Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, April 17, 2019, 6:30-8:00 PM
Santa Clara Family Health Plan, Boardroom
6201 San Ignacio Ave., San Jose, CA 95119

AGENDA

1.	**Introduction**	Dr. Lin	6:30	5 min
2.	**Meeting Minutes** Review minutes of the January 16, 2019 Utilization Management Committee meeting and the March 13, 2019 Ad Hoc Utilization Management meeting. **Possible Action:** Approve 01/16/19 and 03/13/19 minutes.	Dr. Lin	6:35	5 min
3.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The committee reserves the right to limit the duration of public comment to 30 minutes.	Dr. Lin	6:40	5 min
4.	**CEO Update** Discuss status of current topics and initiatives.	Ms. Tomcala	6:45	10 min
5.	**CMO Update** NCQA – Successful 3 year accreditation attained for CMC. DHCS/DMHC (Onsite completed 3/18/19-3/29/19). CMS Independent Validation Audit (Possibly May – July 2019).	Dr. Nakahira	6:55	10 min
6.	**Old Business/Follow up items** None.	Ms. Castillo	7:05	5 min
7.	**Action Items** a. UM Program Eval **Possible Action:** Approve UM Program Eval b. Annual Review of UM Work Plan **Possible Action:** Approve UM Work Plan c. Care Coordinator Guidelines **Possible Action:** Approve Care Coordinator Guidelines	Ms. Castillo	7:10	10 min

8.	**Reports (MediCal/SPD, Healthy Kids)**			
	a. Membership	Dr. Robertson	7:20	5 min
	b. UM Reports 2019	Ms. Castillo	7:25	10 min
	i. Dashboard Metrics: Turn Around Time (Cal MediConnect/ Medi-Cal)			
	ii. Standard Utilization: Metrics Powerpoint			
	c. MLTSS Dashboard	Dr. Boris	7:35	5 min
	d. HS.04.01 Reporting Quality Monitoring of Plan Auths, Denials etc. (Q1 19)	Ms. Castillo	7:40	5 min
	e. Referral Tracking Quarterly Report	Ms. Castillo	7:45	5 min
	f. Nurse Advice Line Stats	Ms. Carlson	7:50	5 min
9.	**Behavioral Health UM Reports**	Ms. McKelvey	7:55	5 min
	i. Turn Around Time/Dashboard Metrics			
	ii. Stats on Autism (ABA Services & Other BHT)			
10.	**Adjournment**	Dr. Boris	8:00	
	Next meeting: Wednesday, July 17, 2019 at 6:30 p.m.			

Notice to the Public—Meeting Procedures

- Persons wishing to address the Committee on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify 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

Meeting Minutes

MINUTES

UTILIZATION MANAGEMENT COMMITTEE

January 16, 2019

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	N
Ngon Hoang Dinh, DO	Head and Neck Surgery	Y
Indira Vemuri, MD	Pediatrics	Y
Dung Van Cai, MD	OB/GYN	Y
Habib Tobaggi, MD	Nephrology	Y
Jeff Robertson, MD, Medical Officer	Managed Care	Y
Laurie Nakahira, DO, Chief Medical Officer	Managed Care	N
Ali Alkoraishi, MD	Adult and Child Psychiatry	N

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	Y
Lily Boris, MD	Medical Director	Y
Jana Castillo	Utilization Management Manager	Y
Sandra Carlson	Health Services Director	Y
Caroline Alexander	Administrative Assistant	N
Natalie McKelvey	Manager of Behavioral Health	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. /II. Introductions Review/Revision/Approval of Minutes	Meeting was started with a Quorum at 6:05 PM. There was a motion to approve the October 18, 2018 minutes.	Minutes approved as presented.
III. Public Comment	No public comment.	

ITEM	DISCUSSION	ACTION REQUIRED
IV. CEO Update **V. CMO Update**	Dr. Robertson presented the CEO & CMO Updates noting the current and upcoming audits for the first half of the year. We completed our Medicare Audit in September a lot of remediation almost done they will come back for a 2nd CMS Independent Validation Audit sometime between May – July 2019. In addition, DHCS/DMHS will be onsite March 18-22, 2019, NCQA (1st Survey submitted 12/11/2018, Onsite February 4-5, 2019. Dr. Robertson further reported the Plan implemented a change to the Division of Financial Responsibility (DOFR) for Valley Health Plan, our largest delegate with half of our members. Previously they did not have responsibility for out of area health care and skilled nursing care beyond two months. The care of patients whether in or out of the area was effective 1/1/2019. Ms. Tomcala reported on the governor's new proposals that would affect the Health Plan; 1) carving out pharmacy as a statewide fee for service and also proposed extending coverage to undocumented youth up through age 26. In addition. There have been discussions in the community regarding the County purchasing O'Connor and St. Louise Hospitals. The attorney general is now raising some concerns about that.	No action required
VI. Old Business/Follow up items	**a.** Ms. Boris presented the MCG Criteria for Colonoscopy, EGD, and Up-to-date criteria for Frenulectomy. Prior authorization requirements were renmoved for colonoscopy procedures because there is no way of determining whether it is a screening colonoscopy of a follow-up colonoscopy. SCFHP does not have Prior authorization criteria for colonoscopy any longer. Dr. Robertson noted the prior authorization preventive services - was eliminated because the State does not allow the Plan to authorize preventive services such as screening colonoscopy. **b.** Ms. Castillo presented data for Skilled Level of Care to Long Term Care Level of Care for the period of 6/1/2018 – 12/31/2018. Data is as follows: • 345 total skilled authorizations	No action required.

ITEM	DISCUSSION	ACTION REQUIRED
	• 578 total LTC authorizations • Combined skilled and LTC authorization and identified duplicate members with skilled and LTC authorizations • Verified that the LTC authorizations were after the skilled authorization 48 members transitioned from skilled level of care to LTC level of care • 46 out of 48 LTC authorizations are still current and active • Two had an end date in August and November. Ms. Castillo noted that the definition of LTC are members who are institutionalized in a long term care facility that has daily needs for their ADL's daily living and they need to meet Medi-Cal criteria for long term care. The previously used term was Custodial Care, institutional not requiring any skilled therapy but unable to live outside the institution.	
VII. Action Items	**a.** UM Program Description 2019 Ms. Carlson provided an update on changes made to the 2018 Utilization Management Program Description noting there were spelling corrections, verbiage and context changes. The changes are as follows: **1.** Cover page: Changed date from ***2018 to 2019*** **2.** Page 5: spelling correction **3.** Page 9: context change, "The Utilization Management ***Department*****"** changed to Utilization ***"staff"*** **4.** Page 11: context change, "The Health Services ***Utilization Manager*** is responsible for the day to day…" changed to the Health Services ***Director and Utilization Manager*** are responsible…" **5.** Page 11: context change, ***"UM Lead Coordinator"*** changed to ***UM Supervisor*****.** Responsibilities section updated to include daily operation management of UM activities to include, "productivity ***and quality monitoring*****"** **6.** Page 12: context change, "Utilization Review and Discharge Planning Nurses"' changed to "Utilization Review and Discharge Planning ***Registered*** Nurses" ***7.*** Page 12: context change (Section g), ***Utilization Management review Nurse (LVN) added along with description, "Under the guidance and direction of the UM department RN Mangere or Health Services Director, Licensed Vocational nurses are responsible for performing prospective and retrospective pre-service clinical review for inpatient and outpatient authorization requests in compliance with all applicable***	Approved as presented

ITEM	DISCUSSION	ACTION REQUIRED
	state and federal regulatory requirements, SCFHP policies and procedures, and applicable business requirements. Following regulatory or evidence-based guidelines, assesses for medical necessity of services and/or benefit coverage which result in approved determination for services or the need to collaborate with Medical Directors for potential denial considerations. **8.** Page 13: context change, "Case management services at the SCFHP are licensed registered ***nurses"*** changed to ***"(RN) or licensed clinical social workers (LCSW)"*** **9.** Page 20: spelling correction **b. Annual Review of UM Policies** Ms. Boris presented changes to Utilization Management Policies HS.01 thru HS.15 noting tall policies meet DHCS, DMHC, CMS and NCQA requirements. To meet regulatory requirements and ensure effectiveness of the program structure changes have been made. **i. HS.01 Prior Authorization** Title Change from Prior-Authorization /Or determinations Updated section H&I **H.** The Plan maintains a ***procedure for*** Continuity of Care for both medical and behavioral health services. ~~I.~~ Out of Area ***and Out of Network*** requests are processed in accordance to the ***Member's Evidence of coverage, the*** Plan's Continuity of Care ***procedure*** for medical and behavioral health ***and reviewed based on medical necessity.*** **ii. HS.02 Medical Necessity Criteria** Update section B: The Plan maintains a Utilization Management (UM) Program description and Prior Authorization Procedure which further describe the Plan's utilization of Medical Necessity Criteria. The following factor apply: **B.** Criteria is specific to ***services and*** procedures ***requested.*** **iii. HS.03 Appropriate Use of Professional** Update section B and D: **B.** The Plan specifies the type of personnel responsible for each level of UM decision making which includes: • Non-licensed staff may apply established and adopted UM ***Care Coordinator*** guidelines that do not require clinical judgement.	The content and numbering as stated on the Agenda were Approved, with the caveat to correct the numbering issue, and updating HS.09 section 4, with the definition to Medical Management Leadership

ITEM	DISCUSSION	ACTION REQUIRED
	D. Non-licensed and licensed staff receive training and daily supervision ***by UM Supervisor, UM Manager, Medical Management Director and Medical Directors.*** **iv. HS.04 Denial Notification** Update section C: **C.** Letters to members for denial, delay, or modification of all or part of the requested service include the following. **8.** Provided in the language noted on the member's plan file ***within the DHCS threshold language requirement*** **9.** Advises that notifications are available in ***other*** languages upon request **v. HS.05 Evaluation of New Technology** No changes from 2018. **vi. HS.06 Emergency Services** No changes from 2018. **vii. HS.07 Clinical Practice Guidelines** Re numbered from HS.14 to HS.07 Update sections D,E,F, and I: *D.* ***Non contracted providers and Out of area providers will follow Out of Network/Out of Area Procedure for Utilization review.*** *E.* ***SCFHP notifies LTC providers of required supporting documentation for Utilization review.*** When PAR submissions do not include required documentation, SCFHP will follow up with the nursing facility with 3 outreach attempts to request the documents and if they are not received, the PAR will be **reviewed and possibly** denied **by a medical professional for insufficient information.** *F.* Changed ~~***RN***~~ to ***Licensed Nurse*** ***I.*** ***Bed Hold*** ***a.*** SCFHP shall include as a separate benefit any leave of absence or Bed Hold that a nursing facility provides in accordance with Medi-Cal requirements ***b.*** Bed Holds (BH) and should be submitted by the SNF at the time of transfer ***c.*** **T**he member's attending physician must write a physician order for a discharge or transfer at the time a member requires a discharge or transfer from an LTC facility to a General Acute Care Hospital and include an order for Bed Hold. ***d.*** Bed Hold (BH) ***is limited to seven (7) calendar days per discharge*** **viii. HS.08 Second Opinion** No changes from 2018	

ITEM	DISCUSSION	ACTION REQUIRED
	ix. HS.09 Interrater Reliability Update section B, III and IV: ***B*. Review** **4.** All cases will be reviewed ***by Medical Management Leadership*** for a consensus decision-making within 1 week following due date. **III. Records** All results and internal Corrective Action Plans CAPS) remain confidential and are maintained within Health Services and are reported to the ***UMC.*** ***IV. Responsibilities*** ***Health Services coordinates with both internal and external stakeholders in development, execution, maintenance and revisions to Denial Notifications. This includes but is not limited to collaboration with Quality, Benefits, IT, UM Committee, QIC, providers and community resources*** **i. HS.10 Financial Incentive** No changes from 2018 **ii. HS.11 Informed Consent** No changes from 2018 **iii. HS.12 Preventive Health Guidelines** No changes from 2018 **iv. HS.13 Nurse Advise Line** No changes from 2018 **v. HS.14 Transportation Services** Emergency medical transportation does not require prior authorization. Non-emergency medical (NEMT) and non-medical transportation services (NMT) as specified in an AP17-01 non-emergency medical and non-medical transportation services requires a physician's certification statement for physicians to have a signature for all non-medical transportation services. **vi. HS.15 Long Term Care Utilization Review** No Changes from 2018 Ms. Carlson noted that moving forward HS.13 Nurse Advice Line Policy and procedures will be moved to claims and presented at the next QIC meeting.	Specify in Policy what Medical Management Leadership is, managers and above.

ITEM	DISCUSSION	ACTION REQUIRED
VIII. Reports	**a. Membership** Dr. Robertson gave an update on membership noting that Medi-Cal experienced a gradual but linear decline, and we contribute this to three factors; 1) the economy is improving, and members are getting jobs and no longer qualifying for Medi-Cal 2) Santa Clara County is expensive and people are moving to less costly counties, and 3) the uncertainty around immigration status. Between those three things, we have seen a loss of approximately 4,000 members. The upside is the Cal Medi-Connect Medicare line of business 2018 UM Report whereas we had a loss of 150-200 a month through much effort we have turned that around and we are now growing that, not tremendous growth. 150 Medicare lives is about 1,000 Medi-Cal lives as far as the cost and amount of work involved. Do not know when it will stabilize. It looks like 250,000 a year and a half ago 285,000. **b. UM Reports 2018** **i. Dashboard Metrics** Dr. Boris reported that the 2018 UM Reports have compliance requirements around doing prior authorizations in a timely matter. We do have the Utilization Dashboard for Cal Medi-Connect as well as for Medi-Cal. Ms. Castillo reported on our daily, weekly, and quarterly tracking, so that you have an idea of the changes that have been made and how it has positively affected what you are seeing on the metrics. Cal MediConnect lines of business.	

