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

Via Teleconference
(669) 900-6833
Meeting ID: 995 9017 6403
Passcode: **umc042021**
https://zoom.us/j/99590176403

AGENDA

1. Introduction	Dr. Lin	6:00	5 min
2. Public Comment Members of the public may speak to any item not on the agenda; two minutes per speaker. The committee reserves the right to limit the duration of public comment to 30 minutes.	Dr. Lin	6:05	5 min
3. Meeting Minutes Review minutes of the Q1 January 20, 2021 Utilization Management Committee (UMC) meeting. **Possible Action:** Approve Q1 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 **b.** Annual Confidentiality Agreements	Dr. Nakahira	6:20	10 min
6. Old Business/Follow-Up Items **a.** Plan-All-Cause Readmissions (PCR) Rates	Dr. Huynh	6:30	5 min
7. UM Program Evaluation – 2020 Annual review of UM Program Evaluation **Possible Action:** Approve UM Program Evaluation	Dr. Boris	6:35	5 min
8. UM Work Plan – 2021 Annual review of UM Work Plan **Possible Action:** Approve Annual UM Work Plan	Dr. Boris	6:40	5 min
9. Care Coordinator Guidelines Annual review of Care Coordinator Guidelines **Possible Action:** Approve Care Coordinator Guidelines	Mr. Perez	6:45	5 min

10. UM 1B Annual Assessment of Senior Level Practitioners for NCQA - 2020 Review of 1B Annual Assessment of Senior Level Practitioners for NCQA.	Dr. Boris	6:50	10 min
11. Home Health Services Authorization Procedure Review of HS.01.23 Home Health Services Authorization Procedure	Dr. Huynh	7:00	5 min
12. Reports			
a. Membership	Dr. Boris	7:05	5 min
b. Over/Under Utilization by Procedure Type/Standard UM Metrics			
c. Dashboard Metrics • Turn-Around Time – Q1 2021	Mr. Perez	7:10	5 min
d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q1 2021	Dr. Huynh	7:15	5 min
e. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q1 2021			
f. Behavioral Health UM	Ms. McKelvey	7:20	10 min
13. Adjournment Next meeting: July 21, 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™

Meeting Minutes – January 20, 2021

Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, January 20, 2021 6:00 – 7:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - DRAFT

Members Present
Jimmy Lin, M.D., Internal Medicine, Chair
Ali Alkoraishi, M.D., Psychiatry
Laurie Nakahira, D.O., Chief Medical Officer
Habib Tobbagi, PCP, Nephrology
Indira Vemuri, Pediatric Specialist

Members Absent
Dung Van Cai, D.O., Head & Neck
Ngon Hoang Dinh, OB/GYN

Staff Present
Christine Tomcala, Chief Executive Officer
Dang Huynh, PharmD, Director, Utilization Management & Pharmacy
Raman Singh, Director, Case Management
Lily Boris, M.D., Medical Director
Angela Chen, Manager, Utilization Management
Natalie McKelvey, Manager, Behavioral Health
Luis Perez, Supervisor, Utilization Management
Amy O'Brien, Administrative Assistant

1. **Roll Call**

   Jimmy Lin, MD, Chair, called the meeting to order at 6:08 p.m. Roll call was taken and a quorum was established.

2. **Public Comment**

   There were no public comments.

3. **Meeting Minutes**

   The minutes of the October 14, 2020 Utilization Management Committee (UMC) meeting were reviewed.

   It was moved, seconded, and the minutes of the October 14, 2020 UMC meeting were **unanimously approved.**

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

4. **Chief Executive Officer Update**

   Christine Tomcala, Chief Executive Officer, provided a brief update, which included SCFHP's participation in calls with the Public Health department. There are some challenges with the vaccine rollout. Southern California has received the majority of the vaccines, as they have more COVID cases, and their demand is greater than Santa Clara County. The state is working on streamlining the tiers for reopening, and ensuring there are more mass vaccination sites available.

