Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, July 21, 2021, 6:00-7:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave., San Jose, CA 95119

Via Zoom
(669) 900-6833
Meeting ID: 858 1226 4736
Passcode: **umc072021**
https://us06web.zoom.us/j/85812264736

AGENDA

1. Introduction	Dr. Lin	6:00	5 min
2. Public Comment Members of the public may speak to any item not on the agenda; two minutes per speaker. The committee reserves the right to limit the duration of public comment to 30 minutes.	Dr. Lin	6:05	5 min
3. Meeting Minutes Review minutes of the Q2 April 21, 2021 Utilization Management Committee (UMC) meeting. **Possible Action:** Approve Q2 2021 UMC Meeting Minutes.	Dr. Lin	6:10	5 min
4. Chief Executive Officer Update Discuss status of current topics and initiatives.	Ms. Tomcala	6:15	5 min
5. Chief Medical Officer Update **a.** General Update	Dr. Nakahira	6:20	5 min
6. Old Business/Follow-Up Items **a.** Prior Authorization Volume 2019 vs. 2020 vs. 2021 **b.** Plan All-Cause Readmissions Rates Due to COVID-19	Dr. Huynh	6:25	5 min
7. UM Policy Updates **a.** HS.02 Medical Necessity Criteria **Possible Action:** Approve UM policy updates.	Dr. Huynh	6:30	5 min
8. Inter-Rater Reliability (IRR) UM Report – 2021 Annual review of IRR UM Report.	Dr. Boris	6:35	5 min

9. UM Review of Delegation Results and Process **a.** Annual Review of UM Delegation Results **b.** Annual Review of the UM Delegation Process **Possible Action:** Approve UM Review of Delegation Results and Process.	Dr. Huynh	6:40	10 min
10. UM 1B Annual Provider and Member Satisfaction with UM Process - 2020 Review of Annual Provider and Member Satisfaction with UM Process – 2020.	Dr. Boris	6:50	5 min
11. Reports			
a. Membership	Dr. Boris	6:55	5 min
b. Over/Under Utilization by Procedure Type/Standard UM Metrics			
c. Dashboard Metrics • Turn-Around Time – Q2 2021	Mr. Perez	7:00	5 min
d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q2 2021	Ms. Vu	7:05	10 min
e. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q2 2021			
f. Behavioral Health UM	Ms. McKelvey	7:15	15 min
12. Adjournment Next meeting: October 20, 2021 at 6:00 p.m.	Dr. Lin	7:30	

Notice to the Public—Meeting Procedures

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

Santa Clara Family Health Plan™

Public Comment

Santa Clara Family Health Plan™

Meeting Minutes – April 21, 2021

Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, April 21, 2021 6:00 – 7:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Minutes

Members Present
Jimmy Lin, M.D., Internal Medicine, Chair
Ali Alkoraishi, M.D., Psychiatry
Ngon Hoang Dinh, OB/GYN
Laurie Nakahira, D.O., Chief Medical Officer
Habib Tobbagi, PCP, Nephrology

Members Absent
Dung Van Cai, D.O., Head & Neck
Indira Vemuri, Pediatric Specialist

Staff Present
Christine Tomcala, Chief Executive Officer
Dang Huynh, PharmD, Director, Utilization Management & Pharmacy
Lily Boris, M.D., Medical Director
Natalie McKelvey, Manager, Behavioral Health
Luis Perez, Supervisor, Utilization Management
Hoang Mai Vu, Utilization Management & Discharge Planning Nurse
Amy O'Brien, Administrative Assistant

1. Roll Call

Jimmy Lin, MD, Chair, called the meeting to order at 6:05 p.m. Roll call was taken and a quorum was established. Dr. Huynh introduced the new SCFHP Utilization Management and Discharge Planning Nurse, Hoang Mai Vu.

2. Public Comment

There were no public comments.

3. Meeting Minutes

The minutes of the January 20, 2021 Utilization Management Committee (UMC) meeting were reviewed.

It was moved, seconded, and the minutes of the January 20, 2021 UMC meeting were **unanimously approved.**

Motion: Dr. Nakahira
Seconded: Dr. Tobbagi
Ayes: Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi
Absent: Dr. Cai, Dr. Dinh, Dr. Vemuri

4. Chief Executive Officer Update

Christine Tomcala, Chief Executive Officer, highlighted the Plan's collaboration with the County Emergency Operations center to hold pop-up vaccination clinics at the Community Resource Center (CRC). At least 300 vaccines were administered during each clinic. The most recent clinic was held on January 19, and SCFHP

was given 470 vaccines. Of those 470 vaccines, there were some left over, which may be attributable to the vaccine hesitancy issue. Ms. Tomcala confirmed SCFHP will connect with Dr. Lin on the best way to inform his patients of upcoming clinics.

Dr. Tobbagi expressed concern with vaccine waste. Ms. Tomcala advised that, up until yesterday's clinic, vaccine waste was not an issue. SCFHP provides the location; the Public Health department coordinates all the staffing and clinical details. The Public Health department is concerned about vaccine waste and this issue is being addressed. Dr. Lin asked for the date of the next clinic. Ms. Tomcala replied that Public Health does not give the Plan advance notice. SCFHP has requested that Public Health devise a more routine schedule which would encourage more public participation and less vaccine waste. Dr. Nakahira directed Dr. Lin to our website which has a link to the Public Health Department. Vaccine availability has increased and Levi Stadium is under consideration as a potential pop-up vaccination site. Ms. Tomcala welcomes the committee's ideas and recommendations to overcome vaccine hesitancy amongst our members.

5. Chief Medical Officer Update

a. General Update

Dr. Laurie Nakahira, Chief Medical Officer, began with a reminder to committee members to sign the annual SCFHP confidentiality agreement. Dr. Nakahira provided the Committee with a COVID-19 update. The Plan provides assistance to members who are 65 years of age and older to help them make vaccine appointments online in conjunction with the Public Health department. Public Health has agreed to reserve a certain number of vaccine appointments for our high-risk members. The Plan continues to call our members to confirm if they have been vaccinated, provide assistance on how to make appointments to be vaccinated, and, if applicable, the reasons why vaccination is declined. The most common reason given is concern over long-term side effects.

Dr. Nakahira continued with the Plan's successful completion of the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) audits in March 2021. A final audit report is pending. The Plan is focusing on Enhanced Case Management (ECM) and In-Lieu-of-Services (ILOS). The Plan is preparing for the sun-setting of the County's Whole Person Care and Home Health programs.

b. Annual Confidentiality Agreements

This item was addressed in the CMO update.

6. Old Business/Follow-Up Items

a. Plan-All-Cause Readmission (PCR) Rates

Dr. Dang Huynh, PharmD, Director Utilization Management and Pharmacy, presented an overview of PCR Rates, and ways to reduce the number of readmissions. PCRs are readmissions that occur in acute settings within 30 days. The Plan's Fiscal Year goal is to reduce Medi-Cal PCRs to 7.48%. Dr. Huynh described the strategies the UM department will implement in order to achieve this goal. The UM department is expanding their TLC in the Case Management department, so calls, follow-up reviews, and HRA's are all in alignment. UM is identifying individuals who are candidates for further outreach, and working with the Plan's provider groups for more oversight on their concurrent review and discharge planning processes, which reduces their PCR, as well as the Plan's PCR. The UM department has built strong relationships with the Plan's contracted hospitals to strategize a more proactive approach to prior authorizations and timely discharge planning procedures. Finally, the UM department will improve their analytics on ADT data to support provider groups. Dr. Lin stated that Medicare readmissions rates are significantly higher than the Plan's 9.58%, and he approves of the Plan's emphasis on communication with contracted hospitals and providers.

7. UM Program Evaluation - 2020

Dr. Lily Boris, Medical Director, presented the Committee with the annual review of the UM Program Evaluation for 2020. The UM Program Evaluation is a requirement of the state, as well as the NCQA. It is divided into Quality of Clinical Care and Quality of Service. The UM department successfully completed quality of clinical care and corresponding HEDIS metrics such as: current reporting; quality of inpatient care; readmissions; the UM Program Description; medical necessity criteria policy; and prior authorizations on outpatient and inpatient stays. The only 2 items that were not completed were Item #9 Track and Monitor Behavioral Health Inpatient Stays for Cal MediConnect, and Item #16 Conduct Member and Provider Satisfaction Surveys. Item #9 was not measured, as the Plan did not have access to the data set. A new parameter has been built so the Plan can provide this information next year. Item #16 was not completed as Medi-Cal and Medicare satisfaction surveys are conducted outside of the Plan's purview. Otherwise, all quality of clinical care and HEDIS items were reviewed and completed in a timely fashion.

It was moved, seconded and the UM Program Evaluation - 2020 was **unanimously approved**.

Motion: Dr. Tobbagi
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi
Absent: Dr. Cai, Dr. Dinh, Dr. Vemuri

8. UM Work Plan – 2021

Dr. Boris next presented the UM Work Plan for 2021 to the Committee. The UM Work Plan reflects the goals for 2021. The requirements are divided by quarter. Dr. Boris highlighted item #9 Track and Monitor Behavioral Health Inpatient Stays for Cal MediConnect, as the strongest focus area of the 2021 Work Plan. Dr. Boris also directed the committee's attention to item #15 Annual Inter-Rater Reliability which should be conducted on an annual basis, not a bi-annual basis as listed in the Work Plan, with achievement of an 80% pass rate for all UM staff.

It was moved, seconded and the UM Work Plan – 2021 was **unanimously approved**.

Motion: Dr. Tobbagi
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi
Absent: Dr. Cai, Dr. Dinh, Dr. Vemuri

9. Care Coordinator Guidelines

Mr. Luis Perez, Supervisor, UM, provided an overview of the UM Care Coordinator Guidelines to the Committee. Dr. Lin remarked that it appears there is improvement on SNF transitions to long-term care, and Mr. Perez agreed. Dr. Lin asked if patients in hospice care remain under SCFHP, or do they qualify for carve out? Mr. Perez clarified hospice care patients remain under the jurisdiction of SCFHP.

Ms. Natalie McKelvey, Manager, Behavioral Health, presented an overview of the Behavioral Health Care Coordinator Guidelines to the Committee. Ms. McKelvey explained that the most important factor for Care Coordinator Guidelines is to follow APL 19-014. The Care Coordinator can approve anything less than 25 hours per week in direct services. Anything above 25 hours per week requires a Manager or a doctor's review and approval.

It was moved, seconded and the Care Coordinator Guidelines were **unanimously approved**.

Motion: Dr. Tobbagi
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi
Absent: Dr. Cai, Dr. Dinh, Dr. Vemuri

10. UM 1B Annual Assessment of Senior Level Practitioners for NCQA – 2020

Dr. Boris gave an overview of the 2020 UM 1B Annual Assessment of Senior Level Practitioners, as required by NCQA. The purpose is to determine how a senior level practitioner participates in the Plan's UM Committee. Dr. Boris co-chairs this committee with Dr. Lin. Dr. Alkoraishi also participates in this committee to address the Behavioral Health perspective. Dr. Boris explained how the answers to 6 targeted questions demonstrate the fact that senior level practitioners meet the necessary NCQA standards and elements.

11. Home Health Services Authorization Procedure

Dr. Huynh presented the Committee with an overview of the purpose of procedure HS.01.23 Home Health Services Authorization. Dr. Huynh explained that the UM department uses MTV as the criteria in order to evaluate the number of approved visits. The MTV recommendation for the 50th percentile is limited to commercial and Medi-Care lines of business. As the Plan has Medi-Cal beneficiaries, a procedure was developed which clearly outlines how the UM team will approve the numbers of visits for Medicare and Cal MediConnect beneficiaries. The UM reviewer will be able to approve up to 200% of the Medicare 50th percentile recommended visits. Any additional visits will require appropriate notes that establish medical necessity.

