not meet criteria for Medi-Cal are being transitioned into Valley Kids. This transition should take full effect on January 1, 2020. Until that date, the two siblings will be covered by SCFHP.

II. One of SCFHP's durable medical equipment (DME) providers, California Home Medical Equipment (CHME), contract is terminating. Their contract ends on December 31, 2019.

III. SCFHP completed the Centers for Medicare and Medicaid Services (CMS) audit with a total of five findings. There will be one more audit to complete.

IV. Dr. Nakahira announced that SCFHP signed a lease for a new Community Resource Center (CRC) located in San Jose, near McKee Road and North Capitol Avenue. Member engagement, educational classes, and physical activity classes are a few of the resources that will be available to members within the CRC.

V. SCFHP has a new website and launched a new mobile app. The mobile app is user friendly and feedback on this new resource is highly encouraged.

VI. Presently, developmental screenings are being conducted during well child visits. However, providers have not been billing for them. Proposition 56 offers an extra payment to providers for performing this task. SCFHP will be working with some of the clinics to ensure providers obtain credit for completed developmental screenings.

b. Plan/Global Medi-Cal Drug Use Review

Tami Otomo, PharmD, SCFHP, provided the final update on the Retrospective Drug Utilization Review (DUR) Morphine Equivalency Initiative program, which aimed to improve the quality of pain treatment and prevent opioid overdose in members with at least one month of prescription opioid claims exceeding 120 morphine equivalent daily dose (MEDD).

Dr. Otomo noted that opioid safety edits at point-of-sale (POS) were implemented on October 1, 2019 for all Medi-Cal members.

Ali Alkoraishi, MD, Committee Member, asked where SCFHP acquired their data. Dr. Otomo explained that the data was obtained from approved pharmacy claims for opioid prescriptions.

Peter Nguyen, DO, Committee Member, arrived at 6:18pm. A quorum was established at this time.

c. Appeals & Grievance 3Q2019 Report

Dang Huynh, PharmD, Director of Pharmacy, SCFHP, presented the 3Q2019 Grievance & Appeals Report.

Dr. Nguyen asked about the number of prior authorization requests with subsequent appeals. Dr. Huynh explained that there is a 24-hour turnaround time for Medi-Cal. If the initial request does not have the necessary information, SCFHP will conduct telephonic outreach to the requesting provider to gather

supporting information. If the provider's office does not submit the supporting information within the turnaround time, then a denial will be made due to not having enough information to approve the request.

For Cal MediConnect (CMC), the majority of appeals are requests for high risk medications (HRM). HRM authorization requests require providers to submit an attestation acknowledging that the medication they are prescribing is considered high risk, but the benefits outweigh the risks for their patient. Dr. Lin asked if this is a state requirement. Dr. Huynh replied that CMS encourages the monitoring of HRM drugs. Dr. Huynh will request that Appeals & Grievances provide details about the other types of appeals for the next P&T Committee meeting.

d. National Committee for Quality Assurance (NCQA) Member Connection Standards – 2019 Pharmacy Report

Duyen Nguyen, PharmD, SCFHP, reported that there were no issues found in the required annual NCQA self-audit of SCFHP's member portal, resulting in a score of 100% in all measurements of quality and accuracy.

e. CY2020 Utilization Management Drug PA Grid

Dr. Otomo presented the Utilization Management Drug Prior Authorization (PA) grid for CY2020 and noted that it was approved at the most recent 4Q2019 Utilization Management Committee meeting.

SCFHP added newly released and soon-to-be released biosimilars to the PA grid. Dr. Otomo noted that if a biosimilar is available, SCFHP requires a step therapy for the brand name product.

At 6:30pm, Dr. Lin resumed the Committee's review of the 3Q2019 Pharmacy and Therapeutics Committee open meeting minutes, as a quorum was established upon Dr. Nguyen's arrival.

Dr. Nguyen motioned to accept the open meeting minutes as presented, and it was seconded by Dr. Alkoraishi. Motion carried.

Adjourn to Closed Session
Pursuant to Welfare and Institutions Code Section 14078.36 (w)

5. Closed Meeting Minutes

The 3Q2019 Pharmacy and Therapeutics Committee closed meeting minutes were reviewed as presented.

Dr. Nguyen motioned to accept the closed meeting minutes as presented, and it was seconded by Dr. Alkoraishi. Motion carried.

6. Metrics and Financial Updates

a. Membership Report

Dr. Nakahira presented the membership report.

b. Pharmacy Dashboard

Dr. Otomo presented the pharmacy dashboard.

c. Drug Use Evaluation

Dr. Huynh presented a follow-up to the 1Q19 Drug Use Evaluation (DUE) program.

d. Drug Utilization & Spend

Dr. McCarty presented the Drug Utilization & Spend.

7. **Discussion and Recommendations for Changes to SCFHP's CMC Formulary & Coverage Determination Criteria**

   a. **Pharmacy Benefit Manager 3Q2019 P&T Minutes**

   b. **Pharmacy Benefit Manager 4Q2019 P&T Part D Actions**

   Dr. McCarty presented the PBM's Medicare Part D Pharmacy & Therapeutics minutes and actions.