5. Chief Medical Officer Update

a. General Update

Dr. Laurie Nakahira began with an update on SCFHP'S participation in Santa Clara County's and the state's vaccine distribution plan. The staff of SCFHP do not yet qualify for the vaccine, as we are not considered frontline health care workers. Currently, the county is concluding vaccine administration for those who qualify based on the 1A guidelines, and they are moving into vaccine administration for those who qualify based on the 1B criteria. Eligibility under the 1B guidelines includes those who are greater than 65 years of age and those with comorbidities. Dr. Nakahira gave an overview of the federal and state vaccination distribution plan. The SCFHP website includes a link to the Santa Clara Public Health site where members can sign up to schedule their vaccinations. Members with Kaiser, PAMF, and Stanford are encouraged to schedule their vaccinations directly with these facilities. Kaiser also offers vaccinations to non-members. Dr. Lin stated that one of his patients, who is not a Kaiser member, tried to sign up for a vaccination, but Kaiser turned them down. Dr. Nakahira stated that she was on the Kaiser website, and there is a toll-free number to call which will give you information on how to complete the online form and schedule your appointment. Dr. Boris explained that patients must go through Member Services to obtain a Kaiser ID number, then call the toll-free number to make an appointment. Oftentimes, the recording instructs you to call tomorrow, but with continued effort it is possible to make a vaccination appointment.

Dr. Nakahira continued with an update on the status of CalAIM, which was on hold due to COVID, but now has an implementation date of January 1, 2022. SCFHP is preparing for this implementation date. The Plan is also preparing for the DHCS and DMHC audits in March 2020.

Dr. Lin remarked that SCFHP staff members should qualify for the vaccination, as our line of business qualifies as patient care. Dr. Boris stated that, per the vaccination guidelines, SCFHP staff members do not qualify as frontline healthcare workers and are currently ineligible for the vaccination.

b. Annual Confidentiality Agreements

This item was not addressed this evening.

6. UM Program Description – 2021

Dr. Boris summarized the more significant changes to the 2021 UM Program Description for the Committee. Dr. Boris advised that the majority of the changes occurred in item "G", Emergency Services and Post-Stabilization care. Dr. Boris highlighted changes in verbiage such as the fact that referrals are no longer required for emergency medical conditions, including for severe pain that a prudent layperson would consider emergent. The Program Description also now states that SCFHP does require prior authorization for post-stabilization care beyond 30 minutes. Additional verbiage states that the Plan will fully document all requests for authorizations and our responses. A bullet point was added which states that, in the event the Plan is unable to provide a determination within 30 minutes, the requested authorization is deemed approved. The Plan's annual communication to providers, which includes the 24/7 managed care website, now states the names of the on-call physicians. Dr. Boris explained that, outside of these changes, the remainder or the 2021 UM Program Description remains the same as the 2020 Program Description.

It was moved, seconded, and the UM Program Description – 2021 was **unanimously approved.**

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

7. BHT Program Description - 2021

Ms. McKelvey presented the BHT Program Description for 2021 to the Committee. It has been 2 years since the last update to the BHT program. Ms. McKelvey advised the Committee that the recent changes are made to reflect the current APL of 19014. There are no changes to the authorization process. Once the request for service is received, all other steps in the process remain the same. The CDE is given to BH from the provider, not the parent. There are no changes or updates to the treatment codes or guidelines. BH reviews all treatment plans to ensure they are based on the individual needs of the child. Ms. McKelvey advised the Committee that an update to APL 19014 is expanded to include any child with a medical necessity for BHT, not just those with an autism diagnosis.

Dr. Vemuri requested improved communication between primary care physicians and therapists. Ms. McKelvey agreed, and she explained that, prior to COVID, BH conducted meetings with ABA providers who also struggled with communication issues. One action item has been implemented which is to request parents sign a Release of Information form which authorizes ABA therapists to communicate with primary care physicians. Dr. Vemuri suggested that, every time the patient visits the therapist, the therapist sends written documentation of the visit to the primary care physician. Ms. McKelvey advised that each authorization period is 6 months, and treatment plans are received by BH and used as criteria to determine continuation of treatment and services. These treatment plans can also be used as progress notes. Dr. Vemuri confirmed this information would be beneficial. Ms. McKelvey will follow-up with the BH team to implement this process. Dr. Alkoraishi indicated that use of the electronic medical record system to send progress notes to the primary care physician would be more beneficial.

Dr. Vemuri also expressed concern with the number of requests she receives from patients for emotional support animals. Her staff forwards these requests to patients' therapists; however, she would like to have confirmation that a patient is actually receiving treatment from a therapist. Dr. Nakahira suggested that patients, providers, and parents make an appointment together to ensure all parties are on the same page in regards to the patient's treatment.