Dr. Boris directed the Committee's attention to the MCG criteria. Dr. Boris explained that the Plan relies on MCG criteria in situations where neither Medicare nor Medi-Cal have clear criteria for what constitutes an approval or denial. It was necessary for the UM team to show specific reasons for denials of service, as the Plan's auditors require a concrete procedure. Dr. Lin expressed his concern with the establishment of the 200% of the 50th percentile guideline. Ms. Tomcala responded that our members deserve the right care at the right time. Dr. Boris reminded Dr. Lin that the Plan's Medi-Cal and MediCare patients have a higher acuity, and the typical Medicare patient does not have the co-morbidity rate or social issues of the typical Medi-Cal patient. Dr. Boris emphasized that all patients must still meet the criteria of medical necessity.

Dr. Huynh explained that this procedure will help to establish the maximum number of home health visits that will be approved per patient on a case by case basis. During audits, the Plan can explain their rationale for approvals or denials through use of this procedure. Dr. Boris stated that the UM department will do an evaluation of this procedure after 6 months and discuss the results at the October 2021 meeting.

Dr. Dinh joined the meeting at 6:42 p.m.

12. Reports

a. Membership

Dr. Boris gave a brief summary of the Membership Report from April 2020 through April 2021. Cal MediConnect membership has increased to 9,924 members, and Medi-Cal membership has increased to 269,043 members. The Plan's total population has increased from 243,774 members to 278,967 members, largely attributable to the pause on Medi-Cal redeterminations due to COVID. The majority of our members remain delegated to Valley Health Plan, with the remaining majority delegated to Physicians Medical Group, Kaiser Permanente, and Premier Care.

b. Over/Under Utilization by Procedure Type/Standard UM Metrics

Dr. Boris presented the Committee with the UM objectives and goals. Dr. Boris summarized the results of the Medi-Cal SPD and non-SPD lines of business for the calendar year 2020, with a comparison to the results from 2019. Dr. Boris also summarized the results for the Cal MediConnect line of business, with a comparison to the data from 2019. Dr. Boris next summarized the number of admissions and re-admissions for both the Medi-Cal and Cal MediConnect lines of business. Ms. Tomcala asked if admissions and readmissions were affected by COVID and the fact that many elective procedures were put on hold. Dr. Boris replied that the UM department will analyze COVID admissions and readmissions for 2020 and bring these

results to the July 2021 meeting. Dr. Huynh advised that some of the data may have been affected by the HEDIS change.

Dr. Boris concluded with a summary of the Cal MediConnect readmission rates, which have increased since 2019. The UM team will perform analysis to determine how COVID may have affected this increase in PCR rates.

c. Dashboard Metrics

- Turn-Around Time – Q1 2021

Mr. Perez summarized the Cal MediConnect Turn-Around Time metrics for Q1 2021. The turn-around times in all categories are compliant at 99% or better, with the exceptions of expedited pre-service prior authorization requests with a 95.9% rate, expedited Part C initial determinations at 96.9%, standard prior authorization requests for Part B drugs at 94.6%, and expedited prior authorization requests for Part B drugs at 97.4%.

Mr. Perez next summarized the Turn-Around times for Medi-Cal authorizations for Q1 2021. The turn-around times for all Medi-Cal authorizations combined is compliant at 98% or better.

Dr. Huynh explained that some of the turn-around times were impacted by issues with the mail room and the fax line. The UM Department is focusing on better reporting, streamlining processes, and additional training, with a commitment to 100% compliance with contractual and regulatory requirements. Dr. Huynh explained to Dr. Lin that even 1 non-compliant case found by the CMS auditors triggers an impact analysis to determine if there are additional cases of non-compliance.

d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q1 2021

Dr. Huynh summarized the data from the Q1 2021 Cal MediConnect and Medi-Cal Quarterly Referral Tracking reports for the Committee. Dr. Huynh explained that the UM team tracks the cycle of prior authorizations from the time the prior authorization is issued through to claims payment. The average claims cycle is 90 days. This report is affected by a claims data lag. Dr. Huynh explained that the annual review, which incorporates this data lag, presents a more accurate picture of timeframes within the claims cycle. Dr. Lin asked how the 2020 results compare with 2019. Dr. Huynh replied that he will review these numbers and present the results at the July 2021 meeting. Dr. Huynh agrees that COVID has affected the number of outpatient services and prior authorization requests.

e. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q1 2021

Dr. Boris summarized the results of the Q1 2021 Quality Monitoring of Plan Authorizations and Denial Letters for the Committee. Dr. Boris reported that the UM department received a 100% score in virtually all categories, with the exception of a small handful of written notifications that either contained unexplained medical terminology, grammatical and punctuation errors, or omitted the rationale for the denial. Dr. Huynh will ensure these errors will be reviewed with all UM staff members. UM leadership will continue to take an active role in QA oversight.

f. Behavioral Health UM

Ms. Natalie McKelvey, Manager, Behavioral Health, presented an overview of utilization of the Behavioral Health Treatment program. Ms. McKelvey highlighted the number of developmental screenings, and Dr. Lin remarked on the high number of Q1 screenings for VHP and PMG. Ms. McKelvey believes this could be due to a claims lag, or the fact that the providers do not promptly bill for services. Ms. McKelvey will provide an update at the July 2021 meeting. Ms. McKelvey discussed how important it is for BH providers to complete ACES Aware training and conduct trauma screenings. Ms. McKelvey discussed the fact that the Plan provides assistance to providers in how to conduct trauma screenings which includes peer-to-peer training via Zoom.

Dr. Tobbagi asked for an explanation of payment structure, and Ms. McKelvey advised the County is responsible for providing specialty mental health, and health plans are responsible for serving the mild to

moderate symptoms population. The payment structure is complicated, as it is based primarily on the patient's function level. A discussion ensued amongst Ms. McKelvey, Dr. Tobbagi, and Dr. Lin as to the Plan's top 10 billing providers, and the cost of BH services. Ms. McKelvey advised BH is not a capitated service with respect to autism. The Plan follows the APL and EPSDT requirements for treatment for kids. Treatment plans are approved every 6 months to confirm medical necessity. Dr. Tobbagi asked about the amount of compensation for initial BH consultations for adults. Ms. McKelvey replied she does not have the specific numbers, but the Plan pays over the Medicare and Medi-Cal rates.

Dr. Boris pointed out that, with respect to the bar graph which shows the top 10 billing providers, the graph includes all BH treatment provided from 2018-2020 and includes children who receive a combination of ABA therapy in the home. Ms. McKelvey clarified the bar graph does not include speech or occupational therapies. The BH team regularly meets with ABA providers to ensure the standard of medical necessity is met, and discussions continue to understand what the community standard is for BH treatment.

Dr. Tobbagi asked why so many patients are having trouble getting referrals to Stanford when they change their primary care physician. Dr. Nakahira and Dr. Boris agreed this may be an issue with Stanford's process. They will research this issue to confirm there is not a problem with the Plan's referral process.

13. Adjournment

The meeting adjourned at 7:26 p.m. The next meeting of the Utilization Management Commitment is on July 21, 2021 at 6:00 p.m.

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Jimmy Lin, M.D, Chair
Utilization Management Committee

Date

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Chief Executive Officer Update

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Chief Medical Officer Update

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Prior Authorization Volume
2019 vs. 2020 vs. 2021

Prior Authorization Volume

2019 vs. 2020 vs. 2021

Line of Business	Prior Authorization Type	2019	2020	2021 (Jan-Jun)
Cal MediConnect	Routine	7,301	6,925	4,209
	Retro	827	883	366
	Urgent Concurrent	100	78	22
	Urgent Preservice	3,612	3,531	1,838
	Total	11,840	11,417	6,435
Healthy Kids	Routine	43	N/A	N/A
	Retro	12	N/A	N/A
	Urgent Preservice	10	N/A	N/A
	Total	65	N/A	N/A
Medi-Cal	Routine	12,096	11,146	6,420
	Retro	4,817	4,146	1,800
	Urgent Concurrent	65	64	19
	Urgent Preservice	2,296	2,008	904
	Total	19,274	17,364	9,143
Grand Total		**31,179**	**28,781**	**15,578**

Santa Clara Family Health Plan™

Plan All-Cause Readmissions Rates (PCR Rates) Due to COVID

Plan All-Cause Readmissions (PCR)

DUE TO COVID-19: **CY2021 – Medi-Cal**

Hospital	# PCR with COVID-19 Admission	# Readmissions	Readmission Rate
El Camino Hospital	4	1	25%
Good Samaritan Hospital	4	0	0%
Kaiser Hospital - San Jose	6	1	17%
Kaiser Hospital - Santa Clara	4	0	0%
Long Beach Memorial Medical	1	0	0%
O'Connor Hospital	5	0	0%
Regional Medical Center of San Jose	13	2	15%
Saint Louise Regional Hospital	6	1	17%
Santa Clara County Valley Medical Center	58	8	14%
Sharp Memorial Hospital	1	0	0%
St. Agnes Medical Center	1	0	0%
Stanford Medical Center Hospital	3	1	33%
Grand Total	**106**	**14**	**13%**

PCR Data: 01/01/2021-06/06/2021

Plan All-Cause Readmissions (PCR)

DUE TO COVID-19: **CY2021 – Cal MediConnect**

Hospital	# PCR member(s) with COVID-19 Admission	# Readmissions	Readmission Rate
El Camino Hospital	1	0	0%
Good Samaritan Hospital	2	1	50%
O'Connor Hospital	8	2	25%
Regional Medical Center of San Jose	4	1	25%
Saint Louise Regional Hospital	3	0	0%
Santa Clara County Valley Medical Center	9	3	33%
Stanford Medical Center Hospital	4	0	0%
Sutter Tracy Community Hospital	1	0	0%
Washington Hospital	2	0	0%
Total	**34**	**7**	**21%**

PCR Data: 01/01/2021-06/06/2021

Santa Clara Family Health Plan™

UM Policy Updates

Santa Clara Family Health Plan™

POLICY

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

I. Purpose

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

II. Policy

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

UM 2A 1

A. Criteria is based on current sound clinical evidence to make utilization decisions
B. Criteria is specific to the services and procedures requested
C. Criteria is used to evaluate the medical necessity of medical, behavioral healthcare and pharmaceutical services decisions
D. The Plan annually defines the hierarchy of criteria application ~~of criteria~~ for each line of business
E. In addition to the UM hierarchy of guidelines, the Plan is licensed to use MCG™ guidelines to guide utilization management decisions.

UM 2A 5

F. The criteria is reviewed and adopted at least annually by the Utilization Management Committee (UMC)
    1. The UMC consists of external physicians, both primary care providers and specialists (including pediatric and behavioral health specialists), in developing, adopting, and reviewing criteria

G. The review for medical necessity ~~takes into~~ is based on ~~account~~ an individual member's needs and circumstances, relative to appropriate clinical criteria and the Plan's policies
H. The Plan defines the availability of criteria and states in writing how practitioners can obtain UM criteria and how the criteria is made available to the practitioners and members upon request
I. The plan evaluates the consistency with which health care professionals involved with any level of applying UM criteria in decision making and takes appropriate corrective actions to improve areas of non-compliance at least annually

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

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

III. Responsibilities

Chief Medical Officer or designee shall review annually and submits criteria, policies and procedures to the Utilization Management Committee for approval.