ITEM	DISCUSSION	ACTION REQUIRED
	• Cal MediConnect (CMC) standard Part C, October 99.2%, November 98.8%, and December 99.0%. • Expedited Part C, October 98.6%, November 98.6%, December 100%, and Year to date 96.4% • Retrospective Review - 100% last quarter and Year to Date 96.7%. Medi-Cal line of business – DHCS goal is 95% compliance. • Routine Authorization - October 97.6%, November 96.8%, December 97.7% and Year to date 92.6% • Expedited Authorizations – October 99.1 %, November 100%, December 98.7%, and Year to date 97.1% • Retrospective Review - October 99.1%, November 99.4%, December 100%, and Year to Date 97.5% Ms. Castillo pointed out that we are required to monitor not just our decision making time but also our notification time. This was brought to our attention during our CMS Audit, so we are monitoring closely and this is added to the dashboard. We are monitoring our notification time from the time that a decision is made to the that we notify our providers and members. **ii. Standard Utilization Metrics** Dr. . Boris presented the Standard Utilization Metrics data for 10/1/2017 thru 9/30/2018. Discharge per thousand per member months. Our goals for this year, we are going to be developing some department specific goals so we are going to use some of these, get some clarity on them, and use them for our department goals. More details in upcoming meeting. • **Inpatient Utilization: Medi-Cal –Non-SPD:** 3.75 and average length of stay is less than 4 (moms, kids & families) • **Inpatient Utilization: Medi-Cal – SPD:** around 12 and average length of stay climbed to almost 1 day above the average for children. (seniors and persons with disabilities)	Highlight going forward

ITEM	DISCUSSION	ACTION REQUIRED
	• **Inpatient Utilization: Cal MediConnect (CMC):** 258 Cal MediConnect and average length of stay doubles to six. (Medicare and Medi-Cal dual eligible patients) • **Medi-Cal Inpatient Utilization NCQA Medicaid Benchmark Comparisons:** 3.75 for non-SPD and the average length of stay 12. Rank less than 10% on non-SPD but greater than 90%, means a higher utilization on SPD population. Average length of stay 4-4.75. • **Medi-Cal SPD & CMC Inpatient Utilization MCG & NCQA Medicare Benchmark Comparisons:** For the CMC line of business, we look more like a loosely managed plan compared to National Medicare patients, which is not an apples to apples comparison but it is the best we have. NCQA Medicare mean at 214 still above NCQA mean. Bed days is average length of stay is ½ day higher • **Inpatient Readmission: Medi-Cal – Non-SP:** part of these are HEDIS rates all cause readmission. Those 4 quarters average around 16%. • **Inpatient Readmissions: Medi-Cal – SPDs:** 21% is a high number SPD act and behave more like our Cal MediConnect product, but they do not have Medicare supporting their resource utilization. • **Inpatient Readmissions: Cal MediConnect (CMC):** Q3 2018 abnormally low at 10%, this will self-adjust as more claims come through. We remain right around 15% • **Cal MediConnect (CMC) Readiness Rates Compared to NCQA Medicare Benchmarks**: A comparison for18-64, 65 and above, and our 18-64 always have a readmission rate that is higher primarily because that population in CMC has disabilities that are resulting in their Medicare benefit. • **Frequency of Selected Procedures: Medi-Cal**: There were no dramatic shifts in frequency of procedures; most members are on the downward trend. We did look bariatric weight loss procedures and still see the highest bariatric ages 20-24, BMI is 39-64. • **ADHD Medi-Cal Behavioral Health Metrics:** looks at children prescribed ADHD medication both initiation phase and maintenance phase, antidepressants and cardiovascular monitoring. **c. MLTSS Dashboard**	

ITEM	DISCUSSION	ACTION REQUIRED
	Ms. Castillo reported that MLTSS covers long-term care authorizations and CBAS authorizations for our community based adult services, also known as adult day cares. Cal MediConnect is 100% compliant and Medi-Cal MLTSS remains 95%, averaging 98% - 100%. **d. HS 04.01 Reporting Quality Monitoring of Plan Auths, Denials etc. (Q4 18)** Ms. Castillo presented the Q4 2018 Quality Monitoring Report. Santa Clara Family Health Plan (SCFHP) completed the 4th quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations. For the 4th Quarter review of 2018, the findings are as follows: III. For the dates of service and denials for October, of CY 2018 were pulled in the 4th quarter sampling year. a. 30 unique authorizations were pulled with a random sampling. i. 60% or 12/30 were Medi-Cal LOB and 40% or 18/30 CMC LOB ii. 100% or 30/30 were denials 1. 10 of the 30 were expedited, processed in 72 hours - 20 were standard depending on whether they were Medi-Cal or CMC – 5 business days or 14 days 2. 80% or 8/10 were compliant with regulatory turnaround, 20% were not of our random sample iv. 90% of the standard authorization were compliant and 2 were non-compliant v. 67% or 20/30 were medical denials, and 10/30 were administrative denials vi. 100% or 30/30 cases were denied by MD vii. 100% or 30/30 provided member and provider notification viii. 70% or 7/10 expedited authorization provided oral notification to member ix. 97% member letters are of member's preferred language x. 97% or 29/30 letters were readable and rationale for denial was provided xi. 97% or 29/30 letters included the criteria or EOC that the decision was based upon	

ITEM	DISCUSSION	ACTION REQUIRED
	xii. 100% or 30/30 letters included interpreter rights and instructions on how to contact CMO or Medical Director Manager of Utilization Management and Director of Health Services reviewed the findings of this audit and recommendations from those finding presented to UMC are as follows: • Provide staff training regarding oral notification to member following an expedited service authorization determination. • Provide staff training in managing regulatory turnaround time based on LOB. • Provide staff training in quality monitoring including denial language and checking members preferred language prior to sending members UM letters. • Continue QA monitoring and reporting. **e. Referral Tracking** Ms. Castillo presented the data for the Referral Tracking report for 2018 noting the report was completed for the rolling 12-month look back of: January 1, 2018 to December 31, 2018. Findings: **1.** There were 14,554 unique authorizations for all lines of business (roughly 1200 auths/month). • Cal MediConnect: 5126 o 2297 without Claims • Healthy Kids: 40 o 19 without claims • Medi-Cal 9388 o 3979 without claim **2.** It was identified that there is an average 3 months claim lag time. • 53.5% Authorized services were rendered within 90 days of authorization • 2.3% were rendered after 90 days of authorization • 44.2% were not yet rendered to date. Follow Up	

ITEM	DISCUSSION	ACTION REQUIRED
	1. 55 unique case authorization were pulled for sample calls. • 21 Cal MediConnect • 34 Medi-Cal **2.** Types of Services • 1 EGD • 1 Home Health • 7 MRI • 25 Outpatient therapy • 3 Sleep studies • 1 SBRT • 7 Transportation • 10 Other **3.** 14 of 55 cases confirmed that they received services already. **4.** Reasons why member did not get service: • Members refuse service – 1 • Member is too sick to receive service – 2 • Scheduling issue – 5 • Taking care of family member, waiting for holidays to pass, member or provider scheduling issues • Wants to talk to PCP prior to receiving service – 1 • Service location issue – 2 **5.** 30 unreachable member to confirm reason for incomplete services **6.** Zero termed members **f. Nurse Advice Line Stats** Ms. Carlson presented the Nurse Advice Line Stats by Line of Business for the dates of October 1, 2018 – December 31, 2018. Call Volume summary by disposition; • Medi-Cal 2,114, Healthy Kids 56 calls, and Cal MediConnect 94 calls Highest volume for Triage Guidelines used for call types; • Medi-Cal: CareNet Health Information only, Influenza/Flu like symptoms, abdominal pain, fever, and Cough/URI	

ITEM	DISCUSSION	ACTION REQUIRED
	• Healthy Kids: Croup, Fever, and Abdominal pain, vomiting with diarrhea • Cal MediConnect: Influenza/Flu like symptoms, CareNet Information only, Cough/URI, and abdominal or pelvic pain **g. Annual report on physician peer to peer process** Dr. . Boris noted that in accordance with Procedures HS.02.02, the provider dispute process includes a Peer to Peer (P2P) review with the SCFHP physicians who make determinations (in case denials of service.) It is the goal of SCFHP medical team to ensure quality of service and return calls when there is a requested P2P. YTD there were 19 requests for Peer-to-Peer Reviews. All 19 cases were reviewed for compliance. This ensures that the P2P process is working and that the community physician requests for call back are completed and do in fact occur. The findings are as follows: 1. 84% (16/19) calls were completed with the SCFHP physician and the requesting physician 2. 81% (13/16) had documentation of the call in our QNXT system SCFHP recommendation to UMC: 1. Corrective Action: a. Since 6/2017, QNXT system holds authorization for all Lines of Business (Medi-Cal, Cal MediConnect, and Healthy Kids.) As such, both physicians know the system and have agreed to enter their call documentation into QNXT. b. The current findings are that the majority of the physician calls are completed. Only three calls were not returned. Two of the cases have no notes, and one case was redirected successfully to Stanford Medical Center. c. SCFHP will reinforce the use of QNXT fir the completion of P2P call notes within the original authorization **d. Conflict of Interest Forms** Dr.. Boris reported on the annual confidentiality agreement and asked all members to sign and return at the close of the meeting.	

ITEM	DISCUSSION	ACTION REQUIRED
	Dr. Robertson introduced Natalie McKelvey the new manager in Behavioral Services you may recall Sherri Holm retired. We do not intend to replace the director position and so Ms. McKelvey is picking up our internal operations. Dr. Robertson responded to Dr. Kai's question regarding autism noting that this is a Brown Act Meeting so we cannot discuss items that are not on the agenda. What I can tell you is 900 children receiving autism services, behavioral treatment out of about 96,000 children which about 1%. Pretty close to the prevalence of autism in the community. We have a high saturation. If you would like a more detailed discussion we can add as this as an agenda item at next meeting.	Add Autism as Agenda item for next meeting

ITEM	DISCUSSION	ACTION REQUIRED
IX. Behavioral Health UM Reports	**i. Turn around time/dashboard metrics** Ms. McKelvey reported on the UM Dashboard for Behavioral Health noting that Cal MediConnect 100%; Medi-Cal 99%; Timely Decisions 89%; Retrospective for timely notification 100%; Retrospective for 99.3%. **ii. Technical assistance guide (TAG) update fir Behavioral Health** Ms. McKlevey presented a report on the Behavioral Health Technical Assistance Guide factors (TAG). California law requires the DMHC to conduct a routine medical survey of each licensed full service and specialty health plan at least once every three years specifically surrounding the following areas: • Quality Assurance • Grievances and Appeals (enrollee complaints) • Access and Availability • Utilization Management (referrals and authorizations) • Overall plan performance in meeting enrollees' health care needs A Technical Assistance Guide (TAG) is used by surveyors to measure a health plan's performance and determine compliance. Each requirement listed will cite the statutory/regulatory citations, those to be interviewed in the survey, documents to be reviewed, and lists the key elements to meet the standards. TAG tools are updated as necessary based on legislative and regulation changes. DMHC has provided TAGS specific to Behavioral Health to help guide our program to ensure compliance. **iii. DMHC findings update and recommendations** Procedure QI.17.01 (Medically Necessary Behavioral Health Treatment Services/EPSDT) was updated to reflect current APL 18-006. **iv. ASD evaluation of timely screening and diagnosis for CY 2018** Ms. McKelvey presented the ASD evaluation for timely screening and diagnosis for CY 2018. The American Academy of Pediatrics (AAP) recommends all children receive autism-specific screening at 18 and 24 months of age, in	

ITEM	DISCUSSION	ACTION REQUIRED
	addition to the broad developmental screening (Ages and Stages Questionnaire) at 9, 18, and 24 months. In July 2017, SCFHP pays the developmental screening code: 96110 as an additional fee-for-service payment if billed with a (Child Health and Disability Prevention) CHDP visit. In CY 2018, SCFHP met with Healthier Kid Foundation and First Five of Santa Clara County to help promote the use of age appropriate screening. Dr. Robertson noted that it is a separately reimbursable code at $58 and most physicians are not aware of this. Health Education sent a memo to providers also included an article in the PCP news. The results are as follows: 2016 - 134 2017 - 284 2018 - 2817	
X. Adjournment	Meeting adjourned at 8:00 PM	

ITEM	DISCUSSION	ACTION REQUIRED
NEXT MEETING	The next meeting is scheduled for Wednesday, April 17, 2019, 6:30 PM	

Prepared by:

_____ Date _____

Reviewed and approved by:

_____ Date _____

Jimmy Lin, M.D.
Committee Chairperson

Utilization Management Ad Hoc
Meeting Minutes
March 13, 2019

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	**Y**
Ngon Hoang Dinh, DO	Head and Neck Surgery	**Y**
Indira Vemuri, MD	Pediatrician	**Y**
Dung Van Cai, MD	OB/GYN	**Y**
Habib Tobaggi, MD	Nephrology	**Y**
Jeff Robertson, MD, MO	Managed Care	**Y**
Ali Alkoraishi, MD	Adult and Child Psychiatry	**Y**
Non-Voting Staff Members	**Title**	**Present Y or N**
Laurie Nakahira, DO	Chief Medical Officer	**Y**
Sandra Carlson	Director of Medical Management	**Y**
Jana Castillo	Manager of UM	**Y**
Nancy Aguirre	Administrative Assistant	**Y**

Item	Discussion	Action Required
I. Roll Call	Meeting was called to order by Dr. Nakahira, with a Quorum established at 12:05 PM. All telephonic attendees were confirmed via roll call.	
II. Public Comment	No public comment.	
III. CMO Update	Changed contract with CHME. Instead of going from a cap, SCFHP is now on a fee-for-service. Ms. Castillo presented Prior Authorization Grid for SCFHP for review. Noted that delegates will also have different grids. Ms. Castillo proposed a change in the Durable Medical Equipment (DME) section of the PA Grid. Previously, SCFHP had been capitated to CHME. On March 1, 2019, contract changed to reflect SCFHP is no longer capitated, hence the requirement to update PA Grid. Proposing to no longer require a prior authorization for the following DME items: • CPAP and BIPAP. • Enteral formula and supplies. • Hospital bed and Mattress. • Oxygen. • Overage items (over benefit limit).	

	• Power Wheelchairs, Scooters and Manual Wheelchairs (except standard adult and pediatric). Including accessories. • Prosthetics & Orthotics (except off the shelf covered items). • Hearing Aids. • Other Specialty Devices. All of these items will still be reviewed based on the benefit and frequency limit, which is already configured in SCFHP's system. In addition to that, additional clarification was added to the Behavioral Health Treatment section due to rising questions regarding BHT services including autism. The clarification now specifies the Behavioral Health Treatment includes developmental diagnosis that may or may not include autism spectrum diagnosis. Dr. Lin asked if there is a limit to some of these affected items. For example, oxygen for patients. Is someone looking into this to ensure patient doesn't need the DME anymore? Ms. Castillo referenced the Policy and Procedures reviewed in January, 2019 reflects that the prior authorizations have a limit of 90 days. SCFHP providers need to review the orders from the physicians to determine if they are accurate and still applicable to our members. We encourage our providers to make sure orders are current before authorizations are sent by our prior authorization nurses. It is also stated in the Policy and Procedure that all prescriptions have an expiration of 1 year. Dr. Vemuri asked if members have to obtain another authorization after 1 year, and if so, would it be the physicians who do this? Ms. Castillo replied, yes, members would have to obtain a new authorization from the physician after 1 year.	

	Ms. Castillo asked if there were any further questions regarding the DME section. Ms. Vemuri asked if there are any changes in writing a prescription for the enteral formula and supplies. Ms. Castillo explained the enteral supplies needs a prescription and there is no change to the current process. The process would be: The doctors would send the prescription to the DME providers and the DME providers will send the authorization to SCFHP.	
IV. Action Items	Dr. Lin motioned to approve the UM Medical Prior Authorization Grid 2019. Seconded and carried. Dr. Nakahira offered clarification when writing a prescription and how they are written. Ms. Castillo replied it is dependent on the product and delivery. Dr. Nakahira asked for any other questions. No other questions.	SCFHP is developing prescription form. Will be available on website soon. Will bring to next committee meeting. Ms. Carlson explained when Ms. Castillo creates a prescription form, she will add a FAQ section.
V. Adjournment	Meeting adjourned at 12:17 PM Next meeting is on April 17, 2019 at 6:30 PM.	