Dr. Vemuri requested Ms. McKelvey contact Community Solutions and Rebekah Childrens' Services and request better communication with physicians. Ms. McKelvey agreed that there needs to be a better communication system. She advised that, for patients under 21 years of age, the EPSDT threshold for benefit management administered by county agencies is much lower than for adults. Ms. McKelvey advised that it is easier to address communication issues with ABA providers, rather than general mental health providers. Dr. Lin advised that he has never received any feedback from private mental health providers. Dr. Lin feels it is easier to provide treatment notes within the county provider network, rather than through private physicians. Ms. McKelvey advised the Committee that she will bring this feedback to the BH provider group to incorporate and implement as much as they can to achieve better communication.

It was moved, seconded and the BHT Program Description – 2021 was **unanimously approved**.

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

8. Annual Review of UM Policies

a. HS. 01 Prior Authorization
b. HS. 02 Medical Necessity Criteria
c. HS.03 Appropriate Use of Professionals
d. HS.04 Denial of Services Notification
e. HS.05 Evaluation of New Technology
f. HS.06 Emergency Services
g. HS.07 Long-Term Care Utilization Review
h. HS.08 Second Opinion

i. HS.09 Inter-Rater Reliability
j. HS.10 Financial Incentive
k. HS.11 Informed Consent
l. HS.12 Preventive Health Guidelines
m. HS.13 Transportation Services
n. HS.14 System Controls

Dr. Boris presented the Committee with the annual review of UM policies. Dr. Boris summarized the purpose of, and changes to, policies HS.01 through HS.06. No changes were made to policies HS.07 through HS.14. Changes may include formatting changes and streamlining of verbiage. Dr. Boris called the Committee's attention to policy HS.13 Transportation Services, as DHCS mandates which types of emergency medical transportation services require prior authorization; however, there are no changes to this policy from 2020. Dr. Boris further highlighted policy HS.14 System Controls, which is primarily required by NCQA; however, there are no changes to this policy from 2020.

It was moved, seconded and the Annual Review of UM Policies and Procedures was **unanimously approved**.

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

9. Reports

a. Membership

Dr. Boris gave a brief summary of the Membership Report from January 2020 through January 2021. Cal MediConnect membership increased approximately 14% from January 2020 to January 2021. Medi-Cal membership increased approximately 10% from January 2020 through January 2021. The majority of our members remain delegated to Valley Health Plan, with the remaining majority delegated to Physicians Medical Group, Premier Care, and Kaiser Care. Ms. Tomcala reminded the Committee that the primary reason for the growth of our Medi-Cal membership is the suspension of redeterminations by the state. Our existing members continue to stay on the plan when, under normal circumstances, the Plan would lose approximately 4,000 members a month due to redeterminations. This trend will continue through the public health emergency. Once COVID is under control, the state will resume redeterminations, and the Plan may see a significant drop in our Medi-Cal membership rolls.

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. Dr. Boris also summarized the 2020 results of the Cal MediConnect line of business. The average length of stay for our Medi-Cal SPD population is approximately 5 days, with Q1 slightly higher due to flu season. Our Q1 discharges per thousand is also higher due to flu season. Otherwise, the numbers remain fairly stable. The average length of stay for our non-SPD Medi-Cal population was approximately 4 days, with the number of discharges per thousand slightly lower than for our Medi-Cal SPD population.

The average length of stay for our Cal MediConnect population is 5.85 days, and this, along with the number of discharges per thousand, is typically higher than our Medi-Cal SPD and non-SPD populations due to higher utilization levels and increases in co-morbidities. Ms. Tomcala requested the UM team compare these numbers to 2019 to see the impact of COVID. Dr. Boris concurred and will bring these results to the April 2021 meeting.

Dr. Boris next summarized the results for Medi-Cal and Cal MediConnect inpatient readmissions, from January through December 2020. The Medi-Cal readmission rate is 17.71%; however, the goal was closer to 10%. The report may not have been run to exclude outliers, which has potentially impacted this number. The Plan's usual readmission rate is closer to 20%. The Cal MediConnect readmission rate is 15.99% which is below the NCQA 50th percentile. Ms. Tomcala remarked that the formula for the metric of the HEDIS PCR measure changed from 2019 to 2020. The goals should have been set, and this data pulled, based on the current 2020 metric. Dr. Boris agreed that the data should be rerun either based on the current metric, or with the outliers omitted. Dr. Lin remarked that he would expect the numbers to be 10-15% less due to COVID. Dr. Boris concurred, and this decrease is reflected in the number of outgoing calls.