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)
v1	Original	Utilization Management	Approve 04/20/2016
v1	Original	Utilization Management	Approve 01/18/2017
v1	Reviewed	Utilization Management	Approve 01/17/2018
v1	Reviewed	Utilization Management	Approve 01/16/2019
v2	Revised	Utilization Management	Approve 01/15/2020
v3	Revised	Utilization Management	Approve 10/14/2020
v4	Revised	Utilization Management	Approve 1/20/2021
v5	Revised	Utilization Management	Pending UMC

Santa Clara Family Health Plan™

Inter-Rater Reliability (IRR) UM Report - 2021

Inter-Rater Reliability Summary
2021

1. In accordance with Policy HS.09, Santa Clara Family Health Plan (SCFHP) UM Staff scheduled and completed the required Annual IRR testing session on July 14, 2021. In accordance with NCQA/DHCS, DMHC, and SCFHP policy, a total of 10 hypothetical UM authorizations were created for testing purposes for Utilization Management (UM and MLTSS) staff, including non-licensed Care Coordinators (CC), licensed professional staff, and Medical Directors (MD) that participate in the UM decision process. Behavioral Health (BH) staff conduct a BH-specific IRR and were excluded from participating.
2. The intent of the IRR testing process is to evaluate the consistency and accuracy of reviewing criteria applied by all reviewers - physicians and non-physicians - who are responsible for conducting Utilization Management reviews and to act on improvement opportunities identified through this monitoring.
3. The Utilization Management Leadership team will review and approve the evaluation summary report reflecting the decision making performance of the staff responsible for conducting Utilization Management reviews. The report results and recommendations for improvement will be presented to the Utilization Management Committee.
4. The Plan classifies reviews into one of two performance categories: Proficient (80% - 100% of the records are in compliance with the criteria); Not proficient (below 80% in compliance) Scores below 80% require increased focus by UM Management with actions described in Policy HS.09 or a corrective action plan.

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

Name	Position	Pass / Fail	%
1	CC	Pass	100%
2	CC	Pass	100%
3	CC	Pass	100%
4	CC	Pass	100%
5	CC	Pass	90%
6	CC	Fail	60%
7	CC	Pass	100%
8	CC	Pass	100%
9	CC	Pass	100%
10	CC	Pass	80%
a	Nursing	Fail	70%
b	Nursing	Pass	90%
c	Nursing	Pass	100%
d	Nursing	Pass	100%

e	Nursing	Pass	90%
f	Nursing	Pass	90%
g	Nursing	Pass	80%
h	Nursing	Pass	100%
i	Nursing	Pass	90%
X	Physician	Pass	80%
Y	Physician	Pass	90%
Z	Physician	Pass	90%

In our 2021 testing, 100% of our staff that participated in the IRR testing.

All 10 cases and all elements were reviewed for staff. All Care Coordinators and all Nursing staff questions were answered. There was meaningful discussion on the consensus in conducting and processing prior authorization requests and reviewing cases against appropriate criteria. Main teaching points were disused on each applicable case and the staff were appreciative of discussion and feedback.

1 Nursing staff had a score of <80% and the areas of opportunities were in mostly the identification of the correct criteria to utilize. 1 Care Coordinator had a score of less than 80% and the area requiring opportunities identified was reviewing the criteria. Remediation will be conducted. All care coordinator and nursing staff participated as below.

Santa Clara Family Health Plan™

UM Review of Delegation Results and Process

UM Delegation Annual Oversight Audit Results - 2020

I. VHP Network (Preliminary Findings)

1. Policies and procedures do not include process on concurrent review indicating care shall not be discontinued until a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.
2. Policies and procedures for written communication of UM decisions to members and providers does not address Approval notices.
3. Policies and procedures did not include process for tracking and monitoring Standing Referrals.
4. Policies and procedures for denial of experimental services to terminal ill members does not address notice requirements to include:
   a. A statement setting forth the specific medical and scientific reasons for denying coverage.
   b. A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.
   c. Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of the plan's grievance system provided under Section 1368.
5. Appropriate, sufficient, and relevant criteria or clinical information were not utilized for appropriate denial determinations.
6. The criteria was referenced on the member and provider notices for 11 out of 29 letters reviewed.
7. Clear and concise explanation for denial reason was provided for 24 out of 29 letters reviewed.
8. Provider notifications were provided timely for 22 out of 29 cases reviewed.

II. Kaiser

1. No Findings.

III. Physicians Medical Group (Preliminary Findings)

1. Policies and procedures submitted do not include established guidelines for denial for treatment, services, or supplies deemed experimental issued to an enrollee with a terminal illness.

IV. Premier Care of Northern California

1. UM6002 - Provider and Member Letter of Notification Process Policy does not specify the specific health care service(s) approved in the member and provider notice.
2. UM6002 - Provider and Member Letter of Notification Process Policy and UM1011 - UM Communications Services Policy do not indicate that providers are educated on an ongoing basis regarding prior authorization procedures and timeframes.
3. Policy does not include a process for standing referrals.
4. PCNC did not accurately document mailing addresses on member notices reviewed. (two files, same member had wrong address).

Utilization Management
Documentation Preparation & Submission

1. **Responding to Document Requests:**

   The Delegate is expected to provide documentation within 15 business days of the engagement letter date. The Audit Team may request additional documentation as needed.

2. **Supporting Documentation:** The Delegate must provide all documents that is applicable to the following subjects within the audit timeframe:

   A. Utilization Management (UM) Program Requirements:
      a. Policies and procedures of UM program
      b. The UM Program Plan and Description or UM Annual Work Plan
      c. An organization chart of the utilization management staff
      d. Key individuals involved in UM and list their qualifications and license numbers
      e. UM committee minutes
      f. Policies and procedures for under- and over-utilization of health care services
         i. Criteria for identifying over and under-utilization
         ii. Processes for detecting and correcting over and under-utilization including pharmaceutical and preventive services
         iii. Corrective actions initiated to address under and over-utilization of services

   B. Medical Director and Medical Decisions:
      a. Job descriptions for the CMO and/or Medical Director.
      b. Policies and procedures
         i. Medical Director's involvement in Quality Improvement activities
         ii. Demonstrate that fiscal management does not influence medical decisions
         iii. Personnel responsible for each level of UM decision making
         iv. Organizational use of licensed health care professionals to supervise medical necessity decisions
         v. Organizational use of practitioners and board certified consultants for UM decisions

   C. Prior Authorization Review:
      a. Policies and procedures:
         i. Prior authorization requests
         ii. Tracking and review of denials, modifications, and deferrals
         iii. Outreach attempts to providers
         iv. Timeliness of medical UM decision making
         v. Authorizing second opinions for members
         vi. Communication requirements of UM decisions
         vii. Disclosure of UM processes and criteria to providers, enrollees and public

viii. Disclosure of specific UM criteria used to modify, delay, or deny care
ix. Terminal Illness
x. Post Stabilization

b. Flow charts or diagrams outlining the PA process for medical and pharmacy services
c. Templates of denial, deferred, modification letters
d. List of all services, procedures, or equipment that require prior authorization
e. Inter-Rater Reliability (IRR) Summary for staff (physicians, nurses, pharmacists, etc.) involved in UM decision making

D. Referral Tracking System:
   a. Policies and procedures on the system to track and monitor services requiring prior authorization
   b. Policies and procedures identifying appropriate specialists and specialty care centers for standing referrals
   c. Tools used to track and monitor these referrals

E. UM Processes as Part of the QA Program
   a. Policies and procedures for QA process for compliance with UM requirements
   b. Policies and procedures for QA process for provider referral tracking

F. Consistency of Applying UM Decisions
   a. Policies and procedures describing the use of Inter Rater Reliability (IRR) studies to evaluate the consistency with which health care professionals involved in UM apply criteria in decision making
   b. IRR Study Results for MDs
   c. IRR Study Results for RNs
   d. Process to conduct improvement activities if IRR scores are not satisfactory

G. Delegated Utilization Management (UM) Activities (if applicable):
   a. Policies and procedures regarding any delegated UM functions
   b. Policies and procedures for monitoring under- and over-utilization of health care services
   c. List all entities, including the contract date, to which the audited entity delegates any UM function including delegated appeals
   d. Corrective action plans (CAP) for any delegates with deficiencies. If a CAP was not implemented, please provide an explanation
   e. Current delegation agreements or subcontracts with delegated entities

Universe Preparation & Submission

1. **Responding to Universe Requests**: The Delegate is expected to provide an accurate and timely universe submission within 15 business days of the engagement letter date. SCFHP may request a revised universe if data issues are identified.

2. **Pull Universe:** The universes collected for this program area test whether the Delegate has deficiencies related to appropriate processing of Service Authorization Requests.

3. **Submit Universe to SCFHP:** Delegates should submit universe in the Microsoft Excel (.xlsx) file format with a header row following the record layouts shown in Appendix A.

Audit Elements

1. **Select Sample Cases:** The Audit Team will select a targeted sample of 30 Denied Service Authorizations cases for testing. The Audit Team reserves the authority to substitute samples in order to ensure the complete review of the UM process.

2. **Review Sample Case Documentation:** The Audit Team will review all sample case file documentation for timeliness, appropriateness of clinical decision, denial notice criteria, member provider notification requirements, and qualified credentials for reviewer. The Delegate will need to provide the following documents for the selected samples as requested:

   A. Authorization Request Form (from requesting provider)
   B. Medical Notes – as applicable (from requesting provider)
   C. Case Notes from Medical Group UM Staff: coordinator, nurse reviewer, and physician reviewers
   D. Member Eligibility Screenshot (from UM system)
   E. Copy of Criteria Used
   F. Outreach Attempts (if applicable)
   G. Provider Notice
      a. Date/Time Notice Sent
      b. Method Notice was Sent (Fax, mail, etc.)
   H. Member Notice of Action in Member's Threshold Language; Including:
      a. Date/Time Notice Sent
      b. Your Rights
      c. Nondiscrimination Notice
      d. Language Assistance, and
      e. State Fair Hearing Rights
      f. Timeframe Extension Notice (if applicable)

Appendix

Appendix A—Utilization Management

The universe for this audit must be submitted as a Microsoft Excel (.xlsx) file with a header row reflecting the field names.

If you do not have data for any of the fields identified below, please discuss that with the Audit Team prior to populating or submitting your universe.

Table 1: Prior Authorizations

Include all medical prior authorization actions that relate to the **Medi-Cal Line of Business** within the audit period. These may include but are not limited to medical requests, out of network referrals, and any other prior authorization requests excluding pharmacy. Record layout must include headers with each of the following data fields. If a cell has no applicable data, please mark "N/A".

A. Member Name
B. Member Client Index Number (CIN)
C. Member Date of Birth
D. Medi-Cal aid code
E. County
F. Prior Authorization Number
G. Date of Prior Authorization
H. Authorization Type (Routine, Urgent, Expedited)
I. Specific service requested and quantity, as applicable
    a. Procedure request (CPT Code with description)
    b. Specialty of consult/office visit (Neurology, DME, PT, etc.)
    c. Description of an DME requested (oxygen, wheelchair)
J. Diagnosis
K. Date Received by Plan
L. Date of Action by Plan
M. Action (approved, modified, denied, deferred)
N. Decision Maker (if denied or modified)
O. Type of Denial (if denied)
    a. Clinical/ Medical Necessity
    b. Administrative/ Benefit
P. Reason to deny or modify (should reflect reason specified in NOA)
Q. Diagnosis Code Description
R. Decision Maker
S. Date of Member/Provider Notification

Santa Clara Family Health Plan™

UM 1B Annual Provider and Member Satisfaction with UM Process - 2020

UM 1B Annual Provider & Member Satisfaction with UM Process - 2020

Review of 1B Annual Provider & Member Satisfaction with UM Process

Santa Clara Family Health Plan (SCFHP) annually evaluates and updates the Utilization Management (UM) program based on: "consideration of member and practitioner experience data when evaluating its UM program and updates the program based on its evaluation.