Reviewed and approved by:

_____ Date: _____

Jimmy Lin, MD
Committee Chairperson

UM Program Eval

SCFHP UTILIZATION MANAGEMENT WORK PLAN AND PROGRAM EVALUATION 2018

	WORK PLAN							EVALUATION	
	SCOPE	OBJECTIVE	ACTION STEPS	GOAL	RESPONSIBLE PARTY	REPORT FREQUENCY	TARGET DATE OF COMPLETION	DATE OF COMPLETION	FINDINGS/COMMENTS
1	Quality of Clinical Care	Expand on Current reporting and present findings to UMC	Review MediCal Inpatient Admissions/1000	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	Reviewed and reported to UMC on a quarterly basis. Medi-Cal Non SPD LOS (avg)=3.55 Medi-Cal SPD LOS(avg)=4.83
2	Quality of Clinical Care	Monitor appropriate inpatient admissions	Review MediCal Inpatient Admissions/1000	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	Reviewed and reported to UMC on a quarterly basis. CMC LOS (avg)=6.11
3	Quality of Clinical Care	Monitor appropriateness of inpatient stays to assess proper level of care	Review MediCal Inpatient ALOS	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	Reviewed and reported to UMC on a quarterly basis. Medi-Cal Non SPD LOS (avg)=3.55 Medi-Cal SPD LOS(avg)=4.83
4	Quality of Clinical Care	Monitor appropriateness of inpatient stays to assess proper level of care	Review CMC Inpatient ALOS	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	Reviewed and reported to UMC on a quarterly basis. CMC LOS (avg)=6.11
5	Quality of Clinical Care	Monitor Readmissions, all cause to minimize unnecessary premature discharge and applicable post discharge follow up and care.	MediCal Inpatient Readmissions	HEDIS goal	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	Reviewed and reported to UMC on a quarterly basis. Medi-Cal Non SPD readmission rate avg=15.57% Medi-Cal SPD readmission rate avg=21.71%
6	Quality of Clinical Care	Monitor Readmissions, all cause to minimize unnecessary premature discharge and applicable post discharge follow up and care.	CMC Inpatient Readmissions	HEDIS goal	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	Reviewed and reported to UMC on a quarterly basis. CMC readmission rate avg=16.5%
7	Quality of Service	Assess Medi-Cal denial rates on PARs; provide benchmarks and compare to CA specific plans	Measure and act on denial rates on Outpatient PARs	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	Reviewed and reported to UMC on a quarterly basis.
8	Quality of Service	Assess CMC denial rates on PARs; provide benchmarks and compare to CA specific plans	Measure and act on denial rates on Inpatient PARs	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	Reviewed and reported to UMC on a quarterly basis.
9	Quality of Service	Track and monitor denial rates on PARs; provide benchmarks and compare to CA specific plans	Track and monitor BH IP Stays for CMC	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	Reviewed and reported to UMC on a quarterly basis.

10	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	MediCal ADD Follow-up Care for Children with ADD	HEDIS Benchmarks	Behavioral health Director	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	Initiation Phase- >10th percentile Continuation &Maintenance Phase- <10th Percentile
11	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	MediCal AMM Antidepressant Medication Management	HEDIS Benchmarks	Behavioral Health Director	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	Acute Phase Treatment->75th Percentile Continuation Phase Treatment- >50th Percentile
12	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	CMC SMC Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	HEDIS Benchmarks	Behavioral Health Director	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	<10th Percentile
13	Quality of Service	Internal audit process and corrective action as necessary	Report Turn Around Times(TAT) for Prior Auth for Medi-Cal and CMC	DHCS and CMS regulatory TAT	Manager of Utilization Maagement	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	Reviewed and reported to UMC on a quarterly basis.
14	Quality of Service	Internal audit process and corrective action as necessary	Report TAT based on Priority for Medi-Cal and CMC	DHCS and CMS regulatory TAT	Manager of Utilization Maagement	Quarterly	1st, 2nd, 3rd, 4th Qtr	1st, 2nd, 3rd and 4th Quarter	Reviewed and reported to UMC on a quarterly basis.
15	Quality of Service	Annual IRR will be presented to the UMC	Assess and measure consistency of applying medical necessity criteria	80% passing rate	Manager of Utilization Maagement	Bi-Annually	2nd and 4th Qtr	2nd, and 4th Quarter	Reviewed and reported to UMC on a Bi-annual basis with all UM, MLTSS and BH staff passing or completing necessary remediation class. See attachment 1-2
20	Quality of Clinical Care	UM Program Description	UM Program Description will be adopted on an annual basis	Adoption	Health Services Director	Annually	1st Qtr.	1st quarter	UM Program Description Revised, Reviewed and approved by UMC.
21	Quality of Clinical Care	Annual Evaluation of Utilization Management Program will be reviewed and updated	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis	Revisions/Adoption	Manager of Utilization Maagement	Annually	2nd Qtr.	2nd quarter	UM Program Description and UM work plan Revised, Reviewed and approved by UMC.
22	Quality of Clinical Care	Implement a UM program which utilizes medical necessity decisions consistently, are objective and based upon evidence based criteria	Annually approve Medical Necessity Criteria Policy	Review and Adoption	Manager of Utilization Maagement	Annually	1st Qtr.	1st quarter	UM policy reviewed and approved by UMC.
23	Quality of Service	Implement a UM program which provides access to staff for members and practitioners seeking information about the UM process and authorization of care	Annually review and approve Communication with Health Services Procedure	Review and Adoption	Manager of Utilization Maagement	Annually	1st Qtr.	1st quarter	UM policy reviewed and approved by UMC.

24	Quality of Clinical Care	Implement a UM program which utilizes qualified health professionals to assess clinical information to support UM decisions	Annually review and approve Appropriate professionals policy	Review and Adoption	Manager of Utilization Maagement	Annually	1st Qtr.	1st quarter	UM policy reviewed and approved by UMC.
25	Quality of Clinical Care	Implement a UM program which determines coverage based on medical necessity.	Annually review and approve Prior Authorization Procedure for clinical information	Review and Adoption	Manager of Utilization Maagement	Annually	1st Qtr.	1st quarter	UM policy reviewed and approved by UMC.
26	Quality of Service	Implement a UM program which documents and communicates reason for a denial with information on appeal process.	Annually review and approve Denial notification policy.	Review and Adoption	Manager of Utilization Maagement	Annually	1st Qtr.	1st quarter	UM policy reviewed and approved by UMC.
27	Quality of Clinical Care	Implement a UM program which evaluates inclusion of new technology and new application of existing technology to ensure that members have equitable access to safe and effective care	Annually review and approve New Technology Policy	Review and Adoption	Manager of Utilization Maagement	Annually	1st Qtr.	1st quarter	UM policy reviewed and approved by UMC.
	Quality of Clinical Care	Annual Adoption of Clinical Practice Guidelines and Preventive Guidelines (Medical and Behavioral)	Annually review and approve Clinical practice guidelines policy	Review and Adoption	Manager of Utilization Maagement	Annually	1st Qtr.	1st quarter	UM policy reviewed and approved by UMC.

UM Program Work Plan

SCFHP UTILIZATION MANAGEMENT WORK PLAN AND PROGRAM EVALUATION 2019

	WORK PLAN							EVALUATION	
	SCOPE	OBJECTIVE	ACTION STEPS	GOAL	RESPONSIBLE PARTY	REPORT FREQUENCY	TARGET DATE OF COMPLETION	DATE OF COMPLETION	FINDINGS/COMMENTS
1	Quality of Clinical Care	Expand on Current reporting and present findings to UMC	Review MediCal Inpatient Admissions/1000	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr		
2	Quality of Clinical Care	Monitor appropriate inpatient admissions	Review MediCal Inpatient Admissions/1000	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr		
3	Quality of Clinical Care	Monitor appropriateness of inpatient stays to assess proper level of care	Review MediCal Inpatient ALOS	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr		
4	Quality of Clinical Care	Monitor appropriateness of inpatient stays to assess proper level of care	Review CMC Inpatient ALOS	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr		
5	Quality of Clinical Care	Monitor Readmissions, all cause to minimize unnecessary premature discharge and applicable post discharge follow up and care.	MediCal Inpatient Readmissions	HEDIS goal	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr		
6	Quality of Clinical Care	Monitor Readmissions, all cause to minimize unnecessary premature discharge and applicable post discharge follow up and care.	CMC Inpatient Readmissions	HEDIS goal	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr		

7	Quality of Service	Assess Medi-Cal denial rates on PARs; provide benchmarks and compare to CA specific plans	Measure and act on denial rates on Outpatient PARs	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr		
8	Quality of Service	Assess CMC denial rates on PARs; provide benchmarks and compare to CA specific plans	Measure and act on denial rates on Inpatient PARs	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr		
9	Quality of Service	Track and monitor denial rates on PARs; provide benchmarks and compare to CA specific plans	Track and monitor BH IP Stays for CMC	MCG and CA benchmarks	Medical Director	Quarterly	1st, 2nd, 3rd, 4th Qtr		
10	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	MediCal ADD Follow-up Care for Children with ADD	HEDIS Benchmarks	Behavioral health Director	Quarterly	1st, 2nd, 3rd, 4th Qtr		
11	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	MediCal AMM Antidepressant Medication Management	HEDIS Benchmarks	Behavioral Health Director	Quarterly	1st, 2nd, 3rd, 4th Qtr		
12	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	CMC SMC Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	HEDIS Benchmarks	Behavioral Health Director	Quarterly	1st, 2nd, 3rd, 4th Qtr		

13	Quality of Service	Internal audit process and corrective action as necessary	Report Turn Around Times(TAT) for Prior Auth for Medi-Cal and CMC	DHCS and CMS regulatory TAT	Manager of Utilization Management	Quarterly	1st, 2nd, 3rd, 4th Qtr		
14	Quality of Service	Internal audit process and corrective action as necessary	Report TAT based on Priority for Medi-Cal and CMC	DHCS and CMS regulatory TAT	Manager of Utilization Management	Quarterly	1st, 2nd, 3rd, 4th Qtr		
15	Quality of Service	Annual IRR will be presented to the UMC	Assess and measure consistency of applying medical necessity criteria	80% passing rate	Manager of Utilization Management	Bi-Annually	2nd and 4th Qtr		
16	Quality of Service	Monitor Member and Provider experience	Conduct Member & Provider satisfaction survey	90% Satisfaction	Manager of Utilization Management	Annually	4th Quarter		
17	Quality of Clinical Care	UM Program Description	UM Program Description will be adopted on an annual basis	Adoption	Health Services Director	Annually	1st Qtr.		
18	Quality of Clinical Care	Annual Evaluation of Utilization Management Program will be reviewed and updated	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis	Revisions/Adoption	Manager of Utilization Management	Annually	2nd Qtr.		
19	Quality of Clinical Care	Implement a UM program which utilizes medical necessity decisions consistently, are objective and based upon evidence based criteria	Annually approve Medical Necessity Criteria Policy	Review and Adoption	Manager of Utilization Management	Annually	1st Qtr.		

20	Quality of Service	Implement a UM program which provides access to staff for members and practitioners seeking information about the UM process and authorization of care	Annually review and approve Communication with Health Services Procedure	Review and Adoption	Manager of Utilization Management	Annually	1st Qtr.		
21	Quality of Clinical Care	Implement a UM program which utilizes qualified health professionals to assess clinical information to support UM decisions	Annually review and approve Appropriate professionals policy	Review and Adoption	Manager of Utilization Management	Annually	1st Qtr.		
22	Quality of Clinical Care	Implement a UM program which determines coverage based on medical necessity.	Annually review and approve Prior Authorization Procedure for clinical information	Review and Adoption	Manager of Utilization Management	Annually	1st Qtr.		
23	Quality of Service	Implement a UM program which documents and communicates reason for a denial with information on appeal process.	Annually review and approve Denial notification policy.	Review and Adoption	Manager of Utilization Management	Annually	1st Qtr.		

24	Quality of Clinical Care	Implement a UM program which evaluates inclusion of new technology and new application of existing technology to ensure that members have equitable access to safe and effective care	Annually review and approve New Technology Policy	Review and Adoption	Manager of Utilization Management	Annually	1st Qtr.		
25	Quality of Clinical Care	Annual Adoption of Clinical Practice Guidelines and Preventive Guidelines (Medical and Behavioral)	Annually review and approve Clinical practice guidelines policy	Review and Adoption	Manager of Utilization Management	Annually	1st Qtr.		

Care Coordinator Guidelines

Santa Clara Family Health Plan

Care Coordinator Guidelines
Summary of Changes

Page	Section	Change
5	Skilled Level of Care (SNF)	VHP DOFR change: 1. Member must be CMC or Medi-Cal assigned to network: a. Independent Physician's b. Palo Alto Medical Foundation c. VHP-Fully delegated ~~c.~~d. ~~,~~ Kaiser, PMG, Premier Care – redirect to Network if within month of admission and month after admission. ~~d.~~ SCFHP will be financially responsible beginning 3rd month of admission
6	Long Term Care	VHP DOFR change 1. Member must be CMC or Medi-Cal assigned to network a. Independent Physician's b. Palo Alto Medical Foundation- MC only c. VHP ~~If the member is deemed to be at Long Term Level of Care, SCFHP will be responsible beginning the month after the facility admission~~ Long Term Custodial Care services become the financial responsibility of SCFHP on the 1st day of the month following admission if VHP submits the Enrollee reassignment request to SCFHP before that date.
7	Bed Hold	VHP DOFR change: **LTC and Skilled level of care in SNF:** 1. Member must be CMC or Medi-Cal assigned to network a. Independent Physician's b. Palo Alto Medical Foundation- MC only c. VHP will be responsible for Bed Hold during the time that member is delegated to them.