Dr. Boris concluded with a summary of the ADHD Medi-Cal BH metrics.

c. Dashboard Metrics

- Turn-Around Time – Q4 2020

  Mr. Perez summarized the Cal MediConnect Turn-Around Time metrics for Q4 2020. The turn-around times for determinations is compliant at 99% or better. The turn-around time for expedited Part C prior authorization requests was compliant for October and November, but decreased in December. The percentages for expedited initial determination notifications also decreased. In the categories of Part B determinations and prior authorization requests, there is some room for improvement; however, the range of percentages still remains at 90% or better.

  Mr. Perez next summarized the Turn-Around times for Medi-Cal authorizations for Q4 2020. The turn-around times for authorizations is compliant at 97% or better. In other areas of authorization requests, the percentages decreased; however, the range of percentages remains at 97% or better.

d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q4 2020

Ms. Chen summarized the data from the Q4 2020 Cal MediConnect and Medi-Cal Quarterly Referral Tracking reports for the Committee. Ms. Chen 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. Some of the more high volume requests include outpatient hospital services, DME requests, and home healthcare, and include the highest number of unpaid services. The results for Q4 2020 are consistent with the results for Q3 2020.

e. Cal MediConnect and Medi-Cal Annual Referral Tracking – Q4 2020

Ms. Chen summarized the data from the Q4 2020 Cal MediConnect and Medi-Cal Annual Referral Tracking reports for the Committee. There were 22, 819 authorizations for both the Cal MediConnect and Medi-Cal lines of business. The Medi-Cal line of business typically has a higher volume than the Cal MediConnect line of business. On average, this accounts for approximately 1,900 authorizations per month on average. Even with the suspension of prior authorization requirements for all covered services and medications in March and April, there is not a large difference between the Q3 2020 and Q4 2020 results. Compared to 2019 data, there was a higher percentage of services rendered within 90 days, and a lower percentage of services not rendered at all. During COVID, the same volume of authorizations were approved and more people received requested services than prior to COVID. Ms. Chen summarized the results of the outreach calls that were made to our Cal MediConnect and Medi-Cal members. Ms. Chen further summarized the results of the data used to track claims mismatch.

f. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q4 2020

Ms. Chen summarized the results of the Q4 2020 Quality Monitoring of Plan Authorizations and Denial Letters for the Committee. Ms. Chen reported that the UM department received a 100% score in virtually all categories, with the exception of a small handful of written notifications that were untimely. As a result,

work flows have been updated to include daily reports, and UM leadership will continue to take an active role in QA oversight.

g. Inter-Rater Reliability (IRR) Report BH – 2021

Ms. McKelvey presented the results of the 2021 BH IRR report to the Committee. Of the 4 staff members who provided authorizations and completed the IRR, 3 achieved a 100% score, and 1 achieved a 90% score. All staff members passed and are cleared to continue with the authorizations.

h. Annual Physician Peer-to-Peer (HS.02.02) – 2020

Dr. Boris presented the purpose and goals of the Annual Physician Peer-to-Peer program for 2020. Dr. Boris summarized the results for the Committee.

i. Behavioral Health UM

Ms. McKelvey summarized the Behavioral Health Treatment utilization for the Committee. Ms. McKelvey highlighted the 2 new ABA providers under contract as of Q4 2020. Ms. McKelvey also highlighted the fact that Array Telehealth was just signed as a new provider for our Medi-Cal line of business. There were 8,027 developmental screenings completed in 2020. The majority of these were completed by VHP. There were 3,221 trauma screenings completed in 2020. The BH work group continues its efforts to raise the level of developmental and trauma screenings.

Dr. Boris asked if members can specifically request the services of Array Telehealth. Ms. McKelvey confirmed members can either access Array directly, or request the BH team connect them to services. Training on Array Telehealth's scheduling app will soon be conducted. Array is the first mild-to-moderate psychiatric services provider for the Plan's adult population.