I. Procedure

For Calendar Year (CY) 2020 for both Lines of Business (LOBs): SCFHP used a combination of:

A. Cal MediConnect (CMC)
   1. CAHPS Survey 2020
   2. CY2020 Grievances against the SCFHP UM Department to evaluate both provider and member feedback

B. Medi-Cal
   1. CY2020 Grievances against the SCFHP UM Department to evaluate both provider and member feedback

II. Data

A. CMC CAHPS Survey 2020.

DOMAIN: MEMBER EXPERIENCE WITH HEALTH PLAN

	2020 Valid n	2018	2019	2020	2020 SPH MMP BoB	2019 CMS MMP National Data
Q38. Rating of Health Plan	438	84.8	84.6	88.1	88.7	87.1
Q9. Rating of Health Care Quality	449	80.4	81.0	83.7	84.7	85.3
Customer Service	435	82.6	82.3	85.2	89.5 ▼	90.2 ▼
Q34. Getting information/help from customer service	225	74.2	74.3	77.2	82.8 ▼	83.0 ▼
Q35. Treated with courtesy and respect by customer service staff	227	86.1	87.3	90.6	93.3	93.5
Q37. Health plan forms easy to fill out	426	87.4	85.5	87.9	92.3 ▼	94.1 ▼

DOMAIN: MEMBER EXPERIENCE WITH DRUG PLAN

	2020 Valid n	2018	2019	2020	2020 SPH MMP BoB	2019 CMS MMP National Data
Q47. Rating of Drug Plan	439	87.2	85.7	89.5	90.2	87.0
Getting Needed Prescription Drugs	431	86.8	85.0	87.6	89.3	89.3
Q42. Ease of using health plan to get prescribed medicines	422	86.0	84.3	86.7	88.4	89.0
Combined Local Pharmacy and Mail	363	87.6	85.7	88.6	90.2	89.6
Q44. Ease of using health plan to fill prescriptions at local pharmacy	306	88.9	87.3	89.4	91.4	89.8
Q46. Ease of using health plan to fill prescriptions by mail	160	83.2	81.0	85.2	78.0 ▲	81.5

B. For the CY 2020 Grievances against SCFHP UM department.
   1. There were 11 member complaints against the UM department in CY 2020.
      a. 6 were Medi-Cal related
      b. 5 were Cal MediConnect related
      c. For the subtypes of the members complaints:

Category	Number of Issues	Appeal Decision
DME	1	Overturned
UM Form / Site of Service	2	Overturned
Enteral Nutrition	3	Overturned
Denied Service	1	Overturned
Non Covered Benefit	1	Upheld
Did not agree with time frame / expedited vs. standard Turn Around Time (TAT)	3	NA

2. There were no physician grievances against the health plan.

III. Analysis

For the CMC CAHPS survey, there were improvements in all member experience domains and ratings of the health plan from 2018 to 2020.

Evaluation of specific complaints reveals that there are very few grievances against SCFHP UM Department.

It also shows that when the grievance is logged it is separated from the appeal review process. The majority of the overturned appeals (originating from the grievance) were resolved in the member's favor.

Only two areas of grievances (very low volume) Enteral Nutrition and Expedited vs Standard TAT are noted as slightly higher. Review of these individually shows that two enteral requests were approvals and only the quantity needed to change. One was a denial and was overturned. The expedited issues were all quality of services and members unhappiness with not having their cases expedited.

IV. Conclusion

SCFHP has continued to provide improving member service both pharmacy and medical to our plan members. There were also no physician grievances.

As such, the UM program did not need any revisions.

Santa Clara Family Health Plan™

Membership

Membership

Source: iCat (7/1/2021)

LOB	Network Name	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
CMC		**9,029**	**9,266**	**9,428**	**9,570**	**9,679**	**9,820**	**9,807**	**9,893**	**9,880**	**9,924**	**9,989**	**10,080**	**10,148**
	Santa Clara Family Health Plan	9,029	9,266	9,428	9,570	9,679	9,820	9,807	9,893	9,880	9,924	9,989	10,080	10,148
MC		**248,007**	**251,004**	**253,252**	**256,490**	**259,202**	**261,287**	**263,093**	**265,095**	**266,962**	**269,043**	**271,246**	**272,590**	**274,030**
	ADMIN-MEDI-CAL ONLY													2,088
	KAISER PERMANENTE	27,212	27,844	28,232	28,868	29,337	29,706	30,131	30,557	31,024	31,418	31,885	32,224	32,568
	MEDICARE PRIMARY	15,696	15,684	15,698	15,742	15,830	16,002	15,941	16,048	16,085	16,094	16,124	16,224	15,925
	PALO ALTO MEDICAL FOUNDATION	6,696	6,759	6,823	6,935	6,985	7,010	7,065	7,143	7,221	7,277	7,338	7,388	7,400
	PHYSICIANS MEDICAL GROUP	43,036	43,436	43,695	44,223	44,560	44,861	45,178	45,466	45,631	45,945	46,224	46,462	46,353
	PREMIER CARE	15,144	15,274	15,344	15,473	15,593	15,646	15,695	15,781	15,852	15,941	15,966	15,981	15,864
	SCFHP DIRECT	15,844	16,113	16,358	16,627	16,829	16,938	16,987	17,132	17,266	17,442	17,510	17,579	17,504
	VHP NETWORK	124,379	125,894	127,102	128,622	130,068	131,124	132,096	132,968	133,883	134,926	136,199	136,732	136,328
Grand Total		**257,036**	**260,270**	**262,680**	**266,060**	**268,881**	**271,107**	**272,900**	**274,988**	**276,842**	**278,967**	**281,235**	**282,670**	**284,178**

Santa Clara Family Health Plan™

Over/Under Utilization

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 –SPD DOS 9/1/2020 – 6/30/2021

Source: MCL Enrollment & QNXT Claims and Encounter Data (Run Date:7/11/2021)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2020-Q3	834	12.74	4,251	5.09
2020-Q4	890	13.25	4,796	5.39
2021-Q1	892	13.26	5,215	5.85
2021-Q2	678	10.11	3,223	4.75
Total	3,294	12.27	17,485	5.31

Note: Data are less complete for more recent quarters due submission lag.

Inpatient Utilization: Medi-Cal – Non-SPD
DOS 9/1/2020 – 6/30/2021

Source: MCL Enrollment & QNXT Claims and Encounter Data (Run Date:7/11/2021)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2020-Q3	2,431	3.98	9,947	4.09
2020-Q4	2,234	3.54	9,842	4.41
2021-Q1	2,525	3.89	11,350	4.49
2021-Q2	1,954	2.94	7,386	3.78
Total	9,144	3.58	38,525	4.21

Note: Data are less complete for more recent quarters due submission lag.

Medi-Cal Inpatient Utilization
DOS 9/1/2020 – 6/30/2021

	Medi-Cal Population		
Measure	**Non-SPD**	**SPD**	**Total**
Discharges / 1,000 Member Months	3.58	12.27	4.40
ALOS	4.21	5.31	4.50

Note: Data are less complete for more recent quarters due submission lag. Therefore comparison is limited.

Inpatient Utilization: Cal MediConnect (CMC)
DOS 9/1/2020 – 6/30/2021

Source: CMC Enrollment & QNXT Claims Data (Run Date:7/11/2021)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2020-Q3	506	18.56	3,137	5.67
2020-Q4	541	18.95	2,969	5.46
2021-Q1	571	19.67	3,546	5.32
2021-Q2	414	13.99	2,224	5.83
Total	2,032	17.75	11,876	5.58

Note: Data are less complete for more recent quarters due submission lag.

Inpatient Readmissions: Medi-Cal

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 2020 and YTD 2021 measurement period (Run Date: 06/15/2021)

Year	LOB	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1,2,3]
2020	MC - All	3,977	380	9.55%
2021	MC - All	2,095	253	12.08%

[1] A lower rate indicates better performance.
[2] Only for members aged 18-64 in Medi-Cal.
[3] Outliers are not included in the rates.

Note: Data are less complete for more recent quarters due submission lag. Therefore comparison is limited.

Cal MediConnect (CMC) Readmission Rates

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 2020 and YTD 2021 measurement period (Run Date: 06/15/2021)

Rate Description	PCR 2020	PCR 2021
Count of Index Hospital Stays	943	483
Count of 30-Day Readmissions	99	65
Actual Readmission Rate	10.50%	13.46%

[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.

Note: Data are less complete for more recent quarters due submission lag. Therefore comparison is limited.

ADHD Medi-Cal Behavioral Health Metrics

Source: HEDIS data for 2020 and YTD 2021 measurement period (Run Date: 06/15/2021)

Measure	NCQA Medicaid 50th Percentile	2020 Rate	2020 SCFHP Percentile Rank	2021 Rate	2021 SCFHP Percentile Rank
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	42.95%	45.26%	50th	36.67%	25th
Continuation & Maintenance Phase	54.73%	49.28%	25th	36.84%	5th
Antidepressant Medication Management					
Acute Phase Treatment	53.37%	64.15%	75th	67.81%	90th
Continuation Phase Treatment	38.18%	50.40%	90th	45.35%	75th
Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia	78.38%	71.43%	10th	28.57%	< 5th

Note: Data are less complete for more recent quarters due submission lag. Therefore comparison is limited.

Santa Clara Family Health Plan™

Dashboard Metrics
Turn-Around Time Q2 2021

Santa Clara Family Health Plan

CONCURRENT ORGANIZATION DETERMINATIONS	Apr	May	Jun	Q2 2021
# of Concurrent Requests Received	178	**165**	**193**	**536**
# of Concurrent Review of Authorization Requests (part C) completed within five (5) working days of request	178	**165**	**192**	**535**
% of Concurrent Review of Authorization Requests (part C) completed within five (5) working days of request	**100.0%**	**100.0%**	**99.5%**	**99.8%**
# of Concurrent Notifications Sent	178	**165**	**193**	**536**
# of Concurrent Initial Determination Notification (part C) sent to Provider/Member within five (5) working days of request	178	**165**	**192**	**535**
% of Concurrent Initial Determination Notification (part C) sent to Provider/Member within five (5) working days of request	**100.0%**	**100.0%**	**99.5%**	**99.8%**
PRE-SERVICE ORGANIZATION DETERMINATIONS				
Standard Part C				
# of Standard Pre-Service Prior Authorization Requests Received	765	721	801	**2,287**
# of Standard Pre-Service Prior Authorization Requests (part C) completed within five (5) working days	764	720	799	**2,283**
% of Standard Pre-Service Prior Authorization Requests (part C) completed within five (5) working days	**99.9%**	**99.9%**	**99.8%**	**99.8%**
# of Standard Pre-Service Prior Authorization Notifications Sent	765	721	801	**2,287**
# of Standard Pre-Service Prior Authorization Notification (part C) sent to Provider/Member within five (5) working days of request	764	720	799	**2,283**
% of Standard Pre-Service Prior Authorization Notification (part C) sent to Provider/Member within five (5) working days of request	**99.9%**	**99.9%**	**99.8%**	**99.8%**
Expedited Part C				
# of Expedited Pre-Service Prior Authorization Requests Received	271	267	294	**832**
# of Expedited Pre-Service Prior Authorization Requests (part C) completed within sevety-two (72) hours	270	267	292	**829**
% of Expedited Pre-Service Prior Authorization Requests (part C) completed within seventy-two (72) hours	**99.6%**	**100.0%**	**99.3%**	**99.6%**
# of Expedited Prior Authorization Notifications Sent	271	279	294	**844**
# of Expedited Initial Determination Notification (part C) sent to Provider/Member verbally within 72 hours from receipt and in writing within 3 calendar days from verbal notification	270	279	293	**842**
% of Expedited Initial Determination Notification (part C) sent to Provider/Member verbally within 72 hours from receipt and in writing within 3 calendar days from verbal notification	**99.6%**	**100.0%**	**99.7%**	**99.8%**