9	Hospice R&B for NCP	VHP DOFR change: 1. Member must be Medi-Cal with Medicare primary (Medicare does not cover room and board) assigned to: a. Independent Physician's b. Palo Alto Medical Foundation ~~b.~~c. VHP-fully delegated for hospice services ~~c.~~d. Any other network (~~VHP,~~ Kaiser, PMG, Premier Care) redirect to delegated network for authorization if within the month of and the month after admission date.
14	NEMT	Kaiser Contract for NEMT: 1. Member can be assigned to ~~any/all~~Independent Providers, VHP, PAMF, PMG, Premier Care and Medicare Primary. ~~1. networks all Lines of Business except Medi-Cal dual with Medicare part B primary~~ *Medicare part B covers ambulance transportation for Facility to Facility. *Kaiser is fully delegated for NEMT benefit
15	BHT	Change in APL:

		1. Member must be Medi-Cal or Healthy Kids and assigned to: a. Independent Providers b. Palo Alto Medical Foundation (PAMF) c. Physician's Medical Group (PMG) d. Premier Care (Conifer) e. Valley Health Plan (VHP) and Kaiser are delegated for BHT 2. A Prior Authorization Request (PAR) must be received by SCFHP from either a licensed physician or licensed psychologist. The appropriate ICD 10 code, ~~typically, (F 84.0)~~ must be identified on the PAR 3. Comprehensive Diagnostic Evaluations (CDEs) which are authorized by a licensed physician or psychologist are also accepted with a diagnosis of Autism or any other approved diagnosis per APL ~~15-025~~18-006. 4. The Coordinator will enter an authorization approving up to 10 hours for up to two months for a BHT assessment. 5. If there is not a specified provider identified initially, the authorization will be approved to an unspecified provider and then changed when a provider is identified. 6. Authorizations will be initiated according to UM guidelines: a. 72 hours for Urgent Requests b. 5 Business Days for Routine c. 30 Days for Retroactive 7. The Health Plan has 15 business days to identify a provider to complete the initial assessment. 8. Following the initial assessment where goals and treatment plans are identified, the plan will be approved for 180 days per APL ~~15-025.~~18-006 9. Any request which is greater than 25 hours per week for Direct Services will be reviewed by the Behavioral Health Director and may require a case conference with the provider.

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

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Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

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

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

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

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

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Inpatient Acute Hospitalization

1. Emergency and observation stay (no inpatient admission)-Does not require Prior Authorization.

2. Inpatient Admission via Emergency room:
   a. Medi-Cal
      - Independent Physician's-Approve 1 day
      - Palo Alto Medical Foundation- MC only (PAMF authorizes for HK)
      - **Out of area emergency admission**-All Networks

        In area emergency admission- VHP, Kaiser, PMG, Premier Care-Redirect to Delegated Group

   b. CMC-All emergency admissions, In area and Out of area approve 1 day
   c. Medi-Cal with Medicare A primary-create authorization and forward to MD for denial for other health provider primary.

3. Inpatient Admission Elective/Scheduled admission: (in area and out of area)
   a. Medi-Cal-Send to Nurse for review if no PA in system
      - Independent Physician's
      - Palo Alto Medical Foundation- MC only (PAMF authorizes for HK)

        ***Kaiser-Redirect to group

        ***VHP–Send to nurse for review for possible redirection back to network

        ***PMG and Premier care-Send to nurse for review. Possible LOA.

   b. Medi-Cal with Medicare A primary-create authorization and forward to MD for denial for other health provider primary.

4. Acute Rehab-send to nurse for review

5. LTAC-Long Term Acute Care-Send to nurse for review

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

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Skilled Level of Care (SNF)

1. Member must be CMC or Medi-Cal assigned to network:
    a. Independent Physician's
    b. Palo Alto Medical Foundation
    c. VHP-Fully delegated
    ~~c.~~d. ~~,~~ Kaiser, PMG, Premier Care – redirect to Network if within month of admission and month after admission.
        ~~d.~~ SCFHP will be financially responsible beginning 3rd month of admission
    e. Medicare primary
        - Without Medicare A-Apply CCG pre approval of 7 days and forward to nurse review for additional days
        - With Medicare A &B-forward to MD for denial. Medicare is financially responsible for skilled services with exemptions:
            - Skilled days exhausted (100 days per benefit period)

              *SNF must provide NOMNC or proof of exhausted Medicare Skilled Days
2. SNF sends Skilled level of care request to SCFHP UM.
3. Coordinator will approve initial 7 days.
4. Coordinator will forward this request to UM nurse for additional days and concurrent review.

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Commented [LA1]: There is nothing in the new VHP DOFR that says month of, or after for skilled care – Does this line ONLY refer to the other networks?

Commented [JC2R1]: Yes, this is only for the other networks. This is only under section "d" Kaiser PMG and Premier.

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Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Long Term Care

1. Member must be CMC or Medi-Cal assigned to network
    a. Independent Physician's
    b. Palo Alto Medical Foundation- MC only
    c. VHP~~, If the member is deemed to be at Long Term Level of Care, SCFHP will be responsible beginning the month after the facility admission~~ Long Term Custodial Care services become the financial responsibility of SCFHP on the 1st day of the month following admission if VHP submits the Enrollee reassignment request to SCFHP before that date.
    ~~c.~~d. Kaiser, PMG, Premier Care-redirect to Network if within month of admission and month after admission.

    *** If member is LTC during the time of eligibility, network must be changed to Independent Provider (except for PAMF and Kaiser).

2. SNF sends LTC request (PAR) to SCFHP UM
3. Coordinator will approve initial authorization for 6 months with receipt of complete required LTC PAR documentation from the provider.
4. Authorization will remain "in process" status and will be assigned to LTC nurse for further review. Send Authorization letter.
5. Nurse may recommend Last Covered Day to MD if LTC criteria is not met.
6. Coordinator will approve 1 year LTC Re-Authorizations with complete LTC PAR documentation and attachments for members that have been in LTC for 2 years or more. These re-authorizations will remain "in process" status and will be assigned to the LTC UM RN for further review. Send re-authorization letter.
7. Re-authorizations for members residing in LTC less than 2 years will be forwarded to nurse for review.

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

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Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Bed Hold

LTC and Skilled level of care in SNF:

1. Member must be CMC or Medi-Cal assigned to network
    a. Independent Physician's
    b. Palo Alto Medical Foundation- MC only
    c. VHP will be responsible for Bed Hold during the time that member is delegated to them.
    ~~c.~~d. ~~,~~ Kaiser, PMG, Premier Care redirect to Network if within month of admission and month after admission.
2. Bed Hold Notification Form is received from Facility
3. Coordinator will enter and approve up to 7 days max per Medi-Cal benefit.
    - Separate authorization will be created for Bed Hold.
4. If bed hold request if over 7 days, or if member is out of SNF bed over 7 days, existing LTC or skilled auth will be updated with correct DC date and a new skilled or LTC auth will be created for the days following the bed hold to continue auth for the level of care.

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Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Home Health

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

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

3. Approve initial request ordered by contracted hospital or physician up to total of 11 visits (Combination of services: PT, OT, ST, Nurse, SW, HHA)

4. Initial request exceeding 11 visits must be forwarded to nurse for review.

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

Hospice Room and Board for Non-Contracted Providers

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

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

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

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

5. Care coordinator may approve up to 90 days.

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

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

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Hearing Aid

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

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

3. Current Audiology exam done by an Audiologist

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Hearing Aid – Repair

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

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

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

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Outpatient Physical, Occupational and Speech Therapy

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

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

3. Approve initial request ordered by contracted hospital or physician up to total of 12 visits (Combination of services: PT, OT, ST,)

4. Initial request exceeding 12 visits must be forwarded to nurse for review.

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

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

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Wheelchair repair

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

2. Wheelchair must be 3 year old or less.

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

Utilization Management
Care Coordinator Guidelines

Non-Emergency Transportation

1. Member can be assigned to ~~any/all~~Independent Providers, VHP, PAMF, PMG, Premier Care and Medicare Primary.

~~1. networks all Lines of Business except Medi-Cal dual with Medicare part B primary~~

*Medicare part B covers ambulance transportation for Facility to Facility.
*Kaiser is fully delegated for NEMT benefit

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

3. Non emergency ground transportation-Approve x 1.

4. Non emergency ground transportation for Dialysis-Approve up to 1 year for initial and reauthorization.

5. Non emergency Air transportation-Forward to nurse for review.

6. Non Medical Transportation (wheelchair van, litter van, cab, etc.) are processed within Customer Service.

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Santa Clara Family Health Plan

Behavioral Health Treatment (BHT) Guidelines

1. Member must be Medi-Cal or Healthy Kids and assigned to:
    a. Independent Providers
    b. Palo Alto Medical Foundation (PAMF)
    c. Physician's Medical Group (PMG)
    d. Premier Care (Conifer)
    e. Valley Health Plan (VHP) and Kaiser are delegated for BHT
2. A Prior Authorization Request (PAR) must be received by SCFHP from either a licensed physician or licensed psychologist. The appropriate ICD 10 code, ~~typically, (F 84.0)~~ must be identified on the PAR
3. Comprehensive Diagnostic Evaluations (CDEs) which are authorized by a licensed physician or psychologist are also accepted with a diagnosis of Autism or any other approved diagnosis per APL ~~15-025~~18-006.
4. The Coordinator will enter an authorization approving up to 10 hours for up to two months for a BHT assessment.
5. If there is not a specified provider identified initially, the authorization will be approved to an unspecified provider and then changed when a provider is identified.
6. Authorizations will be initiated according to UM guidelines:
    a. 72 hours for Urgent Requests
    b. 5 Business Days for Routine
    c. 30 Days for Retroactive
7. The Health Plan has 15 business days to identify a provider to complete the initial assessment.
8. Following the initial assessment where goals and treatment plans are identified, the plan will be approved for 180 days per APL ~~15-025.~~18-006
9. Any request which is greater than 25 hours per week for Direct Services will be reviewed by the Behavioral Health Director and may require a case conference with the provider.

Santa Clara Family Health Plan™

Mbr Ct S		Cap Month												
LOB	Network Name	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
CMC		**7,435**	**7,440**	**7,503**	**7,523**	**7,540**	**7,600**	**7,601**	**7,625**	**7,695**	**7,750**	**7,814**	**7,884**	**7,869**
	Santa Clara Family Health Plan	7,435	7,440	7,503	7,523	7,540	7,600	7,601	7,625	7,695	7,750	7,814	7,884	7,869
MC		**251,680**	**249,188**	**248,776**	**247,755**	**245,954**	**245,884**	**244,493**	**243,399**	**242,695**	**239,998**	**240,010**	**239,836**	**239,444**
	INDEPENDENT PHYSICIANS	15,394	15,641	15,829	15,739	16,138	15,831	15,776	15,760	15,813	15,655	15,807	15,756	15,759
	KAISER PERMANENTE	26,048	26,072	26,056	25,939	25,926	25,925	25,801	25,682	25,468	25,152	25,227	25,442	25,428
	MEDICARE PRIMARY	13,582	13,695	13,735	13,814	13,847	13,870	13,931	14,132	14,270	14,262	14,344	14,409	14,504
	PALO ALTO MEDICAL FOUNDATION	7,310	7,300	7,228	7,265	7,241	7,176	7,133	7,082	7,055	6,999	7,009	6,984	6,976
	PHYSICIANS MEDICAL GROUP	46,377	46,113	45,881	45,481	44,905	44,979	44,553	44,100	43,866	43,311	43,107	42,996	42,718
	PREMIER CARE	15,687	15,643	15,628	15,570	15,487	15,251	15,176	15,139	15,110	14,946	14,911	14,873	14,813
	VHP NETWORK	127,282	124,724	124,419	123,947	122,410	122,852	122,123	121,504	121,113	119,673	119,605	119,376	119,246
HK		**3,454**	**3,220**	**3,196**	**3,278**	**3,187**	**3,163**	**3,217**	**3,460**	**3,345**	**3,252**	**3,375**	**3,348**	**3,465**
	INDEPENDENT PHYSICIANS	386	355	349	365	368	331	338	386	382	382	400	390	380
	PALO ALTO MEDICAL FOUNDATION	93	111	93	94	92	99	97	94	89	88	92	82	92
	PHYSICIANS MEDICAL GROUP	1,142	1,076	1,089	1,138	1,111	1,124	1,144	1,227	1,200	1,131	1,179	1,169	1,230
	PREMIER CARE	248	240	237	230	230	235	234	248	233	243	261	252	265
	VHP NETWORK	1,585	1,438	1,428	1,451	1,386	1,374	1,404	1,505	1,441	1,408	1,443	1,455	1,498
Grand Total		**262,569**	**259,848**	**259,475**	**258,556**	**256,681**	**256,647**	**255,311**	**254,484**	**253,735**	**251,000**	**251,199**	**251,068**	**250,778**

Santa Clara Family Health Plan

InterRater Reliability Summary
2019 #1

1. In accordance with Policy HS.09, Santa Clara Family Health Plan (SCFHP) UM Staff scheduled and completed the first of two required Bi-Annual IRR testing sessions on 4/8/2019. The first IRR testing session is expected to be completed within the first half of calendar year 2019. In accordance with NCQA/DHCS, DMHC guidelines, and SCFHP policy, a total of 10 hypothetical UM authorizations are created for testing purposes for all of our Utilization Management (UM and MLTSS) staff, including non-licensed Care Coordinators (CC), licensed professional staff, and Medical Directors (MD).
2. The intent of the IRR testing process is to evaluate the consistency and accuracy of review criteria applied by all reviewers - physicians and non-physicians - who are responsible for conducting Utilization Management reviews and to act on improvement opportunities identified through this monitoring.
3. The Utilization Management Leadership team will review and approve the evaluation summary report reflecting the decision making performance of the staff responsible for conducting Utilization Management reviews. The report results and recommendations for improvement will be presented to the Utilization Management Committee.
4. The Plan classifies reviews into one of two performance categories: Proficient (80% - 100% of the records are in compliance with the criteria); Not proficient (below 80% in compliance) Scores below 80% require increased focus by UM Management with actions described in Policy HS.09 or a corrective action plan.

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

UM Staff Position	Pass/Fail	Score %
Medical Director 1	Pass	83
Medical Director 2	Pass	91
Health Services Director	Pass	85
UM Manager	Pass	98
UM Supervisor	Pass	93
UM review and DC planning nurse-1	Pass	90
Utilization Management Review Nurse-1	Pass	83
Utilization Management Review Nurse-2	Pass	94
Medical Management Care Coordinator-1	Pass	80
Medical Management Care Coordinator-2	Pass	90
Medical Management Care Coordinator-3	Pass	95
Medical Management Care Coordinator-4	Pass	93
Medical Management Care Coordinator-5	Pass	98
UM Clerk-Temp	Pass	83
Medical Management Review Nurse	Pass	98
MLTSS UM review and DC planning nurse	Pass	90
MLTSS Case Manager-Nurse	Pass	81
MLTSS Medical Management Care Coordinator	Pass	80

In the 1st testing in 2019, we found that 100% or 18/18 of our staff that participated in the IRR testing are proficient while.
1 new staff did not complete the IRR testing and will be completing the IRR testing within the 1st half of the calendar year. The result will be reported to UMC.

The second bi-annual IRR testing will be conducted on the second half of the calendar year. The results will be reported to UMC on the 4th Quarter meeting of 2019.