10. Adjournment

The meeting adjourned at 7:10 p.m. The next meeting of the Utilization Management Commitment is on April 21, 2021 at 6:00 p.m.

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Jimmy Lin, M.D, Chair Date
Utilization Management Committee

Santa Clara Family Health Plan™

Plan-All-Cause Readmission (PCR) Rates

Measurement Year	Start Date	End Date	LOB	Measure	Numerator	Denominator	Rate
2019	1/1/2019	12/31/2019	Cal MediConnect	PCR	174	1962	8.87%
2019	1/1/2019	12/31/2019	Medi-Cal	PCR	354	4263	8.30%
2020	1/1/2020	12/31/2020	Cal MediConnect	PCR	398	4154	9.58%
2020	1/1/2020	12/31/2020	Medi-Cal	PCR	895	10733	8.34%

Goal: Reduce Medi-Cal Plan All-Cause Readmissions (PCR) to 7.48%

Santa Clara Family Health Plan™

UM Program Evaluation

Santa Clara Family Health Plan

UTILIZATION MANAGEMENT PROGRAM EVALUATION 2020

	WORK PLAN							EVALUATION	
	SCOPE	OBJECTIVE	ACTION STEPS	GOAL	RESPONSIBLE PARTY	REPORT FREQUENCY	TARGET DATE OF COMPLETION	DATE OF COMPLETION	FINDINGS/COMMENTS
1	Quality of Clinical Care	Expand on Current reporting and present findings to UMC	Review Medi-Cal Inpatient Admissions/1000	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4	Jan 15, April 15, July 15, Oct 14 all in 2020	Discharges / 1000 member months are used as a marker of admits. A delay in data was noted for the first two UMC meetings, Followed with data Q3-4 which shows continued SPD d/c / 1000 member months at 15 and non-spd at 5. This has been stable
2	Quality of Clinical Care	Monitor appropriate inpatient admissions	Review CMC Inpatient Admissions/1000	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4	Jan 15, April 15, July 15, Oct 14 all in 2020	Discharges / 1000 member months are used as a marker of admits. A delay in data was noted for the first two UMC meetings, Followed with data Q3-4 which shows continued CMC D/C / 1000 member months at 230-250 indicating loosely managed.
3	Quality of Clinical Care	Monitor appropriateness of inpatient stays to assess proper level of care	Review Medi-Cal Inpatient ALOS	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4	Jan 15, April 15, July 15, Oct 14 all in 2020	ALOS for MCAL has been stable: Non-SPD and SPD members at approx 5 days. SCFHP has not had any changes in contracted hosptials. LOS is stable
4	Quality of Clinical Care	Monitor appropriateness of inpatient stays to assess proper level of care	Review CMC Inpatient ALOS	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4	Jan 15, April 15, July 15, Oct 14 all in 2020	ALOS for CMC is higher at 5-6.5 indicating that our CMC members are higher risk based on their dual elig.
5	Quality of Clinical Care	Monitor Readmissions, all cause to minimize unnecessary premature discharge and applicable post discharge follow up and care.	Medi-Cal Inpatient Readmissions	HEDIS goal	Medical Director	Quarterly	Q1, Q2, Q3, Q4	Jan 15, April 15, July 15, Oct 14 all in 2020	Medi-Cal readmissions are approx 14-17%. SCFHP implemented Transitions of Care for all COVID patient's. Delegated networks which manage most of Medi-Cal members will be crucial to achieving readmission reduction
6	Quality of Clinical Care	Monitor Readmissions, all cause to minimize unnecessary premature discharge and applicable post discharge follow up and care.	CMC Inpatient Readmissions	HEDIS goal	Medical Director	Quarterly	Q1, Q2, Q3, Q4	Jan 15, April 15, July 15, Oct 14 all in 2020	CMC readmissions are approx 16-17%. SCFHP board has now set goals for readmissions as a company focus / strategy. SCFHP implemented Transitions of Care for all CMC members in CY 2020 to assist in readmission reduction.
7	Quality of Service	Assess Medi-Cal denial rates on PARs; provide benchmarks and compare to CA specific plans	Measure and act on denial rates on Outpatient PARs	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4	Jan 15, April 15, July 15, Oct 14 all in 2020	Denial rate is stable and at community standard of 4-6%. No recommendations.
8	Quality of Service	Assess CMC denial rates on PARs; provide benchmarks and compare to CA specific plans	Measure and act on denial rates on Inpatient PARs	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4	Jan 15, April 15, July 15, Oct 14 all in 2020	Denial rate is stable and at community standard of 4-6%. No recommendations.
9	Quality of Service	Track and monitor denial rates on PARs; provide benchmarks and compare to CA specific plans	Track and monitor BH IP Stays for CMC	MCG and CA benchmarks	Medical Director	Quarterly	Q1, Q2, Q3, Q4	Unable to calculate	BH reports show <20 admissions in BH / quarter. Follow up is completed with BH Case Management. IT team will assist with both inpt and outpt BH tracking for 2021 and developing reports.