POST SERVICE ORGANIZATION DETERMINATIONS	Apr	May	Jun	Q2 2021
# of Retrospective Requests Received	50	55	64	**169**
# of Retrospective Requests (part C) completed within thirty (30) calendar days	50	55	64	**169**
% of Retrospective Requests (part C) completed within thirty (30) calendar days	**100.0%**	**100.0%**	**100.0%**	**100.0%**
PART B DRUGS ORGANIZATION DETERMINATIONS				
# of Standard Prior Authorization Requests (part B drugs) Requests Received	11	16	8	**35**
# of Standard Prior Authorization Requests (part B drugs) completed within sevety-two (72) hours of request	11	16	8	**35**
% of Standard Prior Authorization Requests (part B drugs) completed within seventy-two (72) hours of request	**100.0%**	**100.0%**	**100.0%**	**100.0%**
# of Standard Prior Authorization Requests (part B drugs) Notifications Sent	11	16	8	35
# of Standard Prior Authorization Notification (part B drugs) sent within seventy-two (72) hours of request	11	16	8	35
% of Standard Prior Authorization Notification (part B drugs) sent within seventy-two (72) hours of request	**100.0%**	**100.0%**	**100.0%**	**100.0%**
# of Expedited Prior Authorization (part B drugs) Requests Received	13	15	14	**42**
# of Expedited Prior Authorization requests (part B drugs) completed within twenty-four (24) hours of request	13	15	14	**42**
% of Expedited Prior Authorization requests (part B drugs) completed within twenty-four (24) hours of request	**100.0%**	**100.0%**	**100.0%**	**100.0%**
# of Expedited Prior Authorization (part B drugs) Notifications Sent	13	15	14	**42**
# of Expedited Initial Determination Notification (part B drugs) sent to Provider/Member verbally within twenty-four (24) hours from receipt and in writing within three (3) calendar days from verbal notification	13	15	14	**42**
% of Expedited Initial Determination Notification (part B drugs) sent to Provider/Member verbally within twenty-four (24) hours from receipt and in writing within three (3) calendar days from verbal notification	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Santa Clara Family Health Plan

MEDICAL AUTHORIZATIONS - HS COMBINED				
Concurrent Review	**Apr**	**May**	**Jun**	**Q2 2021**
Total # of Concurrent Requests Resolved	186	185	191	562
# of Concurrent Review of Authorization Requests completed within five (5) working days of request	185	184	190	559
% of Concurrent Review of Authorization Requests completed within five (5) working days of request	**99.5%**	**99.5%**	**99.5%**	**99.5%**
Routine Authorizations				
Total # of Routine Prior Authorization Requests Resolved	1,222	1,061	1,165	3,448
# of Routine Prior Authorization Requests completed within five (5) working days of request	1,218	1,061	1,161	3,440
% of Routine Prior Authorization Requests completed within five (5) working days of request	**99.7%**	**100.0%**	**99.7%**	**99.8%**
Expedited Authorizations				
Total # of Expedited Prior Authorization Requests Resolved	155	143	120	418
# of Expedited Prior Authorization Requests completed within seventy-two (72) hours of request	154	143	120	417
% of Expedited Prior Authorization Requests completed within seventy-two (72) hours of request	**99.4%**	**100.0%**	**100.0%**	**99.8%**
Retrospective Review				
Total # of Retrospective Requests Resolved	302	265	253	820
# of Retrospective Requests completed within thirty (30) calendar days of request	302	265	253	820
% of Retrospective Requests completed within thirty (30) calendar days of request	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Member Notification of UM Decision				
Total # of UM decisions	1,765	1,490	1,555	4,810
# Member Notification of UM decision in writing within two (2) working days of the decision.	1,743	1,486	1,549	4,778
% Member Notification of UM decision in writing within two (2) working days of the decision.	**98.8%**	**99.7%**	**99.6%**	**99.3%**
Provider Notification of UM Decision				
# Provider Notification of UM decision by telephone, facsimile or electronic mail and then in writing within twenty-four (24) hours of making the decision	1,743	1,479	1,537	4,759
% Provider Notification of UM decision by telephone, facsimile or electronic mail and then in writing within twenty-four (24) hours of making the decision	**98.8%**	**99.3%**	**98.8%**	**98.9%**

Santa Clara Family Health Plan™

Cal MediConnect and Medi-Cal Quarterly Referral Tracking

Cal MediConnect Q2 2021
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	12	12	0	0	0.0%
		Routine - Extended Service	11	8	0	3	27.3%
		Routine - Initial Request	1	1	0	0	0.0%
	CONT OF CARE	Member Initiated Org Determi..	1	0	0	1	100.0%
		Member Rep Initiated Org Det..	1	0	0	1	100.0%
		Member Rep Initiated Org Det..	1	0	0	1	100.0%
	CUSTODIAL	Non Contracted Provider - Ro..	2	2	0	0	0.0%
		Retro Request	96	89	0	7	7.3%
		Routine - Initial Request	32	25	0	7	21.9%
	DME	Member Initiated Org Determi..	2	0	0	2	100.0%
		Member Initiated Org Determi..	3	1	0	2	66.7%
		Member Rep Initiated Org Det..	1	1	0	0	0.0%
		Non Contracted Provider - Ro..	29	17	0	12	41.4%
		Non Contracted Provider - Urg..	5	4	0	1	20.0%
		Retro Request	2	2	0	0	0.0%
		Routine - Extended Service	4	3	0	1	25.0%
		Routine - Initial Request	184	120	0	64	34.8%
		Urgent - Extended Service	3	1	0	2	66.7%
		Urgent - Initial Request	19	15	0	4	21.1%
	HomeHealth	Member Initiated Org Determi..	1	0	0	1	100.0%
		Non Contracted Provider - Urg..	5	0	0	5	100.0%
		Retro Request	10	4	0	6	60.0%
		Routine - Extended Service	18	10	0	8	44.4%
		Routine - Initial Request	26	14	0	12	46.2%
		Urgent - Extended Service	135	51	0	84	62.2%
		Urgent - Initial Request	203	111	0	92	45.3%
	HOSPICE	Non Contracted Provider - Ret..	5	2	0	3	60.0%
		Non Contracted Provider - Ro..	2	1	0	1	50.0%
	Inpatient	CMC Part B Drugs – Urgent	1	1	0	0	0.0%
		Member Rep Initiated Org Det..	1	1	0	0	0.0%
		Non Contracted Provider - Ro..	3	3	0	0	0.0%
		Retro Request	2	2	0	0	0.0%
		Routine - Extended Service	1	1	0	0	0.0%
		Routine - Initial Request	562	552	0	10	1.8%
		Urgent - Initial Request	7	6	0	1	14.3%
	InpatientPsych	Routine - Initial Request	10	9	0	1	10.0%
	Inpt Elective	CMC Part B Drugs – Urgent	1	1	0	0	0.0%
		Routine - Initial Request	39	10	0	29	74.4%
		Urgent - Initial Request	13	4	0	9	69.2%
	OP-BehavioralGr	Care Coordinator Initiated Org..	3	3	0	0	0.0%
	OP-Behavorial	Care Coordinator Initiated Org..	1	0	0	1	100.0%
	OPHospital	CMC Part B Drugs – Routine	20	6	0	14	70.0%
		CMC Part B Drugs – Urgent	27	10	0	17	63.0%
		Member Initiated Org Determi..	15	3	0	12	80.0%
		Member Initiated Org Determi..	7	2	0	5	71.4%
		Member Rep Initiated Org Det..	1	0	0	1	100.0%
		Member Rep Initiated Org Det..	1	1	0	0	0.0%
		Non Contracted Provider - Ret..	1	0	0	1	100.0%
		Non Contracted Provider - Ro..	34	8	0	26	76.5%

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	OPHospital	Non Contracted Provider - Urg..	11	6	0	5	45.5%
		Non-contracted CMC Part B D..	1	0	0	1	100.0%
		Non-contracted CMC Part B D..	1	1	0	0	0.0%
		Retro Request	22	9	0	13	59.1%
		Routine - Extended Service	8	3	0	5	62.5%
		Routine - Initial Request	785	237	0	548	69.8%
		Urgent - Extended Service	1	1	0	0	0.0%
		Urgent - Initial Request	257	124	0	133	51.8%
	OPHospitalGr	CMC Part B Drugs – Routine	6	1	0	5	83.3%
		CMC Part B Drugs – Urgent	4	2	0	2	50.0%
		Member Initiated Org Determi..	7	4	0	3	42.9%
		Member Initiated Org Determi..	4	2	0	2	50.0%
		Member Rep Initiated Org Det..	1	0	0	1	100.0%
		Member Rep Initiated Org Det..	2	2	0	0	0.0%
		Retro Request	1	1	0	0	0.0%
		Routine - Extended Service	21	7	0	14	66.7%
		Routine - Initial Request	236	107	0	129	54.7%
		Urgent - Extended Service	1	1	0	0	0.0%
		Urgent - Initial Request	42	25	0	17	40.5%
	SkilledNursing	Retro Request	10	5	0	5	50.0%
		Routine - Initial Request	27	22	0	5	18.5%
		Urgent - Initial Request	74	71	0	3	4.1%
	Transportation	Member Initiated Org Determi..	1	0	0	1	100.0%
		Member Initiated Org Determi..	1	1	0	0	0.0%
		Member Rep Initiated Org Det..	2	1	0	1	50.0%
		Retro Request	6	1	0	5	83.3%
		Routine - Initial Request	64	12	0	52	81.3%
Grand Total			**3,160**	**1,763**	**0**	**1,397**	**44.2%**