Attachment 2

InterRater Reliability Summary – Behavioral Health Department
2019

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

The following are the findings for all UM staff tested on March 9th, 2018:

Reviewer	Percent Score	UM Staff Position	Pass/Failed
1	100	Behavioral Health PCC	Pass
2	100	Behavioral Health PCC	Pass
3	100	Project Manager BHT	Pass
4	100	Manager Hehavioral Health	Pass

In the testing, we found that 4/4 of our staff are proficient during this review. There was no need for any corrective action planning. The Project Manager for Behavioral Health Treatment has provided trainings to Behavioral Health staff to monitor and implement any necessary UM Chagnes.

Currently all Behavioral Health Department PCCs have received a passing grade.

Our common finding after the testing process was:

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

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

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

Santa Clara Family Health Plan

TURN AROUND TIME: CAL MEDICONNECT

HEALTH SERVICES COMBINED

UTILIZATION MANAGEMENT					
Pre-Service Organization Determinations - HS	YTD 2018	Jan 2019	Feb 2019	March 2019	YTD 2019
Standard Part C					
# of Prior Authorization Requests Received	**5,796**	597	525	576	**1,698**
# of Prior Auth Requests Completed within 14 days	**5,628**	596	523	576	**1,695**
% of Timely Decisions made within 14 days	**97.1%**	99.8%	99.6%	100.0%	**99.8%**
# Approved	**5,524**	556	495	541	**1,592**
# Denied	**274**	41	30	35	**106**
% Approved	**95.3%**	93.1%	94.3%	93.9%	**93.8%**
# of Prior Authorization Notification Sent	**3,226**	597	525	576	**1,698**
# of Prior Authorization Notification Sent Within 14 Days	**3,170**	593	521	564	**1,678**
% Timely Notification of HS decision	**98.3%**	99.3%	99.2%	97.9%	**98.8%**
Expedited Part C					
# of Prior Authorization Requests Received	**2,585**	279	269	315	**863**
# of Prior Auth Requests Completed within 72 Hours	**2,493**	278	269	308	**855**
% of Timely Decisions made within 72 Hours	**96.4%**	99.6%	100.0%	97.8%	**99.1%**
# of Requests with Extensions	**unavailable**	unavailable	unavailable	unavailable	**unavailable**
# Approved	**2,418**	259	257	303	**819**
# Denied	**169**	20	12	12	**44**
% Approved	**93.5%**	92.8%	95.5%	96.2%	**94.9%**
# of Prior Authorization Notification Sent	**1,499**	279	269	315	**863**
# of Prior Authorization Notification Sent Within 72 hours	**1,451**	271	268	298	**837**
% timely notification of HS decision	**96.8%**	97.1%	99.6%	94.6%	**97.0%**
Urgent Concurrent Organization Determinations					
# of Urgent Concurrent Requests Received	**133**	15	16	7	**38**
# of Urgent Concurrent Requests Completed within 24 Hours	**103**	11	15	5	**31**
% of Timely Decisions made within 24 Hours	**77.4%**	73.3%	93.8%	71.4%	**81.6%**
# Approved	**132**	15	16	7	**38**
# Denied	**1**	0	0	0	-
% Approved	**99.2%**	100%	100%	100%	**100.0%**
# of Prior Authorization Notification Sent	**90**	15	16	7	**#DIV/0!**
# of Prior Authorization Notification Sent Within 24 hours	**71**	11	15	6	**32**
% timely notification of HS decision	**78.9%**	73.3%	93.8%	85.7%	**#DIV/0!**
Post Service Organization Determinations					
# of Requests Received	**453**	30	36	48	**114**
# of Post Service Requests Completed within 30 Days	**438**	30	36	48	**114**
% of Timely Decisions made within 30 days	**96.7%**	100%	100.0%	100%	**100.0%**
# of Requests with Extensions	**unavailable**	unavailable	unavailable	unavailable	**unavailable**
# Approved	**446**	30	35	47	**112**
# Denied	**7**	0	1	1	**2**
% Approved	**98.5%**	100.0%	97%	97.9%	**98.2%**
# of Prior Authorization Notification Sent	**255**	30	36	48	**114**
# of Prior Authorization Notification Sent Within 30 Days	**247**	30	35	46	**111**
% timely notification of HS decision	**96.9%**	100.0%	97.2%	95.8%	**97.4%**

UTILIZATION MANAGEMENT

Pre-Service Organization Determinations - UM	YTD 2018	Jan 2019	Feb 2019	March 2019	YTD 2019
Standard Part C					
# of Prior Authorization Requests Received	**5,266**	563	498	550	**1,611**
# of Prior Auth Requests Completed within 14 days	**5,119**	562	496	550	**1,608**
% of Timely Decisions made within 14 days	**97.2%**	99.8%	99.6%	100.0%	**99.8%**
# Approved	**4,995**	523	468	515	**1,506**
# Denied	**272**	40	30	35	**105**
% Approved	**94.9%**	92.9%	94.0%	93.6%	**93.5%**
# of Prior Authorization Notification Sent	**2,993**	563	498	550	**1,611**
# of Prior Authorization Notification Sent Within 14 Days	**2,941**	559	494	538	**1,591**
% timely notification of UM decision	**98.3%**	99.3%	99.2%	97.8%	**98.8%**
Expedited Part C					
# of Prior Authorization Requests Received	**2,583**	279	269	315	**863**
# of Prior Auth Requests Completed within 72 Hours	**2,491**	278	269	308	**855**
% of Timely Decisions made within 72 Hours	**96.4%**	99.6%	100.0%	97.8%	**99.1%**
# of Requests with Extensions	**unavailable**	unavailable	unavailable	unavailable	**unavailable**
# Approved	**2,416**	259	257	303	**819**
# Denied	**169**	20	12	12	**44**
% Approved	**93.5%**	92.8%	95.5%	96.2%	**94.9%**
# of Prior Authorization Notification Sent	**1,496**	279	269	315	**863**
# of Prior Authorization Notification Sent Within 72 hours	**1,448**	271	268	298	**837**
% timely notification of UM decision	**96.8%**	97.1%	99.6%	94.6%	**97.0%**
Urgent Concurrent Organization Determinations					
# of Urgent Concurrent Requests Received	**134**	15	16	7	**38**
# of Urgent Concurrent Requests Completed within 24 Hours	**107**	11	15	5	**31**
% of Timely Decisions made within 24 Hours	**79.9%**	73.3%	93.8%	71.4%	**81.6%**
# Approved	**132**	15	16	7	**38**
# Denied	**1**	0	0	0	-
% Approved	**98.5%**	100%	100%	100%	**100.0%**
# of Prior Authorization Notification Sent	**81**	15	16	7	
# of Prior Authorization Notification Sent Within 24 hours	**65**	11	15	6	**#DIV/0!**
% timely notification of UM decision	**80.2%**	73.3%	93.8%	85.7%	**n/a**
Post Service Organization Determinations					
# of Requests Received	**277**	13	19	20	**52**
# of Post Service Requests Completed within 30 Days	**262**	13	19	20	**52**
% of Timely Decisions made within 30 days	**94.6%**	100%	100.0%	100%	**100.0%**
# of Requests with Extensions	**unavailable**				
# Approved	**271**	13	18	19	**50**
# Denied	**6**	0	1	1	**2**
% Approved	**97.8%**	100.0%	95%	95%	**96.2%**
# of Prior Authorization Notification Sent	**139**	13	19	20	**52**
# of Prior Authorization Notification Sent Within 30 Days	**134**	13	18	20	**51**
% timely notification of UM decision	**96.4%**	100.0%	94.7%	100.0%	**98.1%**

BEHAVIORAL HEALTH

Pre-Service Organization Determinations - BH	YTD 2018	Jan 2019	Feb 2019	March 2019	YTD 2019
Standard Part C					
# of Prior Authorization Requests Received	**41**	6	1	-	**#DIV/0!**
# of Prior Auth Requests Completed within 14 days	**40**	6	1	-	**#DIV/0!**
% of Timely Decisions made within 14 days	**97.6%**	100.0%	100.0%	#DIV/0!	**#DIV/0!**
# Approved	**41**	6	1	-	**7**
# Denied	-	0	0	0	-
% Approved	**100.0%**	100.0%	100.0%	#DIV/0!	**#DIV/0!**
# of Prior Authorization Notification Sent	**16**	6	1	0.0%	**7**
# of Prior Authorization Notification Sent Within 14 Days	**16**	6	1	0.0%	**7**
% timely notification of BH decision	**100.0%**	100.0%	100.0%	n/a	**100.0%**
Expedited Part C					
# of Prior Authorization Requests Received	**2**	0	0	0	-
# of Prior Auth Requests Completed within 72 Hours	**2**	0	0	0	-
% of Timely Decisions made within 72 Hours	**100.0%**	n/a	n/a	n/a	**n/a**
# of Requests with Extensions	**unavailable**	unavailable	unavailable	unavailable	**unavailable**
# Approved	**2**	0	0	0	-
# Denied	-	0	0	0	-
% Approved	**0.0%**	n/a	n/a	n/a	**n/a**
# of Prior Authorization Notification Sent	**2**	0	0	0	**0**
# of Prior Authorization Notification Sent Within 72 hours	**2**	0	0	0	**0**
% timely notification of BH decision	**100.0%**	n/a	n/a	n/a	**n/a**
Urgent Concurrent Organization Determinations					
# of Urgent Concurrent Requests Received	-	0	0	0	-
# of Urgent Concurrent Requests Completed within 24 Hours	-	0	0	0	-
% of Timely Decisions made within 24 Hours	**n/a**	n/a	n/a	n/a	**n/a**
# Approved	-	0	0	0	-
# Denied	-	0	0	0	-
% Approved	**n/a**	n/a	n/a	n/a	**n/a**
# of Prior Authorization Notification Sent	-	0	0	0	**0**
# of Prior Authorization Notification Sent Within 24 hours	-	0	0	0	**0**
% timely notification of BH decision	**n/a**	n/a	n/a	n/a	**n/a**
Post Service Organization Determinations					
# of Requests Received	**47**	1	1	1	**3**
# of Post Service Requests Completed within 30 Days	**47**	1	1	1	**3**
% of Timely Decisions made within 30 days	**100.0%**	100%	100.0%	100%	**100.0%**
# of Requests with Extensions	**unavailable**	unavailable	unavailable	unavailable	**unavailable**
# Approved	**47**	1	1	1	**3**
# Denied	-	0	0	0	-
% Approved	**100.0%**	100.0%	100%	100%	**100.0%**
# of Prior Authorization Notification Sent	**23**	1	1	1	**3**
# of Prior Authorization Notification Sent Within 30 Days	**21**	1	1	1	**3**
% timely notification of BH decision	**91.3%**	100.0%	100.0%	100.0%	**100.0%**

MLTSS

Pre-Service Organization Determinations - MLTSS	YTD 2018	Jan 2019	Feb 2019	March 2019	YTD 2019
Standard Part C					
# of Prior Authorization Requests Received	**490**	28	26	26	**80**
# of Prior Auth Requests Completed within 14 days	**469**	28	26	26	**80**
% of Timely Decisions made within 14 days	**95.7%**	100.0%	100.0%	100.0%	**100.0%**
# Approved	**488**	27	26	26	**79**
# Denied	**2**	1	0	0	**1**
% Approved	**99.6%**	96.4%	100.0%	100.0%	**98.8%**
# of Prior Authorization Notification Sent	**214**	28	26	26	**80**
# of Prior Authorization Notification Sent Within 14 Days	**210**	28	26	26	**80**
% timely notification of MLTSS decision	**98.1%**	100.0%	100.0%	100.0%	**100.0%**
Expedited Part C					
# of Prior Authorization Requests Received	**1**	0	0	0	-
# of Prior Auth Requests Completed within 72 Hours	**1**	0	0	0	-
% of Timely Decisions made within 72 Hours	**100.0%**	n/a	n/a	n/a	**n/a**
# of Requests with Extensions	**unavailable**	unavailable	unavailable	unavailable	**unavailable**
# Approved	**1**	0	0	0	-
# Denied	-	0	0	0	-
% Approved	**100.0%**	n/a	n/a	n/a	**n/a**
# of Prior Authorization Notification Sent	**1**	0	0	0	**0**
# of Prior Authorization Notification Sent Within 72 hours	**1**	0	0	0	**0**
% timely notification of MLTSS decision	**100.0%**	n/a	n/a	n/a	**n/a**
Urgent Concurrent Organization Determinations					
# of Urgent Concurrent Requests Received	-	0	0	0	-
# of Urgent Concurrent Requests Completed within 24 Hours	-	0	0	0	-
% of Timely Decisions made within 24 Hours	**n/a**	n/a	n/a	n/a	**n/a**
# Approved	-	0	0	0	-
# Denied	-	0	0	0	-
% Approved	**n/a**	n/a	n/a	n/a	**n/a**
# of Prior Authorization Notification Sent	-	0	0	0	**0**
# of Prior Authorization Notification Sent Within 24 hours	-	0	0	0	**0**
% timely notification of MLTSS decision	**n/a**	n/a	n/a	n/a	**n/a**
Post Service Organization Determinations					
# of Requests Received	**129**	16	16	27	**59**
# of Post Service Requests Completed within 30 Days	**129**	16	16	27	**59**
% of Timely Decisions made within 30 days	**100.0%**	100%	100.0%	100%	**100.0%**
# of Requests with Extensions	**unavailable**	unavailable	unavailable	unavailable	**unavailable**
# Approved	**128**	16	16	27	**59**
# Denied	**1**	0	0	0	-
% Approved	**99.2%**	100.0%	100%	100%	**100.0%**
# of Prior Authorization Notification Sent	**80**	16	16	27	**59**
# of Prior Authorization Notification Sent Within 30 Days	**80**	16	16	25	**57**
% timely notification of MLTSS decision	**100.0%**	100.0%	100.0%	92.6%	**96.6%**