10	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	Medi-Cal ADD Follow-up Care for Children with ADD	HEDIS Benchmarks	Manager of Behavioral Health	Quarterly	Q1, Q2, Q3, Q4	Jan 15, April 15, July 15, Oct 14 all in 2020	Initiation and Continuation of meds has been stabel at approx the 50th % HEDIS for ADHD in children.
11	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	Medi-Cal AMM Antidepressant Medication Management	HEDIS Benchmarks	Manager of Behavioral Health	Quarterly	Q1, Q2, Q3, Q4	Jan 15, April 15, July 15, Oct 14 all in 2020	Acute and Continuation phase of treatment has been stable and >75th % of HEDIS
12	Quality of Clinical Care	Review with the QIC and UMC reports of over/under utilization against National and State benchmarks	CMC SMC Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	HEDIS Benchmarks	Manager of Behavioral Health	Quarterly	Q1, Q2, Q3, Q4	Jan 15, April 15, July 15, Oct 14 all in 2020	CV monitoring is at <10% HEDIS and will be followed with Quality
13	Quality of Service	Internal audit process and corrective action as necessary	Report Turn Around Times (TAT) for Prior Authorizations for Medi-Cal and CMC LOB	DHCS and CMS regulatory TAT	Manager of Utilization Management	Quarterly	Q1, Q2, Q3, Q4	Jan 15, April 15, July 15, Oct 14 all in 2020	TAT has been stable at 90-100% in both Lines of Business
14	Quality of Service	Internal audit process and corrective action as necessary	Report TAT based on priority for Medi-Cal and CMC	DHCS and CMS regulatory TAT	Manager of Utilization Management	Quarterly	Q1, Q2, Q3, Q4	Jan 15, April 15, July 15, Oct 14 all in 2020	TAT has been stable at 90-100% in both Lines of Business
15	Quality of Service	Annual IRR will be presented to the UMC	Assess and measure consistency of applying medical necessity criteria	80% passing rate	Manager of Utilization Management	Bi-Annually	Q2, Q4	July 15 2020 UM and BH	IRR showed no gaps in staff and UM has had no significant turnover in 2020.
16	Quality of Service	Monitor Member and Provider experience	Conduct Member & Provider satisfaction survey	90% Satisfaction	Manager of Utilization Management	Annually	Q4	NA	Satisfaction Survey was not conducted. UM Management will use the CAHPS and Grievances against UM as a measure of satisfaction
17	Quality of Clinical Care	UM Program Description	UM Program Description will be adopted on an annual basis	Adoption	Health Services Director	Annually	Q1	Jan 15 2020	Completed and no findings
18	Quality of Clinical Care	Annual Evaluation of Utilization Management Program will be reviewed and updated	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis	Revisions/Adoption	Manager of Utilization Management	Annually	Q2	April 15 2020	Completed and no findings
19	Quality of Clinical Care	Implement a UM program which utilizes medical necessity decisions consistently, are objective and based upon evidence based criteria	Annually review and approve Medical Necessity Criteria policy	Review and Adoption	Manager of Utilization Management	Annually	Q1	Jan 15 2020	Completed and no findings
20	Quality of Service	Implement a UM program which provides access to staff for members and practitioners seeking information about the UM process and authorization of care	Annually review and approve Communication with Health Services Procedure	Review and Adoption	Manager of Utilization Management	Annually	Q1	Jan 15 2020	Completed and no findings
21	Quality of Clinical Care	Implement a UM program which utilizes qualified health professionals to assess clinical information to support UM decisions	Annually review and approve Appropriate Use of Professionals policy	Review and Adoption	Manager of Utilization Management	Annually	Q1	Jan 15 2020	Completed and no findings
22	Quality of Clinical Care	Implement a UM program which determines coverage based on medical necessity.	Annually review and approve Prior Authorization Procedure for clinical information	Review and Adoption	Manager of Utilization Management	Annually	Q1	Jan 15 2020	Completed and no findings
23	Quality of Service	Implement a UM program which documents and communicates reason for a denial with information on appeal process.	Annually review and approve Denial of Services Notification policy.	Review and Adoption	Manager of Utilization Management	Annually	Q1	Jan 15 2020	Completed and no findings
24	Quality of Clinical Care	Implement a UM program which evaluates inclusion of new technology and new application of existing technology to ensure that members have equitable access to safe and effective care	Annually review and approve Evaluation of New Technology Policy	Review and Adoption	Manager of Utilization Management	Annually	Q1	Jan 15 2020	Completed and no findings