Medi-Cal Q2 2021
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	49	49	0	0	0.0%
		Routine - Extended Service	63	62	0	1	1.6%
		Routine - Initial Request	2	2	0	0	0.0%
	CUSTODIAL	Non Contracted Provider - Ro..	6	5	0	1	16.7%
		Retro Request	571	533	0	38	6.7%
		Routine - Initial Request	201	137	0	64	31.8%
	Dental	Non Contracted Provider - Ro..	1	0	0	1	100.0%
		Routine - Extended Service	1	0	0	1	100.0%
		Routine - Initial Request	30	17	0	13	43.3%
		Urgent - Initial Request	15	8	0	7	46.7%
	DME	Non Contracted Provider - Ret..	37	27	0	10	27.0%
		Non Contracted Provider - Ro..	18	11	0	7	38.9%
		Non Contracted Provider - Urg..	2	2	0	0	0.0%
		Retro Request	7	5	0	2	28.6%
		Routine - Extended Service	2	2	0	0	0.0%
		Routine - Initial Request	293	177	0	116	39.6%
		Urgent - Initial Request	32	21	0	11	34.4%
	HomeHealth	Non Contracted Provider - Ret..	7	0	0	7	100.0%
		Retro Request	4	1	0	3	75.0%
		Routine - Extended Service	6	1	0	5	83.3%
		Routine - Initial Request	8	2	0	6	75.0%
		Urgent - Extended Service	10	4	0	6	60.0%
		Urgent - Initial Request	22	14	0	8	36.4%
	HOSPICE	Non Contracted Provider - Ret..	23	20	0	3	13.0%
		Non Contracted Provider - Ro..	9	8	0	1	11.1%
		Non Contracted Provider - Urg..	4	1	0	3	75.0%
		Retro Request	1	1	0	0	0.0%
	Inpatient	Non Contracted Provider - Ro..	3	2	0	1	33.3%
		Retro Request	2	2	0	0	0.0%
		Routine - Extended Service	2	2	0	0	0.0%
		Routine - Initial Request	587	560	0	27	4.6%
		Urgent - Initial Request	1	1	0	0	0.0%
	InpatientAdmin	Concurrent Review	1	0	0	1	100.0%
		Routine - Initial Request	1	1	0	0	0.0%
	InpatientPsych	Routine - Initial Request	1	0	0	1	100.0%
	Inpt Elective	Routine - Initial Request	35	18	0	17	48.6%
		Urgent - Initial Request	11	5	0	6	54.5%
	OP-BehavioralGr	Non Contracted Provider - Ret..	1	1	0	0	0.0%
		Non Contracted Provider - Ro..	10	9	0	1	10.0%
		Retro Request	19	15	0	4	21.1%
		Routine - Extended Service	98	86	0	12	12.2%
		Routine - Initial Request	6	4	0	2	33.3%
	OP-Behavorial	Non Contracted Provider - Ro..	10	2	0	8	80.0%
		Retro Request	6	2	0	4	66.7%
		Routine - Extended Service	47	16	0	31	66.0%
		Routine - Initial Request	45	13	0	32	71.1%
		Urgent - Initial Request	4	0	0	4	100.0%
	OPHospital	Non Contracted Provider - Ret..	2	1	0	1	50.0%
		Non Contracted Provider - Ro..	31	10	0	21	67.7%

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Medi-Cal	OPHospital	Non Contracted Provider - Urg..	6	1	0	5	83.3%
		Retro Request	17	13	0	4	23.5%
		Routine - Extended Service	55	16	0	39	70.9%
		Routine - Initial Request	524	203	0	321	61.3%
		Urgent - Extended Service	4	1	0	3	75.0%
		Urgent - Initial Request	130	73	0	57	43.8%
	OPHospitalGr	Concurrent Review – BH	1	1	0	0	0.0%
		Non Contracted Provider - Ret..	3	3	0	0	0.0%
		Non Contracted Provider - Ro..	5	3	0	2	40.0%
		Non Contracted Provider - Urg..	1	1	0	0	0.0%
		Retro Request	11	10	0	1	9.1%
		Routine - Extended Service	117	48	0	69	59.0%
		Routine - Initial Request	502	178	0	324	64.5%
		Urgent - Extended Service	5	3	0	2	40.0%
		Urgent - Initial Request	81	45	0	36	44.4%
	SkilledNursing	Retro Request	6	5	0	1	16.7%
		Routine - Initial Request	19	14	0	5	26.3%
		Urgent - Initial Request	46	44	0	2	4.3%
	Transportation	Non Contracted Provider - Ro..	1	0	0	1	100.0%
		Retro Request	16	9	0	7	43.8%
		Routine - Initial Request	368	137	0	231	62.8%
Grand Total			**4,265**	**2,668**	**0**	**1,597**	**37.4%**

Santa Clara Family Health Plan™

Quality Monitoring of Plan Authorizations and Denial Letters

Quality Monitoring of Denial Letters for HS.04.01
2nd Quarter 2021

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 quarterly 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 2nd quarter of 2021 in order to assess for the following elements.

A. Quality Monitoring

1. The UM Manager and Medical Director are 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:
        - Turn-around time for decision making
        - Turn-around time for member notification
        - Turn-around time for provider notification
        - Assessment of the reason for the denial, in clear and concise language
        - 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.
        - Type of denial: medical or administrative
        - Addresses the clinical reasons for the denial
        - Specific to the Cal Medi-Connect membership, the denial notification includes what conditions would need to exist to have the request be approved.
        - Appeal and Grievance rights
        - Member's letter is written in member's preferred language within plan's language threshold.
        - Member's letter includes interpretation services availability
        - Member's letter includes nondiscriminatory notice.
        - Provider notification includes the name and direct phone number of the appropriately licensed professional making the denial decision

III. Findings

A. For Q2 2021, the dates of service and denials were pulled in July 2021.

1. 30 unique authorizations were pulled with a random sampling.
    a. 50% or 15/30 Medi-Cal LOB and 50% or 15/30 CMC LOB
    b. 100% or 30/30 were denials
    c. 33% or 10/30 were expedited requests
        - 100% of the expedited authorizations are compliant with regulatory turnaround time of 72 calendar hours
    d. 66% or 20/30 were standard requests
        - 100% of the standard authorizations are compliant with regulatory turnaround time (5 business days for Medi-Cal LOB and 14 calendar days for CMC LOB / or 30 calendar days for retro)
    e. 47% or 14/30 were medical denials
    f. 53% or 16/30 were administrative denials
    g. 100% were denied by a Medical Director
    h. 100% or 30/30 of all requests were provided written notifications to both member and provider
    i. 100% or 10/10 of the expedited authorizations were provided oral notifications to member.
    j. 100% or 30/30 of the member letters are in the member's preferred language.
    k. 100% or 30/30 of the written notifications were readable
    l. 100% or 30/30 of the written notifications included the rationale for denial
    m. 97% or 29/30 of the letters included the criteria or EOC that the decision was based upon.
        - 1 did not include the Medicare guideline
    n. 100% or 30/30 of the letters included interpreter rights and instructions on how to contact the Medical Director.

IV. Follow-Up

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

1. Quality and productivity will continue to be monitored on a regular basis including these quarterly audits. Findings were reviewed by the Medical Director.
2. Issues will be addressed with the appropriate staff member.

Santa Clara Family Health Plan™

Behavioral Health UM

Behavioral Health

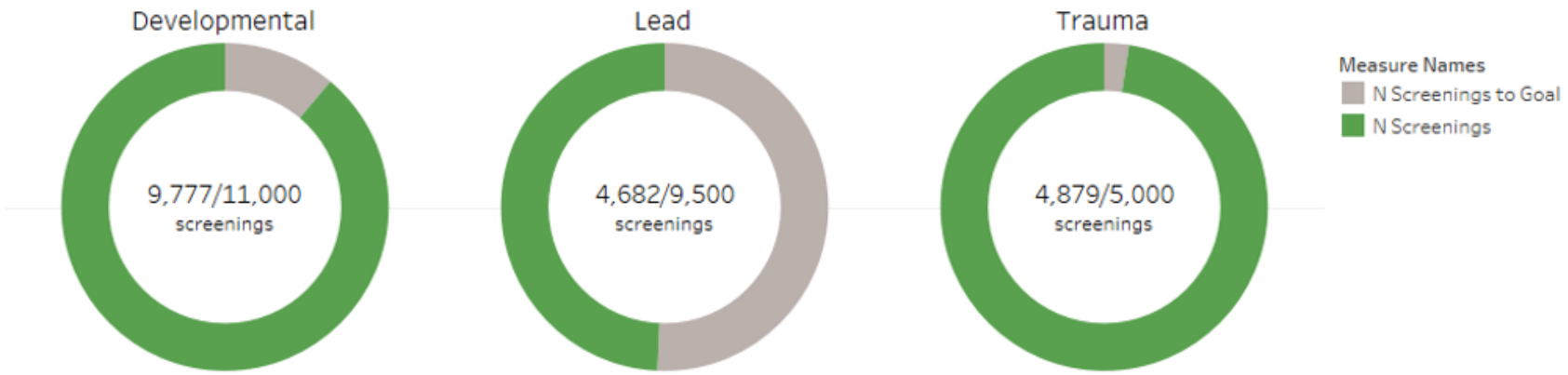
SCFHP Organizational Goals 2021-2022

- Increase Screenings
  - ≥ 11,000 developmental
  - ≥ 9,500 blood lead (< 6 years)
  - ≥ 7,500 trauma (< 65 years)
    - Implement process to ID positive screens, and
    - Expand provider education & engagement regarding referrals