Santa Clara Family Health Plan

TURN AROUND TIME: MEDI-CAL

HEALTH SERVICES COMBINED

	2018	2019			
	YTD	Jan	Feb	Mar	YTD
Medical Authorizations - HS Combined					
Routine Authorizations					
# of Routine Prior Authorization Requests Received	**12,993**	1,112	1,003	1,082	**3,197**
# of Routine Prior Authorization Requests Completed within 5 Business Days	**12,032**	1,088	981	1,066	**3,135**
% of Timely Decisions made within 5 Business Days of request	**92.6%**	97.8%	97.8%	98.5%	**98.1%**
# of Prior Authorization Notification Sent	**7,044**	1,112	1,003	1,082	**3,197**
# of Prior Authorization Notification Sent Within 5 Business Days	**6,873**	1,100	978	1,054	**3,132**
% timely notification of HS decision	**97.6%**	98.9%	97.5%	97.4%	**98.0%**
Expedited Authorizations					
# of Expedited Prior Authorization Requests Received	**2,205**	148	149	234	**531**
# of Expedited Prior Authorization Requests Completed within 72 Hours	**2,141**	148	149	230	**527**
% of Timely Decisions made within 72 Hours of request	**97.1%**	100.0%	100.0%	98.3%	**99.2%**
# of Prior Authorization Notification Sent	**1,266**	148	149	231	**528**
# of Prior Authorization Notification Sent Within 72 hours	**1,248**	144	147	230	**521**
% timely notification of HS decision	**98.6%**	97.3%	98.7%	99.6%	**98.7%**
Urgent Concurrent Review					
# of Urgent Concurrent Requests Received	**111**	10	5	9	**24**
# of Urgent Concurrent Requests Completed within 24 Hours of request	**94**	10	5	9	**24**
% of Timely Decisions made within 24 Hours of request	**84.7%**	100.0%	100.0%	100.0%	**100.0%**
# of Prior Authorization Notification Sent	**67**	10	5	9	**24**
# of Prior Authorization Notification Sent Within 24 hours	**65**	0	4	9	**13**
% timely notification of HS decision	**97.0%**	0.0%	80.0%	100.0%	**54.2%**
Retrospective Review					
# of Retrospective Requests Received	**2,118**	207	159	282	**648**
# of Retrospective Requests completed within 30 Calendar Days of request	**2,066**	206	159	280	**645**
% of Retrospective Reviews completed within 30 Calendar Days of request	**97.5%**	99.5%	100.0%	99.3%	**99.5%**
# of Prior Authorization Notification Sent	**1,606**	207	159	282	**648**
# of Prior Authorization Notification Sent Within 30 Calendar days	**1,569**	195	155	278	**628**
% timely notification of HS decision	**97.7%**	94.2%	97.5%	98.6%	**96.9%**
Denied Authorizations (Routine, Expedited, CCR, Retro)					
Total Requests Approved	**16,733**	1403	1254	1514	**4,171**
Total Requests Denied	**892**	74	62	93	**229**
Total Requests Pended/Extended	-	0	0	0	-
Total Requests Cancelled	-	0	0	0	-
% of Total Requests Denied	**5.1%**	5.0%	4.7%	5.8%	**5.2%**

UTILIZATION MANAGEMENT

	2018	2019			
	YTD	Jan	Feb	Mar	YTD
Medical Authorizations - UM					
Routine Authorizations					
# of Routine Prior Authorization Requests Received	**9,497**	871	790	865	**2,526**
# of Routine Prior Authorization Requests Completed within 5 Business Days	**9,038**	852	777	854	**2,483**
% of Timely Decisions made within 5 Business Days of request	**95.2%**	97.8%	98.4%	98.7%	**98.3%**
# of Prior Authorization Notification Sent	**5,264**	871	790	865	**2,526**
# of Prior Authorization Notification Sent Within 5 Business Days	**5,117**	861	769	845	**2,475**
% timely notification of UM decision	**97.2%**	98.9%	97.3%	97.7%	**98.0%**
Expedited Authorizations					
# of Expedited Prior Authorization Requests Received	**2,175**	147	149	229	**525**
# of Expedited Prior Authorization Requests Completed within 72 Hours	**2,115**	147	149	225	**521**
% of Timely Decisions made within 72 Hours of request	**97.2%**	100.0%	100.0%	98.3%	**99.2%**
# of Prior Authorization Notification Sent	**1,247**	147	149	229	**525**
# of Prior Authorization Notification Sent Within 72 hours	**1,230**	143	147	226	**516**
% timely notification of UM decision	**98.6%**	97.3%	98.7%	98.7%	**98.3%**
Urgent Concurrent Review					
# of Urgent Concurrent Requests Received	**111**	10	5	9	**24**
# of Urgent Concurrent Requests Completed within 24 Hours of request	**94**	10	5	9	**24**
% of Timely Decisions made within 24 Hours of request	**84.7%**	100.0%	100.0%	100.0%	**100.0%**
# of Prior Authorization Notification Sent	**67**	10	5	9	**24**
# of Prior Authorization Notification Sent Within 24 hours	**65**	10	4	9	**23**
% timely notification of UM decision	**97.0%**	100.0%	80.0%	100.0%	**95.8%**
Restrospective Review					
# of Retrospective Requests Received	**914**	70	50	130	**250**
# of Retrospective Requests completed within 30 Calendar Days of request	**869**	69	50	128	**247**
% of Retrospective Reviews completed within 30 Calendar Days of request	**95.1%**	98.6%	100.0%	98.5%	**98.8%**
# of Prior Authorization Notification Sent	**631**	70	50	130	**250**
# of Prior Authorization Notification Sent Within 30 Calendar days	**606**	60	48	128	**236**
% timely notification of UM decision	**96.0%**	85.7%	96.0%	98.5%	**94.4%**
Denied Authorizations (Routine, Expedited, CCR, Retro)					
Total Requests Approved	**12,042**	1,026	936	1,143	**3,105**
Total Requests Denied	**845**	72	58	90	**220**
Total Requests Pended/Extended	**unavailabl**	unavailable	unavailable	unavailable	**unavailable**
Total Requests Cancelled	**unavailabl**	unavailable	unavailable	unavailable	**unavailable**
% of Total Requests Denied	**6.6%**	6.6%	5.8%	7.3%	**6.6%**

BEHAVIORAL HEALTH

	2018	2019			
	YTD	Jan	Feb	Mar	YTD
Routine Authorizations					
# of Routine Prior Authorization Requests Received	**593**	77	51	62	**190**
# of Routine Prior Authorization Requests Completed within 5 Business Days	**565**	73	42	60	**175**
% of Timely Decisions made within 5 Business Days of request	**95.3%**	94.8%	82.4%	96.8%	**92.1%**
# of Prior Authorization Notification Sent	**312**	77	51	62	**190**
# of Prior Authorization Notification Sent Within 5 Business Days	**310**	77	49	60	**186**
% timely notification of BH decision	**99.4%**	100.0%	96.1%	96.8%	**97.9%**
Expedited Authorizations					
# of Expedited Prior Authorization Requests Received	**29**	1	0	5	**6**
# of Expedited Prior Authorization Requests Completed within 72 Hours	**26**	1	0	5	**6**
% of Timely Decisions made within 72 Hours of request	**89.7%**	100.0%	n/a	100.0%	**100.0%**
# of Prior Authorization Notification Sent	**19**	1	0	5	**6**
# of Prior Authorization Notification Sent Within 72 hours	**18**	1	0	5	**6**
% timely notification of BH decision	**94.7%**	100.0%	n/a	100.0%	**100.0%**
Urgent Concurrent Review					
# of Urgent Concurrent Requests Received	-	0	0	0	-
# of Urgent Concurrent Requests Completed within 24 Hours of request	-	0	0	0	-
% of Timely Decisions made within 24 Hours of request	**n/a**	n/a	n/a	n/a	**n/a**
# of Prior Authorization Notification Sent		0	0	0	
# of Prior Authorization Notification Sent Within 24 hours		0	0	0	
% timely notification of BH decision	**n/a**	n/a	n/a	n/a	**n/a**
Restrospective Review					
# of Retrospective Requests Received	**137**	25	5	14	**44**
# of Retrospective Requests completed within 30 Calendar Days of request	**136**	25	5	14	**44**
% of Retrospective Reviews completed within 30 Calendar Days of request	**99.3%**	100.0%	100.0%	100.0%	**100.0%**
# of Prior Authorization Notification Sent	**104**	25	5	14	**44**
# of Prior Authorization Notification Sent Within 30 Calendar days	**104**	25	5	14	**44**
% timely notification of BH decision	**100.0%**	100.0%	100.0%	100.0%	**100.0%**
Denied Authorizations (Routine, Expedited, CCR, Retro)					
Total Requests Approved	**677**	102	53	79	**234**
Total Requests Denied	**12**	1	3	2	**6**
Total Requests Pended/Extended	-	0	0	0	-
Total Requests Cancelled	-	0	0	0	-
% of Total Requests Denied	**1.7%**	1.0%	5.4%	2.5%	**2.5%**

MLTSS

	2018	2019			
	YTD	Jan	Feb	Mar	YTD
Medical Authorizations - MLTSS					
Routine Authorizations					
# of Routine Prior Authorization Requests Received	**2,903**	164	162	155	**481**
# of Routine Prior Authorization Requests Completed within 5 Business Days	**2,429**	163	162	152	**477**
% of Timely Decisions made within 5 Business Days of request	**83.7%**	99.4%	100.0%	98.1%	**99.2%**
# of Prior Authorization Notification Sent	**1,471**	164	162	155	**481**
# of Prior Authorization Notification Sent Within 5 Business Days	**1,448**	162	160	149	**471**
% timely notification of MLTSS decision	**98.4%**	98.8%	98.8%	96.1%	**97.9%**
Expedited Authorizations					
# of Expedited Prior Authorization Requests Received	**1**	0	0	0	-
# of Expedited Prior Authorization Requests Completed within 72 Hours	-	0	0	0	-
% of Timely Decisions made within 72 Hours of request	**0%**	n/a	n/a	n/a	**#DIV/0!**
# of Prior Authorization Notification Sent	**unavailable**	0	0	0	**unavailable**
# of Prior Authorization Notification Sent Within 72 hours	**unavailable**	0	0	0	**unavailable**
% timely notification of MLTSS decision	**unavailable**	n/a	n/a	n/a	**unavailable**
Urgent Concurrent Review					
# of Urgent Concurrent Requests Received	-	0	0	0	-
# of Urgent Concurrent Requests Completed within 24 Hours of request	-	0	0	0	-
% of Timely Decisions made within 24 Hours of request	**#DIV/0!**	n/a	n/a	n/a	**#DIV/0!**
# of Prior Authorization Notification Sent	**unavailable**	0	0	0	**unavailable**
# of Prior Authorization Notification Sent Within 24 hours	**unavailable**	0	0	0	**unavailable**
% timely notification of MLTSS decision	**unavailable**	n/a	n/a	n/a	**unavailable**
Restrospective Review					
# of Retrospective Requests Received	**1,078**	112	104	138	**354**
# of Retrospective Requests completed within 30 Calendar Days of request	**1,071**	112	104	138	**354**
% of Retrospective Reviews completed within 30 Calendar Days of request	**99.4%**	100.0%	100.0%	100.0%	**100.0%**
# of Prior Authorization Notification Sent	**882**	112	104	138	**354**
# of Prior Authorization Notification Sent Within 30 Calendar days	**870**	110	102	136	**348**
% timely notification of MLTSS decision	**98.6%**	98.2%	98.1%	98.6%	**98.3%**
Denied Authorizations (Routine, Expedited, CCR, Retro)					
Total Requests Approved	**3,981**	275	265	292	**832**
Total Requests Denied	**29**	1	1	1	**3**
Total Requests Pended/Extended	-	0	0		-
Total Requests Cancelled	-	0	0		-
% of Total Requests Denied	**0.7%**	0.4%	0.4%	0.3%	**0.4%**

Santa Clara Family Health Plan™

Utilization Management Committee (UMC)

April 2019

UMC Goals and Objectives

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

Inpatient Utilization: Medi-Cal – Non-SPD 1/1/2018 – 12/31/2018

Source: HEDIS Inpatient Utilization (IPU) data for measurement year ending 12/31/2018

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2018 Q1	2,565	4.10	9,490	3.70
2018 Q2	2,348	3.82	8,329	3.55
2018 Q3	2,527	4.18	9,095	3.60
2018 Q4	2,435	4.09	8,871	3.64
Total	9,875	4.05	35,785	3.62

TNInpatient Utilization: Medi-Cal – SPD 1/1/2018 – 12/31/2018

Source: HEDIS Inpatient Utilization (IPU) data for measurement year ending 12/31/2018

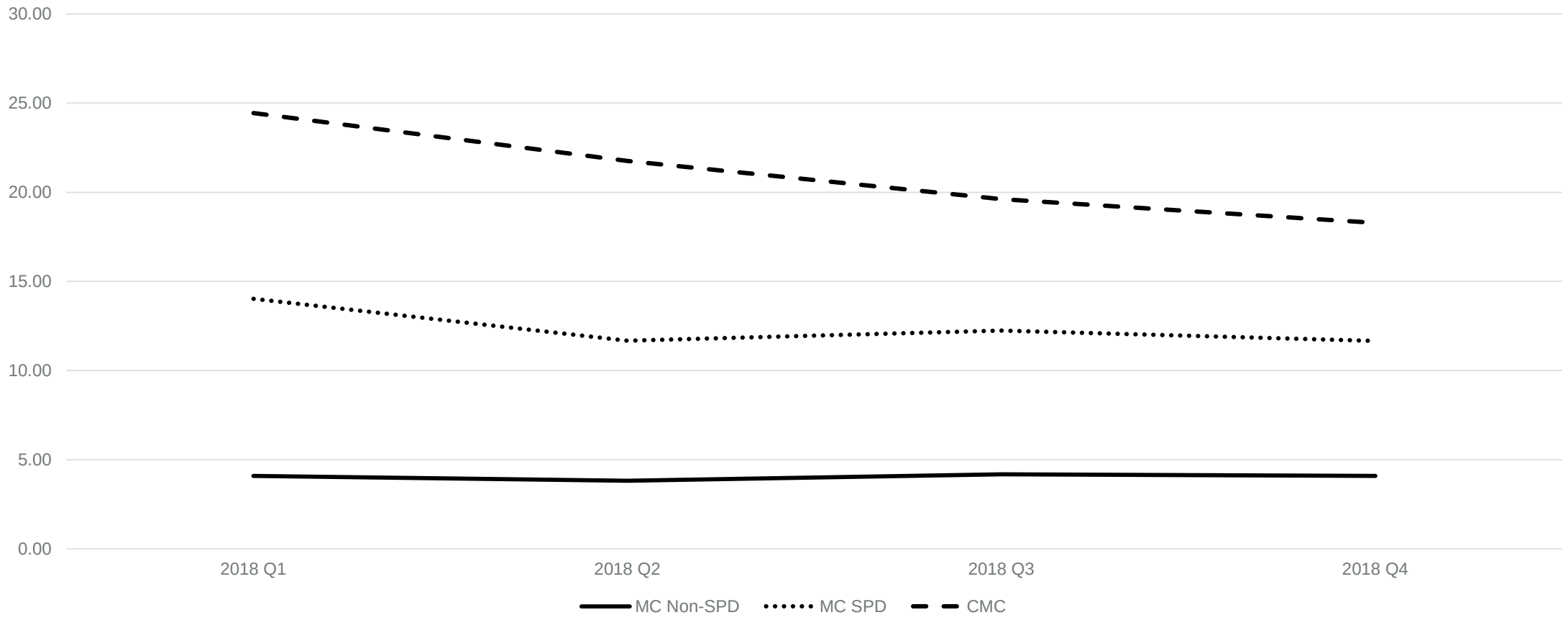
Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2018 Q1	932	14.02	4,728	5.07
2018 Q2	777	11.68	3,830	4.93
2018 Q3	809	12.25	3,666	4.53
2018 Q4	768	11.67	3,786	4.93
Total	3,286	12.41	16,010	4.87