   Dr. Nguyen motioned to accept the PBM's 3Q2019 P&T Minutes and 4Q2019 P&T Part D Actions, and it was seconded by Dr. Nakahira. Motion carried.

8. **Discussion and Recommendations for Changes to SCFHP's Medi-Cal & Prior Authorization Criteria**

   a. **Old Business/Follow-Up**

      i. **Continuous Glucose Monitors (CGM)**
      Dr. Huynh reviewed the cost of Abbott FreeStyle Libre's CGM sensor.

      ii. **Opioid Point-of-Sale Safety Edits**
      Dr. Huynh reviewed the provider memo faxed out on October 1, 2019 with details about these opioid safety edits.

      iii. **Insulin Vial and Insulin Pen**
      Dr. Huynh reviewed the cost difference between an insulin pen and an insulin vial.

      iv. **Prior Authorization Approval Length**
      Dr. Huynh addressed Dr. Nguyen's question from the previous P&T Committee meeting regarding the consideration of approving PAs.

   b. **Formulary Modifications**

   Dr. Otomo presented Medi-Cal formulary changes.

   Dr. Nguyen motioned to accept the Formulary Modifications, and it was seconded by Jesse Parashar-Rokicki, MD, Committee Member. Motion carried.

   c. **Fee-for-Service Contract Drug List Comparability**

   Dr. McCarty reviewed the summary of changes to the Medi-Cal Fee-for-Service (FFS) Contract Drug List (CDL).

   Dr. Nguyen motioned to accept the recommendation that no action was needed by SCFHP, and it was seconded by Dr. Parashar-Rokicki. Motion carried.

   d. **Prior Authorization Criteria**

   Dr. Duyen Nguyen presented the following PA criteria:

   i. **New or Revised Criteria:**
      1. Non-Formulary
      2. Hepatitis C Policy
      3. Epclusa
      4. Mavyret
      5. Norditropin Flexpro
      6. Retacrit

   ii. **Annual Review:**
      1. Zarxio

Dr. Nguyen motioned to accept the PA criteria as presented, and it was seconded by Dr. Alkoraishi. Motion carried.

9. New Drug and Class Reviews

Dr. McCarty presented the following new drugs and class reviews:

a. Review

i. **Vumerity (diroximel fumarate)**
ii. **Nourianz (istradefylline)**
iii. **Glucagon-like peptide-1 (GLP-1) Class – Diabetes**

Dr. Nguyen motioned to accept the New Drugs and Class Reviews as presented, and it was seconded by Dr. Cung. Motion carried.

b. Informational Only

i. Adakveo (crizanlizumab) – Sickle Cell Disease
ii. Beovu (brolucizamab) – Age-Related Macular Degeneration
iii. Nubeqa (darolutamide) – Prostate Cancer
iv. Rozlytrek (entrectinib) – Oncology
v. Inrebic (fedratinib) – Oncology
vi. Reyvow (lasmiditan) – Migraine
vii. Ubrogepant – Migraine
viii. Rimegepant – Migraine
ix. Palforzia (AR101) – Peanut Allergy
x. Bonsity (teriparatide) – Osteoporosis
xi. Pretomainid – Tuberculosis
xii. Aklief (triparatide) – Acne
xiii. Guideline Updates – Pulmonary Arterial Hypertension
xiv. Biosimilar Update
xv. New and Expanded Indications

No questions were asked about the Informational Only items.

Reconvene in Open Session

10. Discussion Items

a. New and Generic Pipeline

Dr. McCarty noted an upcoming high impact-interest agent coming in 1Q2020 for peanut allergies. A second agent for peanut allergies will be released in the second half of 2020.

Dr. McCarty shared that generic Novolog Flexpen and Novolog vial will be available early 2020. These drugs are not on SCFHP's Medi-Cal formulary.

11. Adjournment

The next Pharmacy and Therapeutics Committee meeting will be on March 19, 2020. The meeting was adjourned at 7:37pm.

Approved via teleconference 04/30/2020

Jimmy Lin, MD, Chair of Pharmacy &Therapeutics Committee Date

Santa Clara Family Health Plan™

Utilization Management Committee

Meeting Minutes

January 15, 2020

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 - Approved

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

Members Absent
Laurie Nakahira, DO, Chief Medical Officer

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

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.

10. 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.

Approved via teleconference – 04/15/2020

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Jimmy Lin, MD, Utilization Management Committee Chairperson

Santa Clara Family Health Plan™

Credentialing Committee

Report

April 1, 2020

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Monitoring or Meeting Period:

Credentialing Committee 04/01/2020

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	15	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	10	
Number practitioners recredentialed within 36-month timeline	10	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 03/31/2020	287	

(For Quality of Care ONLY)	**Stanford**	**LPCH**	**VHP**	**PAMF**	**PMG**	**PCNC**
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0
Total # of practitioners	1617	1551	746	830	405	139

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.

Actions Taken

1. All current network practitioners were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. - # currently credentialed practitioner or provider had an identified issue on any of the exclusion lists or licensing boards.
2. Staff education conducted regarding the recredentialing of practitioners within the required 36-month timeframe. Procedure review of mailing pre-populated recredentialing applications six months prior to due date reviewed.

Outcomes & Re-measurement

Weekly re-measurement will be conducted on recredentialing applications to measure compliance

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.