- Funding to increase BH in schools
  - School incentive Program

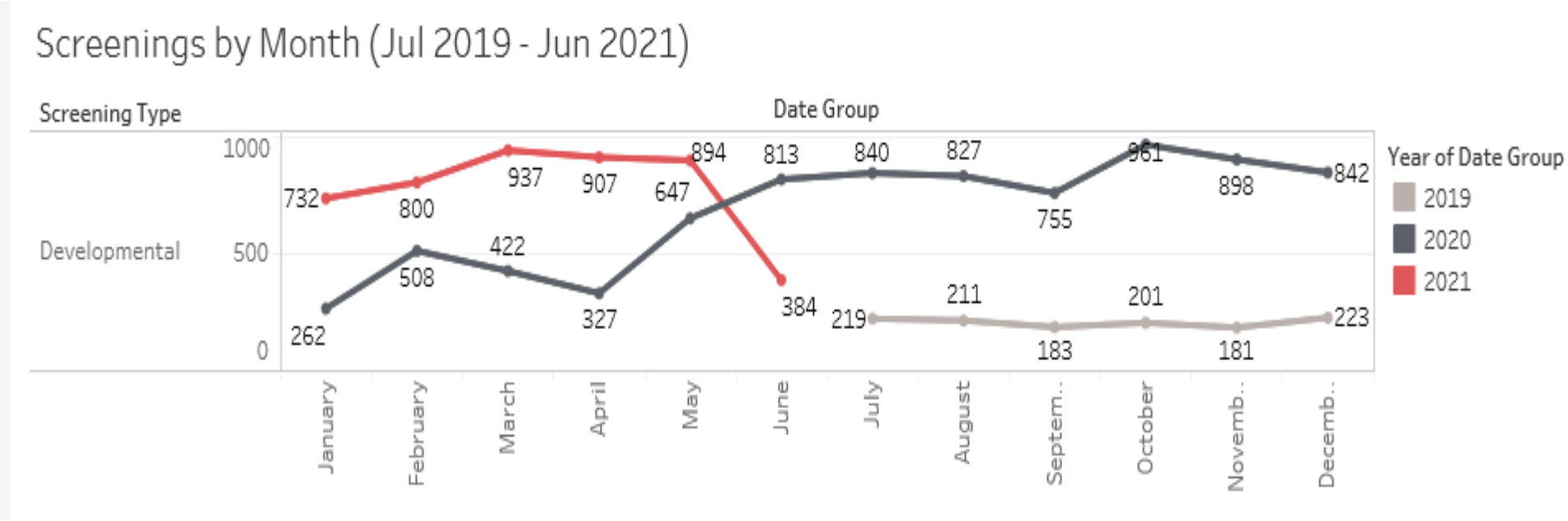
Behavioral Health

All Screening Goals Status as of 7/8/2021



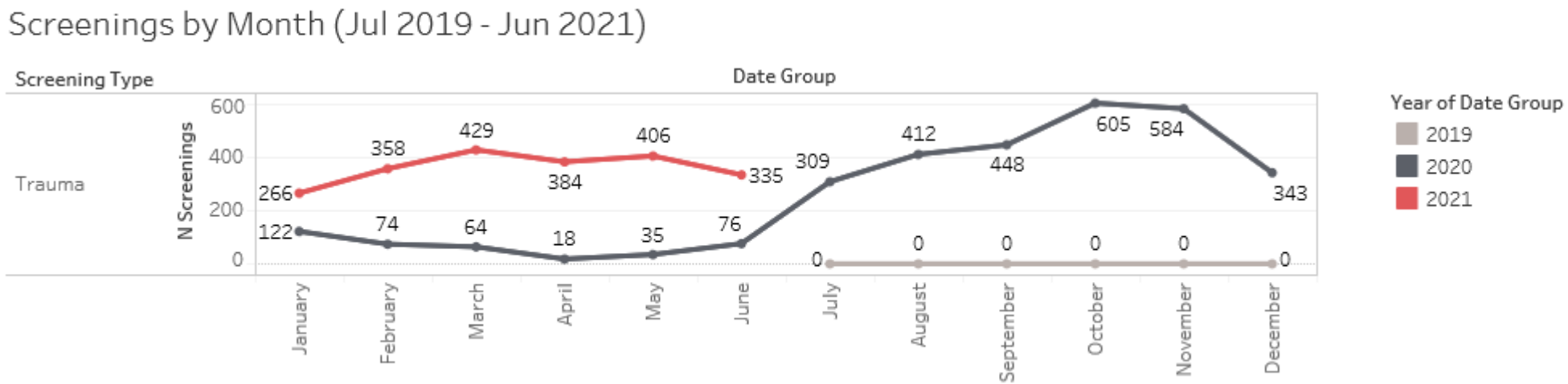
Behavioral Health

Developmental Screening



Behavioral Health

Trauma Screening



Behavioral Health

Developmental Screening by Network

Network	Total Quarter 1	Total Quarter 2	YTD Total
SCFHP Direct	87	14	120
VHP	695	1,040	2,305
PAMF	38	28	68
PMG	710	577	1,496
Premier	378	403	895
			4,884 (44.4%)

Run date 7/1/2021

Goal = ≥ 11,000

Behavioral Health

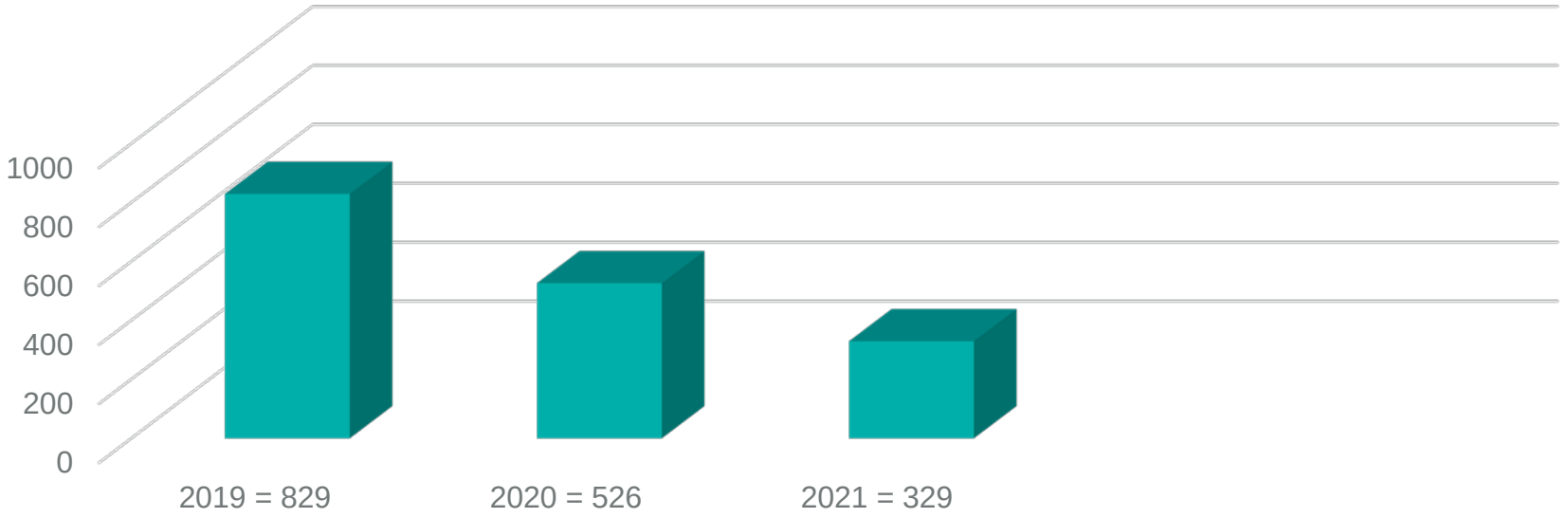
Psychiatric Admissions: **CMC**

Quarter 1- 2021: 11 admissions, one readmission at Reno Behavioral Health

Quarter 2- 2021: 9 admissions

Behavioral Health

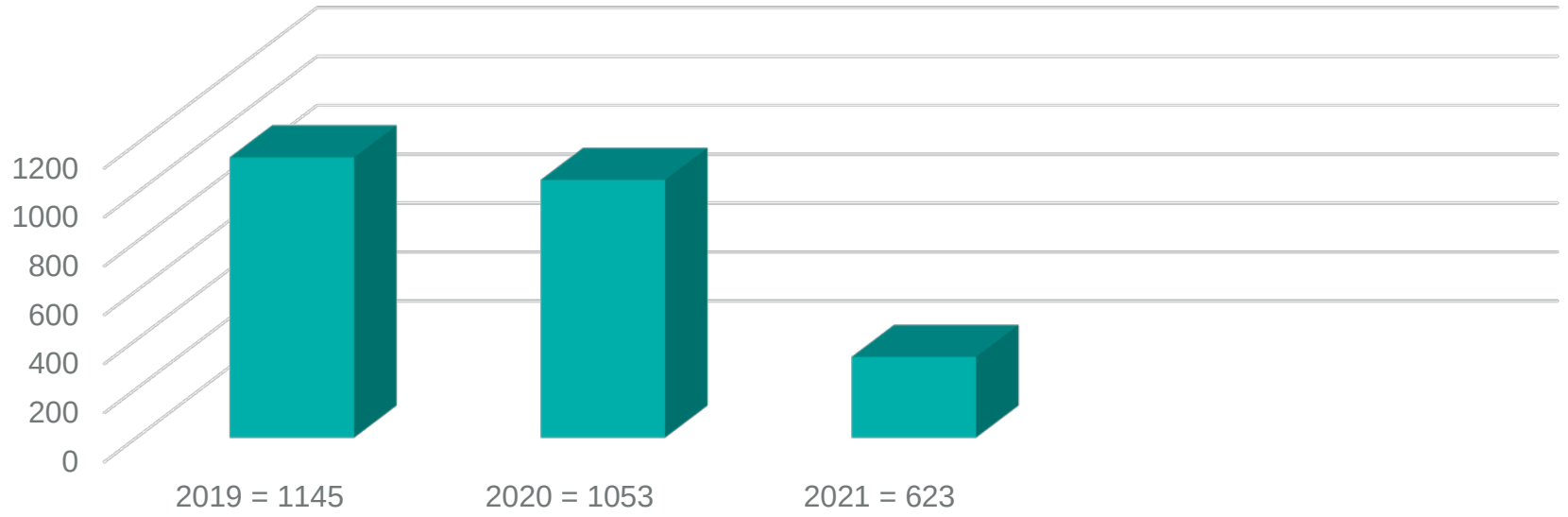
Utilization: **Mild to Moderate Cal MediConnect per 1,000**



2021* = Jan – Jun
Run Date 7/1/2021
Category of Service: Visit, Unique member, Service NPI, Date of service