Inpatient Utilization: Cal MediConnect (CMC) 1/1/2018 – 12/31/2018

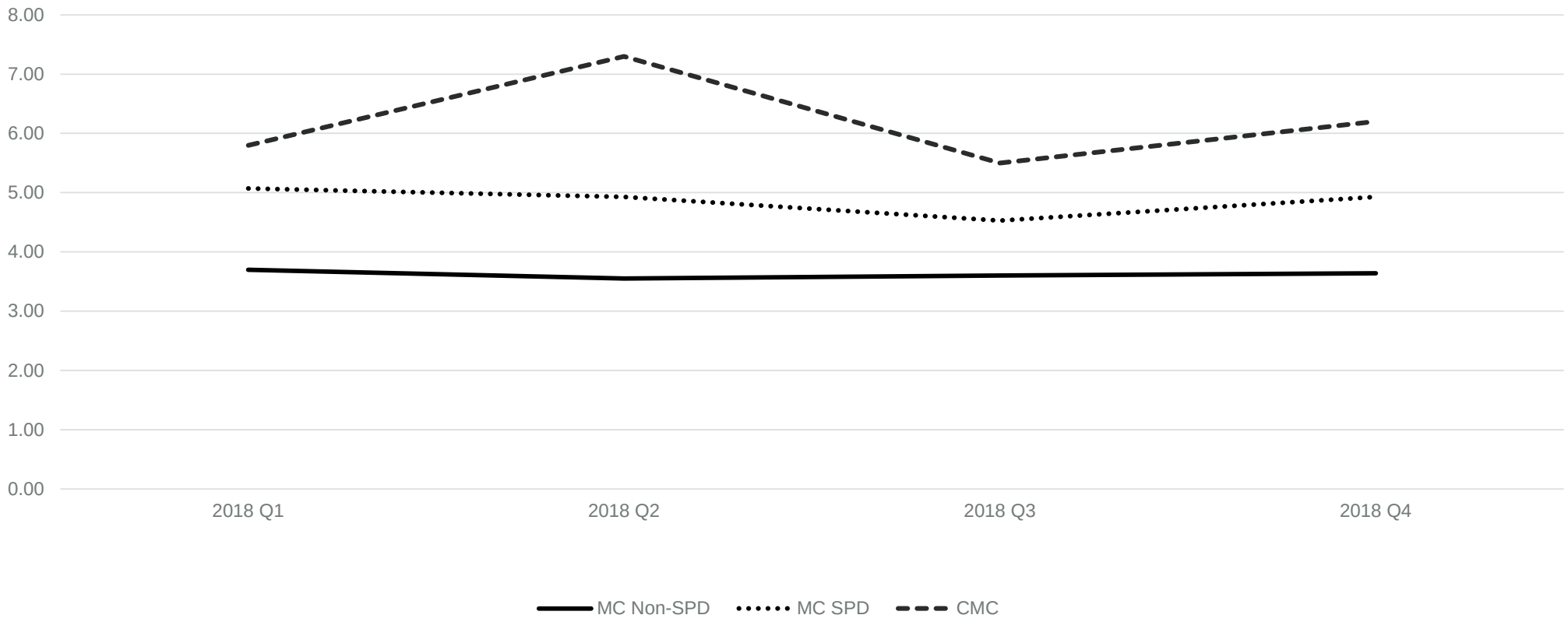
Source: CMC Enrollment & QNXT Claims Data

Quarter	Discharges	Discharges / 1,000 Members per Year	Days	Average Length of Stay
2018 Q1	548	271.5	3,556	5.8
2018 Q2	492	259.5	3,145	7.3
2018 Q3	447	244.8	2,433	5.5
2018 Q4	422	271.0	2,463	6.2
Total	1,909	261.8	11,597	6.2

SCFHP Medi-Cal & Cal MediConnect
Acute Inpatient Discharges per 1,000 Member Months (MM)
1/1/2018 – 12/31/2018



SCFHP Medi-Cal & Cal MediConnect
Acute Inpatient Average Length of Stay (ALOS)
1/1/2018 – 12/31/2018



Medi-Cal Inpatient Utilization NCQA Medicaid Benchmark Comparisons 1/1/2018 – 12/31/2018

	Medi-Cal Population		
Measure	**Non-SPD**	**SPD**	**Total**
Discharges / 1,000 Member Months	4.05	12.41	4.87
NCQA Medicaid Percentile Rank[1]	<10th	>90th	<10th
ALOS	3.62	4.87	3.94
NCQA Medicaid Percentile Rank[2]	<25th	>75th	<50th

[1] NCQA Medicaid 50th percentile = 6.54
[2] NCQA Medicaid 50th percentile = 4.18

Medi-Cal SPD & CMC Inpatient Utilization
MCG & NCQA Medicare Benchmark Comparisons
1/1/2018 – 12/31/2018

	Discharges / 1,000 Members per Year	Days / 1,000 Members per Year	ALOS
SCFHP Population			
Medi-Cal SPD	148.9	725.4	5.07
CMC	261.8	1,674.5	6.20
MCG Medicare Plans			
Loosely Managed	258.7	1,406.9	5.44
Moderately Managed	214.8	1,078.7	5.02
Well Managed	171.0	750.6	4.39
NCQA Medicare Mean	214.6	1,208.9	5.41

Inpatient Readmissions: Medi-Cal – Non-SPD

Source: HEDIS All Cause Readmissions (ACR) data for 1/1/2018 – 12/31/2018 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1, 2]
2018 Q1	2,605	285	10.94%
2018 Q2	2,442	305	12.49%
2018 Q3	2,545	267	10.49%
2018 Q4	1,680	171	10.18%
Total	9,273	1,028	11.09%

[1] A lower rate indicates better performance.
[2] The 30-day readmission rate for the ACR measure is Medi-Cal specific and only includes non-dual members ages 21 years and older.

Inpatient Readmissions: Medi-Cal – SPD

Source: HEDIS All Cause Readmissions (ACR) data for 1/1/2018 – 12/31/2018 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1,2]
2018 Q1	1,049	243	23.16%
2018 Q2	890	193	21.69%
2018 Q3	896	197	21.99%
2018 Q4	577	133	23.05%
Total	3,412	766	22.45%

[1] A lower rate indicates better performance.
[2] The 30-day readmission rate for the ACR measure is Medi-Cal specific and only includes non-dual members ages 21 years and older.

Inpatient Readmissions: Cal MediConnect (CMC)

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 1/1/2018 – 12/31/2018 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1, 2]
2018 Q1	462	91	19.70%
2018 Q2	430	68	15.81%
2018 Q3	390	53	13.59%
2018 Q4	247	34	13.77%
Total	1,529	246	16.09%

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

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

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 1/1/2018 – 12/31/2018 measurement period

Rate Description	Ages 18 – 64 (PCR-A)	Ages 65+ (PCR-B)
Count of Index Hospital Stays	352	1177
Count of 30-Day Readmissions	63	183
Actual Readmission Rate	17.90%	15.55%
NCQA Medicare 50th Percentile	16.34%	12.68%
SCFHP Percentile Ranking	>90th	>50th

[1] A lower rate indicates better performance.

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

Frequency of Selected Procedures: Medi-Cal

Source: HEDIS data for 1/1/2018 – 12/31/2018 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Tonsillectomy				
Male & Female, Age 0-9	194	0.31	0.63	↓
Male & Female, Age 10-19	84	0.13	0.29	↓
Hysterectomy, abdominal				
Female, Age 15-44	16	0.03	0.10	↓
Female, Age 45-64	49	0.17	0.24	↓
Hysterectomy, vaginal				
Female, Age 15-44	21	0.04	0.10	↓
Female, Age 45-64	28	0.1	0.17	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 1/1/2018 – 12/31/2018 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Cholecystectomy, open				
Male, Age 30-64	9	0.02	0.03	↓
Female, Age 15-44	3	0.01	0.01	↔
Female, Age 45-64	4	0.01	0.03	↓
Cholecystectomy, closed (laparoscopic)				
Male, Age 30-64	64	0.16	0.26	↓
Female, Age 15-44	257	0.45	0.61	↓
Female, Age 45-64	79	0.27	0.58	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 1/1/2018 – 12/31/2018 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Back Surgery				
Male, Age 20-44	16	0.05	0.19	↓
Female, Age 20-44	15	0.04	0.14	↓
Male, Age 45-64	30	0.12	0.52	↓
Female, Age 45-64	32	0.11	0.51	↓
Mastectomy				
Female, Age 15-44	14	0.02	0.02	↑
Female, Age 45-64	24	0.08	0.12	↓
Lumpectomy				
Female, Age 15-44	43	0.07	0.11	↓
Female, Age 45-64	84	0.29	0.34	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 1/1/2018 – 12/31/2018 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Bariatric Weight Loss Surgery				
Male, Age 0-19	1	0.00	0.00	↔
Female, Age 0-19	1	0.00	0.00	↔
Male, Age 20-44	5	0.02	0.01	↑
Female, Age 20-44	40	0.09	0.05	↑
Male, Age 45-64	6	0.02	0.01	↑
Female, Age 45-64	27	0.09	0.06	↑

ADHD Medi-Cal Behavioral Health Metrics

Source: HEDIS data for 1/1/2018 – 12/31/2018 measurement period

Measure	Rate	NCQA Medicaid 50th Percentile	SCFHP Percentile Rank
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	64.68%	44.80%	>90th
Continuation & Maintenance Phase	73.49%	55.90%	>90th
Antidepressant Medication Management			
Acute Phase Treatment	62.24%	57.90%	>75th
Continuation Phase Treatment	46.07%	36.21%	>75th
Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia	66.67%	77.94%	<10th

Santa Clara Family Health Plan™

Questions?

Santa Clara Family Health Plan

Quarterly Quality Monitoring for UM Procedure: HS04 01

I. Purpose of the Quality Assurance (QA)

In order to present the results to Utilization Management Committee (UMC), Santa Clara Family Health Plan (SCFHP) completed the 4th quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations.

II. Procedure

Santa Clara Family Health Plan reviewed in accordance to this procedure, 30 authorizations for the 1st quarter of 2019 in order to assess for the following elements.

A. Quality Monitoring

1. The UM Manager is responsible for facilitating a random review of denial letters to assess the integrity of member and provider notification.
    a. At least 30 denial letters per quarter
    b. Is overseen by the Utilization Management Committee on a quarterly basis
    c. Assessment of denial notices includes the following:
        1. Turn-around time for decision making
        2. Turn-around time for member notification
        3. Turn-around time for provider notification
        4. Assessment of the reason for the denial, in clear and concise language
        5. Includes criteria or Evidence of Benefit (EOB) applied to make the denial decision and instructions on how to request a copy of this from UM department.
        6. Type of denial: medical or administrative
        7. Addresses the clinical reasons for the denial
        8. Specific to the Cal MediConnect membership, the denial notification includes what conditions would need to exist to have the request be approved.
        9. Appeal and Grievance rights
        10. Member's letter is written in member's preferred language within plan's language threshold.
        11. Member's letter includes interpretation services availability
        12. Member's letter includes nondiscriminatory notice.
        13. Provider notification includes the name and direct phone number of the appropriately licensed professional making the denial decision

Quarterly Quality Report in Accordance with Procedure HS.04.01
For 3rd Quarter 2018

III. Findings

For the 1st quarter review of 2019, the findings are as follows:

A. For the dates of services and denials for the months of January, February and March of CY 2019 were pulled in the 1st quarter sampling year.
   a. 30 unique authorizations were pulled with a random sampling.
      i. 60% or 12/30 Medi-Cal LOB and 40% or 18/30 CMC LOB
      ii. 100% or 30/30 were denials
      iii. 27% or 8/30 were expedited request; 73% or 22/30 were standard request.
         1. 88% or 7/8 of the expedited authorizations are compliant with regulatory turnaround time of 72 calendar hours , 12% or 1/8 of the expedited authorizations are non-compliant with regulatory turnaround time of 72 calendar hours ,
         2. 100% or 22/22 of the standard authorizations are compliant with regulatory turnaround time. (5 business days for Medi-Cal LOB and 14 calendar days for CMC LOB)
      iv. 97% or 29/30 were medical denials, 3% or 1/30 was administrative denials
      v. 97% or 29/30 of cases were denied by MD, 3% or 1/30 was denied by a Pharmacist
      vi. 100% or 30/30 were provided member and provider notification.
      vii. 100% or 8/8 expedited authorizations were provided oral notifications to member.
      viii. 100% or 30/30 of the member letters are of member's preferred language.
      ix. 90% or 27/30 of the letters were readable and rationale for denial was provided.
      x. 90% or 27/30 of the letters included the criteria or EOC that the decision was based upon.
      xi. 100% or 30/30 of the letters included interpreter rights and instructions on how to contact CMO or Medical Director.

IV. Follow-Up

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

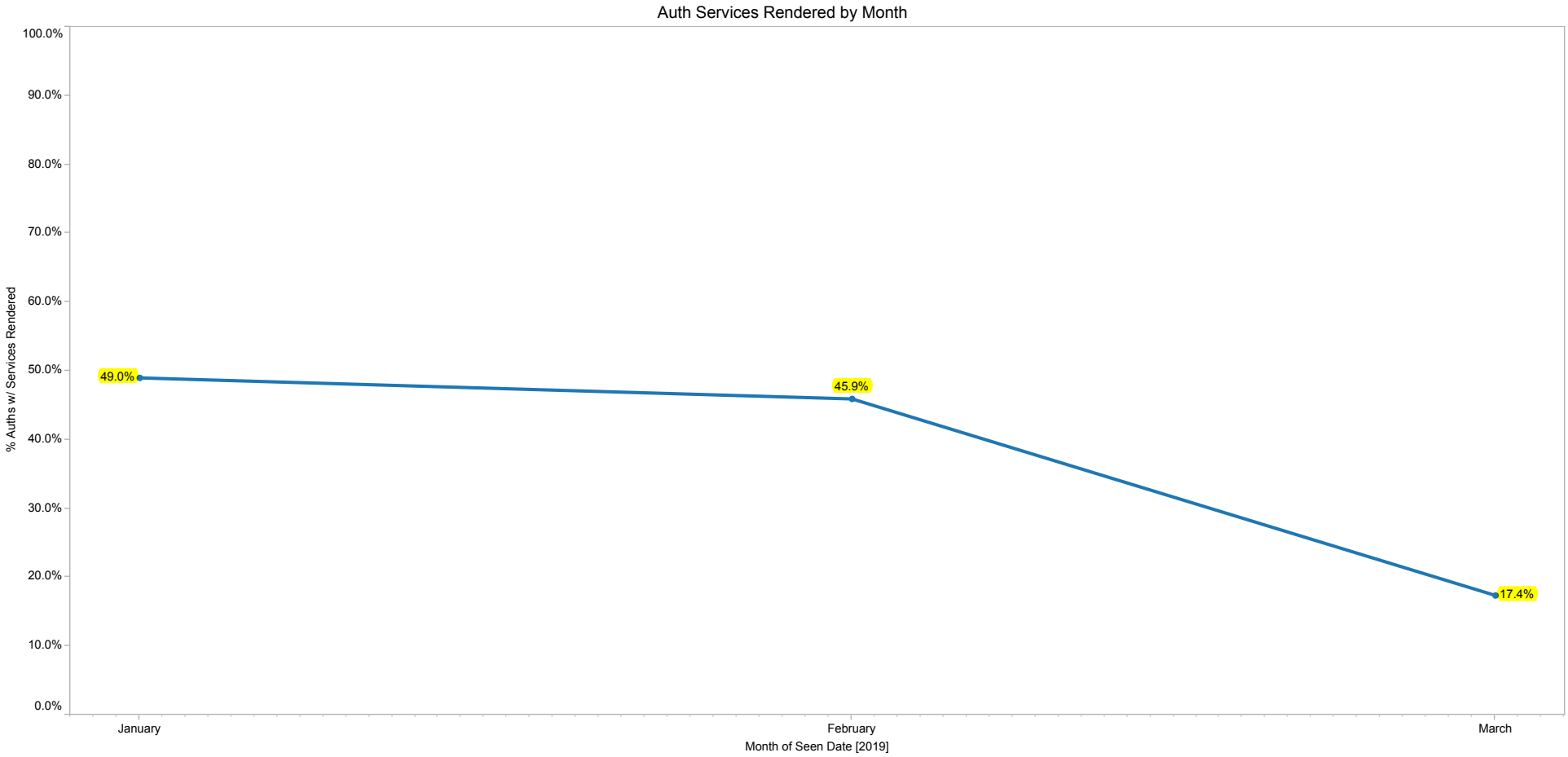
1. Provide staff training in managing regulatory turnaround time based on LOB by utilizing self-run report of pending Authorization based on days left to review.
2. Re-education of staff in avoiding Medical abbreviations in member letters and using appropriate Evidence of Coverage (EOC) based on member's enrollment (Medi-Cal vs Cal MediConnect) if the denial is based on Coverage denial and the denial letter is quoting the EOC.
3. Re-education of staff to utilize letter view feature of the Letter Generator program prior to sending the denial letter to review all aspects of the letter including the template, content of the letter and the letter packet.
4. Continue QA monitoring and reporting.