Santa Clara Family Health Plan™

UM Work Plan

Santa Clara Family Health Plan

UTILIZATION MANAGEMENT WORKPLAN FOR CY 2021

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

Santa Clara Family Health Plan™

Care Coordinator Guidelines

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

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Utilization Management Care Coordinator Guidelines

OVERVIEW

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

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

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

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

INPATIENT ACUTE HOSPITALIZATION

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

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

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

4. Acute Rehab - send to nurse for review

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

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

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

SKILLED LEVEL OF CARE (SNF)

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

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

3. Coordinator will approve initial 7 days.

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

LONG TERM CARE

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

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

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

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

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

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

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

BED HOLD

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

2. Bed Hold Notification Form is received from Facility

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

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

HOME HEALTH

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

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

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

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

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

HOSPICE ROOM AND BOARD FOR NON-CONTRACTED PROVIDERS

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

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

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

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

5. Care coordinator may approve up to 90 days.

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

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

HEARING AID

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

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

3. Current Audiology exam done by an Audiologist

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

HEARING AID REPAIR

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

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

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

OUTPATIENT PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

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

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

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

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

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

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

WHEELCHAIR REPAIR

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

2. Wheelchair must be 3 year old or less.

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

NON-EMERGENCY TRANSPORTATION

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

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

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

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

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

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

Santa Clara Family Health Plan

Utilization Management Care Coordinator Guidelines

BEHAVIORAL HEALTH TREATMENT (BHT)

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

Santa Clara Family Health Plan™

UM 1B Annual Assessment of Senior Level Practitioners

UM 1B - Annual Assessment of Senior Level Utilization Management Practitioner in activities relative to Utilization Management 2020

Santa Clara Family Health Plan (SCFHP) annually assesses the senior level practitioner involvement in all activities related to UM. This includes both Medical and Behavioral Health components of the UM process.

The following activities were completed with both senior level practitioners on a quarterly basis in UM:

1. **What committee's does he/she chair for UM?**
    a. The UM Medical Director Dr. Boris, co-chairs the Utilization Management Committee (UMC) Meetings with our committee practitioner Dr. Lin. In addition, the UMC has a Dr. Alkorashi a psychiatrist on the committee.
    b. The Committee met in CY 2020 quarterly: Jan 15, April 15, July 15, Oct 14 -- 2020
    c. As per the minutes all three providers, Dr. Lin, Dr. Boris, and Dr. Alkorashi had active participation in the meetings.

2. **Are they involved in development of medical necessity policy and approval of criteria?**
    a. SCFHP does not produce internal criteria for medical necessity. The UMC approves Care Coordinator Guidelines, MCG, and the hierarchy of criteria annually.

3. **Are they involved in Inter-Rater Reliability (IRR) testing for the physicians, do they provide review sessions with the physicians on the IRR results?**
    a. Dr. Boris, the UM Medical Director does actively participate in the IRR process. Please see UMC Packet: July 15, 2020

4. **Do they provide input to the UM program development and the evaluation process?**
    a. Dr. Lin, Dr. Boris, and Dr. Alkorashi, all participate in the review and development of the UM program description annually.

5. **Do they report to the board or the Chief Medical Officer (CMO) on UM activities and programs?**
    a. All UMC meeting minutes are taken through the Quality Improvement Committee to the Governing Board.
    b. The CMO, Dr. Nakahira, also attends the UMC.