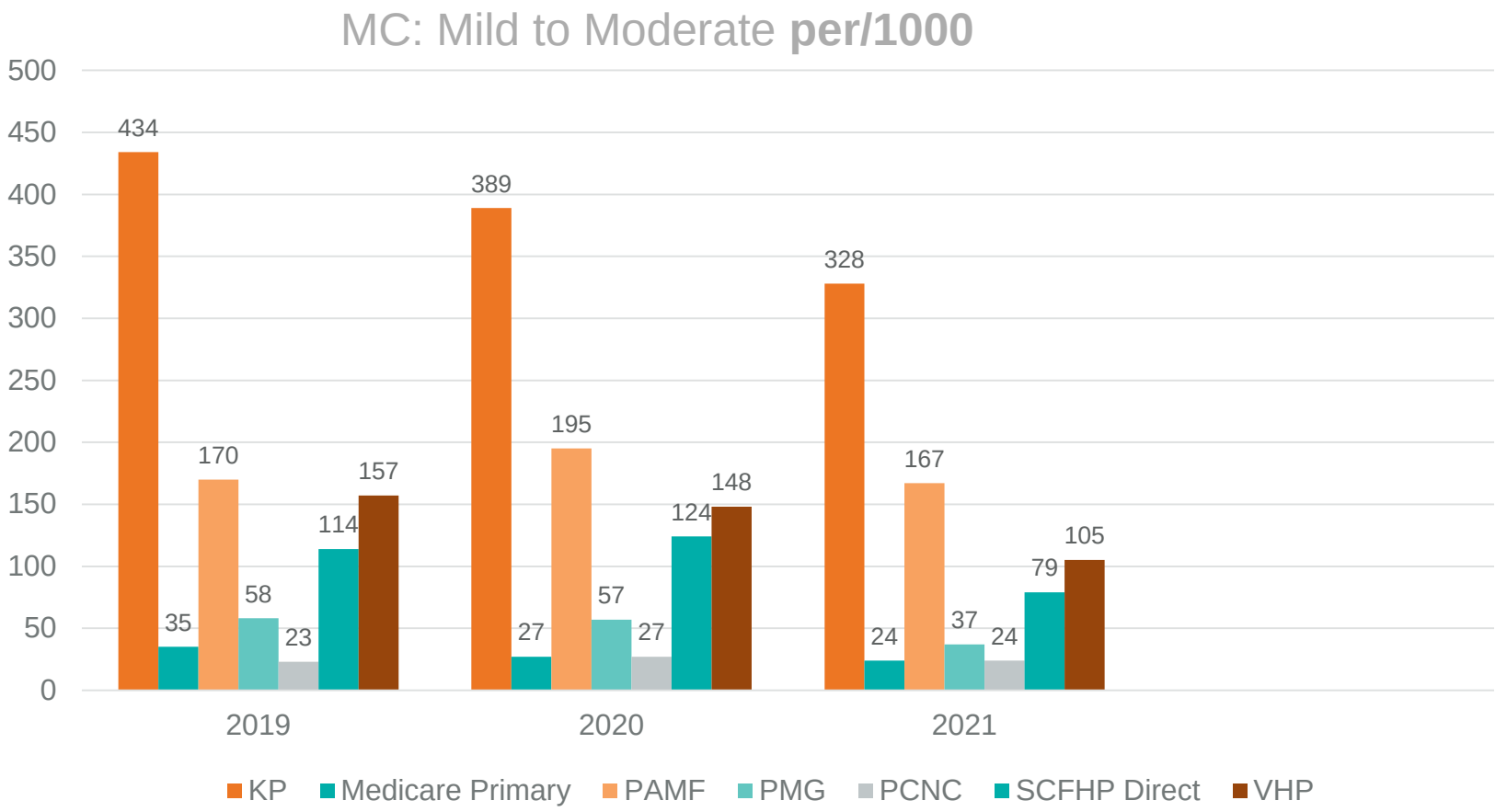
Behavioral Health

Utilization: **Mild to Moderate Cal MediConnect Unique Members**

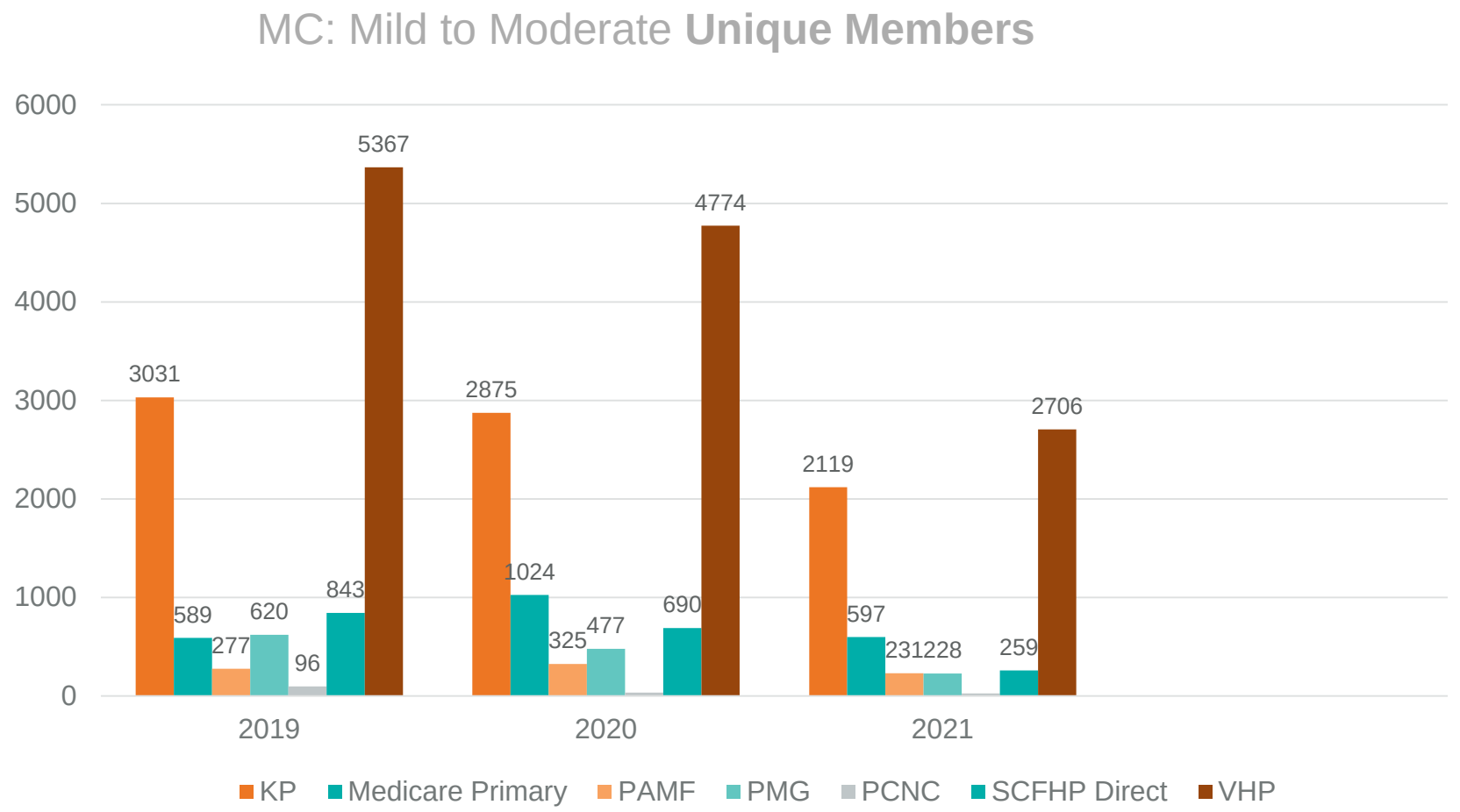


2021* = Jan – Jun months
Run Date 7/1/2021
Category of Service: Visit, Unique member, Service NPI, Date of service
Mental Health = All ages

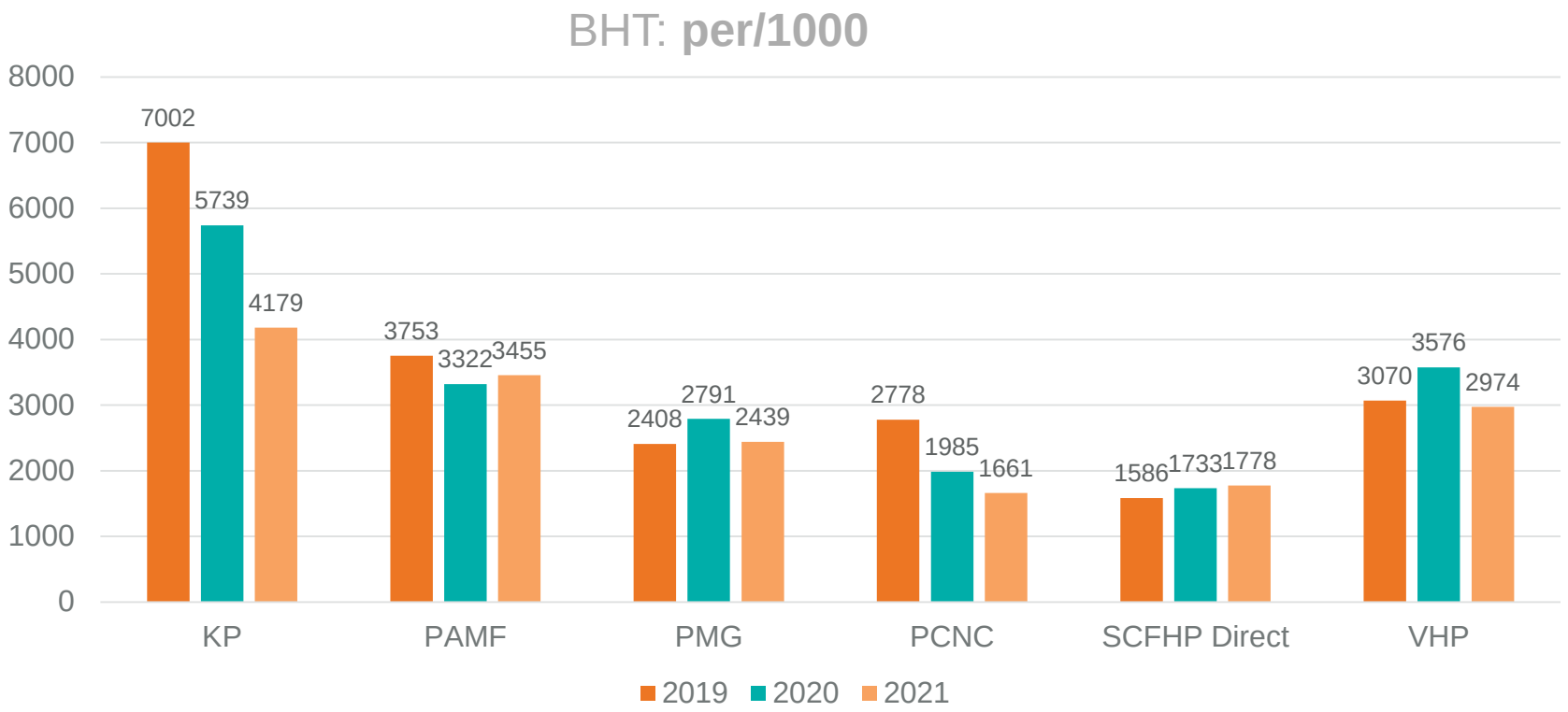
Behavioral Health



Behavioral Health

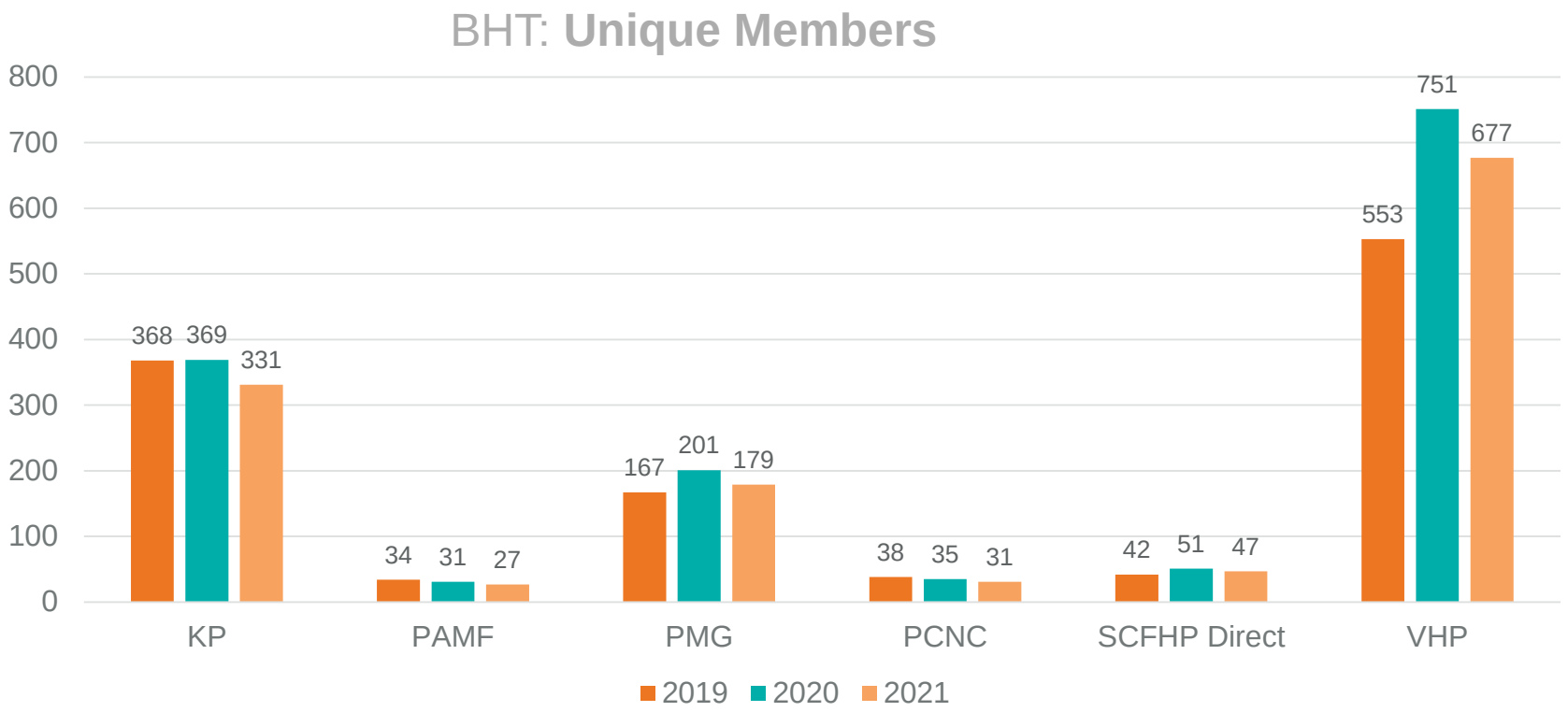


Behavioral Health Treatment



2021 = Jan – Jun
Run date 7/1/21
BHT = Units = hours
Member = <21 years

Behavioral Health Treatment



2021 = Jan – Jun
Run date 7/1/21
BHT = Units = hours
Member = <21 years

Santa Clara Family Health Plan™

Adjournment