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Cal MediConnect	CBAS	Retro Request	4	4	0	0	0.0%
		Routine - Extended Service	8	7	0	1	12.5%
		Routine - Initial Request	4	4	0	0	0.0%
	CONT OF CARE	Non Contracted Provider - Ro..	1	1	0	0	0.0%
		Routine - Initial Request	1	0	0	1	100.0%
	CONT OF CARE GR	Routine - Initial Request	1	0	0	1	100.0%
	DME	Non Contracted Provider - Ro..	6	4	0	2	33.3%
		Non Contracted Provider - Urg..	2	1	0	1	50.0%
		Retro Request	15	6	0	9	60.0%
		Routine - Extended Service	8	3	0	5	62.5%
		Routine - Initial Request	184	111	0	73	39.7%
		Urgent - Initial Request	20	9	0	11	55.0%
	HomeHealth	Non Contracted Provider - Ret..	1	0	0	1	100.0%
		Non Contracted Provider - Ro..	1	0	0	1	100.0%
		Non Contracted Provider - Urg..	97	45	0	52	53.6%
		Retro Request	7	2	0	5	71.4%
		Routine - Extended Service	4	3	0	1	25.0%
		Routine - Initial Request	4	2	0	2	50.0%
		Urgent - Extended Service	110	22	0	88	80.0%
		Urgent - Initial Request	144	48	0	96	66.7%
	HOSPICE	Non Contracted Provider - Ret..	2	2	0	0	0.0%
		Non Contracted Provider - Ro..	2	0	0	2	100.0%
		Non Contracted Provider - Urg..	3	0	0	3	100.0%
	OP-Behavorial	Non Contracted Provider - Ret..	3	3	0	0	0.0%
		Routine - Initial Request	1	0	0	1	100.0%
	OPHospital	Non Contracted Provider - Ro..	25	14	0	11	44.0%
		Non Contracted Provider - Urg..	21	7	0	14	66.7%
		Retro Request	6	3	0	3	50.0%
		Routine - Extended Service	20	8	0	12	60.0%
		Routine - Initial Request	585	177	0	408	69.7%
		Urgent - Extended Service	11	4	0	7	63.6%
		Urgent - Initial Request	251	94	0	157	62.5%

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Cal MediConnect	OPHospitalGr	Non Contracted Provider - Ro..	1	0	0	1	100.0%
		Non Contracted Provider - Urg..	1	0	0	1	100.0%
		Retro Request	5	2	0	3	60.0%
		Routine - Extended Service	4	2	0	2	50.0%
		Routine - Initial Request	87	29	0	58	66.7%
		Urgent - Extended Service	3	0	0	3	100.0%
		Urgent - Initial Request	43	24	0	19	44.2%
	Transportation	Retro Request	6	1	0	5	83.3%
		Routine - Extended Service	1	0	0	1	100.0%
		Routine - Initial Request	68	8	0	60	88.2%
Grand Total			**1,771**	**650**	**0**	**1,121**	**63.3%**

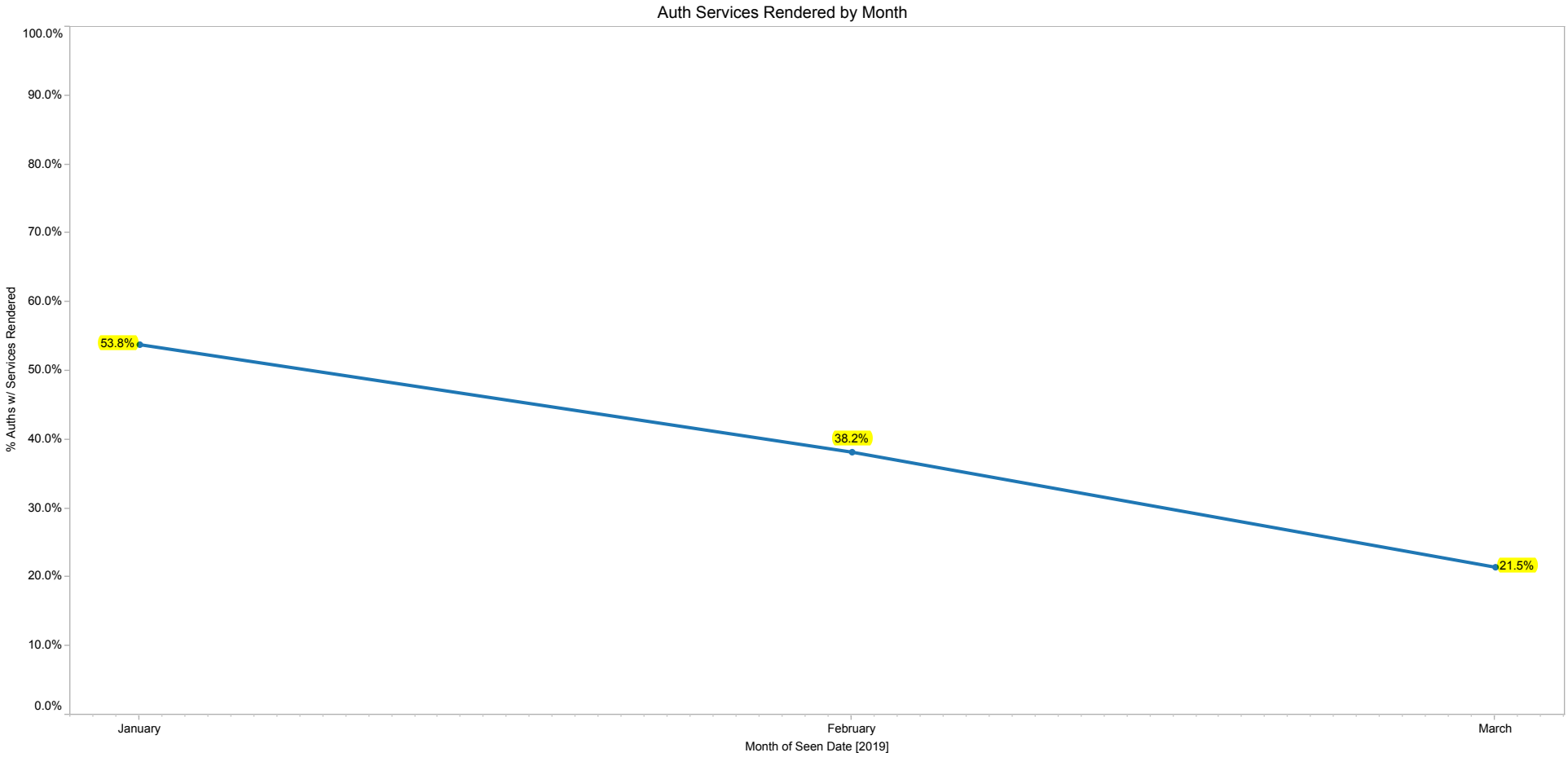

Auth Services Rendered by Month
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
% Auths w/ Services Rendered
49.0%
45.9%
17.4%
January
February
March
Month of Seen Date [2019]

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Medi-Cal	CBAS	Retro Request	10	7	0	3	30.0%
		Routine - Extended Service	54	41	0	13	24.1%
		Routine - Initial Request	22	16	0	6	27.3%
	CONT OF CARE	Routine - Initial Request	2	1	0	1	50.0%
	CONT OF CARE GR	Routine - Initial Request	1	0	0	1	100.0%
	Dental	Routine - Initial Request	37	24	0	13	35.1%
		Urgent - Initial Request	22	13	0	9	40.9%
	DME	Non Contracted Provider - Ret..	9	6	0	3	33.3%
		Non Contracted Provider - Ro..	2	0	0	2	100.0%
		Retro Request	121	58	0	63	52.1%
		Routine - Extended Service	6	2	0	4	66.7%
		Routine - Initial Request	307	168	0	139	45.3%
		Urgent - Extended Service	2	0	0	2	100.0%
		Urgent - Initial Request	20	7	0	13	65.0%
	HomeHealth	Non Contracted Provider - Ret..	1	0	0	1	100.0%
		Non Contracted Provider - Ro..	1	1	0	0	0.0%
		Non Contracted Provider - Urg..	1	0	0	1	100.0%
		Retro Request	2	1	0	1	50.0%
		Routine - Extended Service	11	4	0	7	63.6%
		Routine - Initial Request	5	3	0	2	40.0%
		Urgent - Extended Service	25	6	0	19	76.0%
		Urgent - Initial Request	35	15	0	20	57.1%
	HOSPICE	Non Contracted Provider - Ret..	10	8	0	2	20.0%
		Non Contracted Provider - Ro..	1	0	0	1	100.0%
		Non Contracted Provider - Urg..	3	1	0	2	66.7%
		Retro Request	1	1	0	0	0.0%
	OP-BehavioralGr	Non Contracted Provider - Ret..	1	1	0	0	0.0%
		Non Contracted Provider - Ro..	1	0	0	1	100.0%
	OP-Behavorial	Non Contracted Provider - Ret..	30	17	0	13	43.3%
		Non Contracted Provider - Ro..	45	18	0	27	60.0%
		Retro Request	22	6	0	16	72.7%
		Routine - Extended Service	76	60	0	16	21.1%

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Medi-Cal	OP-Behavorial	Routine - Initial Request	62	18	0	44	71.0%
		Urgent - Extended Service	2	0	0	2	100.0%
		Urgent - Initial Request	4	0	0	4	100.0%
	OPHospital	Non Contracted Provider - Ret..	8	2	0	6	75.0%
		Non Contracted Provider - Ro..	35	7	0	28	80.0%
		Non Contracted Provider - Urg..	9	7	0	2	22.2%
		Retro Request	17	10	0	7	41.2%
		Routine - Extended Service	25	5	0	20	80.0%
		Routine - Initial Request	432	122	0	310	71.8%
		Urgent - Extended Service	13	3	0	10	76.9%
		Urgent - Initial Request	198	69	0	129	65.2%
	OPHospitalGr	Non Contracted Provider - Ret..	2	0	0	2	100.0%
		Non Contracted Provider - Ro..	2	1	0	1	50.0%
		Non Contracted Provider - Urg..	1	0	0	1	100.0%
		Retro Request	9	1	0	8	88.9%
		Routine - Extended Service	53	9	0	44	83.0%
		Routine - Initial Request	420	142	0	278	66.2%
		Urgent - Extended Service	12	5	0	7	58.3%
		Urgent - Initial Request	79	36	0	43	54.4%
	Transportation	Retro Request	57	19	0	38	66.7%
		Routine - Extended Service	2	0	0	2	100.0%
		Routine - Initial Request	460	91	0	369	80.2%
		Urgent - Extended Service	1	0	0	1	100.0%
		Urgent - Initial Request	1	0	0	1	100.0%
Grand Total			**2,790**	**1,032**	**0**	**1,758**	**63.0%**


Auth Services Rendered by Month
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
% Auths w/ Services Rendered
53.8%
38.2%
21.5%
January
February
March
Month of Seen Date [2019]

2019 Q1 Nurse Advice Line Stats by LOB

1. Call Volume summary

Medi-Cal: 1804 total calls to NAL

- 53 “Call 911 Immediately” dispositions (2.9% of all NAL calls this LOB))

Healthy Kids: 48 total calls to NAL

- 1 “Call 911 Immediately” disposition (hives) (2.1% of all NAL calls this LOB)

Cal MediConnect: 116 total calls to NAL

- 11 ”Call 911 Immediately” dispositions (**9.5% of all NAL calls this LOB)

2. Highest volume for Triage Guidelines used for 911 Dispositions

Medi-Cal:

- Irregular heartbeat, seizure, GI Bleeding, Post pregnancy issues, Pregnancy pre-term labor, Dizziness/Vertigo, Chest pain, Neurological deficits, fainting, poisoning, Diabetes control problems, Allergic reactions, Headache, Pediatric difficulty breathing, Adult breathing problems, Weakness/Paralysis, Dementia, Bronchiolitis (peds), Teeth/Jaw problems, Croup (peds), vaginal bleeding, Confusion/Disorientation/Agitation

Healthy Kids:

- Hives

Cal MediConnect:

- Diabetes Control Issues, Flank pain, Breathing problems, Chest pain, Poisoning, Weakness/Paralysis

Stats on Autism

(ABA Services & Other BHT)

BEHAVIORAL HEALTH

MILD TO MODERATE REFERRALS

CY 2018

- Medi-CAL only referrals sent from County Call Center, excluding VHP and Kaiser
- Authorizations for non-contracted providers for CY 2018:

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
10	19	12	17	21	3	10	29	8	10	15	10

CY 2019

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
12	17	10									

BHT SERVICES

CY 2018

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
NA	185	184	189	194	200	186	197	202	207	219	224

CY 2019

New referrals for BHT

Excludes VHP and Kaiser

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
13	8	12									