6. **How involved are they with UM Delegates?**
    a. Delegation issues that would need UMC input are brought on an as needed basis. Delegation oversight is structurally under Compliance. Compliance shall involve Senior Level UM Practitioners in their audits and oversights.

As noted in 1-6 above, SCFHP has met the annual assessment of senior level practitioner (medical and behavioral health) in UM.

Santa Clara Family Health Plan™

Authorization for Home Health Services Procedure

PROCEDURE

Procedure Title:	**Home Health Services Authorization**	**Procedure No.:**	HS.01.23
Replaces Procedure Title (if applicable):	None	**Replaces Procedure No. (if applicable):**	None
Issuing Department:	Utilization Management	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal ☒ CMC		

I. Purpose

To outline Santa Clara Family Health Plan (SCFHP)'s process for authorizing initial and continuing home health services.

II. Procedure

A. Home health services prior authorization requests shall follow existing Utilization Management (UM) prior authorization policies and procedures.
B. Home health services requests exceeding SCFHP's Care Coordinator Guidelines shall be reviewed by the plan's nurses and Medical Directors.
C. 200% of Medicare 50th percentile for home health service visits shall be deemed appropriate for all Medi-Cal beneficiaries include Cal MediConnect members.
D. Clinical reviewers may approve up to twice the number (200%) of Medicare 50th percentile recommended visits per each MCG guideline of home health services.
E. Extension request for additional services shall require current home health clinical notes to support the need for on-going services and shall not exceed 200% number of visits for the Medicare 50th percentile outlined in MCG guidelines.

III. Responsibilities

Health Services collaborates with internal and external stakeholders to ensure optimal utilization management of services for plan members. This includes working with of Quality, Information Technology, Provider Network Operations, Customer Services, outside community resources and providers.

IV. Policy References

HS.01 Prior Authorization

V. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval

PROCEDURE

V1	Revised	Dang Huynh, Pharm.D. Director, Pharmacy & Utilization Management Date	Lily Boris, M.D. Medical Director Date

Santa Clara Family Health Plan™

Membership

Santa Clara Family Health Plan

Membership

Source: iCat (04/01/2021)

Mbr Ct Sum		Cap Month												
LOB	Network Name	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
CMC		**8,725**	**8,837**	**8,987**	**9,029**	**9,266**	**9,428**	**9,570**	**9,679**	**9,820**	**9,807**	**9,893**	**9,880**	**9,924**
	Santa Clara Family Health Plan	8,725	8,837	8,987	9,029	9,266	9,428	9,570	9,679	9,820	9,807	9,893	9,880	9,924
MC		**235,049**	**240,656**	**244,888**	**248,007**	**251,004**	**253,252**	**256,490**	**259,202**	**261,287**	**263,093**	**265,095**	**266,962**	**269,043**
	INDEPENDENT PHYSICIANS	14,781	15,216	15,610	15,844	16,113	16,358	16,627	16,829	16,938	16,987	17,132	17,266	17,442
	KAISER PERMANENTE	25,300	25,985	26,541	27,212	27,844	28,232	28,868	29,337	29,706	30,131	30,557	31,024	31,418
	MEDICARE PRIMARY	15,463	15,649	15,653	15,696	15,684	15,698	15,742	15,830	16,002	15,941	16,048	16,085	16,094
	PALO ALTO MEDICAL FOUNDATION	6,448	6,583	6,633	6,696	6,759	6,823	6,935	6,985	7,010	7,065	7,143	7,221	7,277
	PHYSICIANS MEDICAL GROUP	41,212	42,040	42,632	43,036	43,436	43,695	44,223	44,560	44,861	45,178	45,466	45,631	45,945
	PREMIER CARE	14,487	14,802	15,011	15,144	15,274	15,344	15,473	15,593	15,646	15,695	15,781	15,852	15,941
	VHP NETWORK	117,358	120,381	122,808	124,379	125,894	127,102	128,622	130,068	131,124	132,096	132,968	133,883	134,926
Grand Total		**243,774**	**249,493**	**253,875**	**257,036**	**260,270**	**262,680**	**266,060**	**268,881**	**271,107**	**272,900**	**274,988**	**276,842**	**278,967**

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

Membership

Source: iCAT (1/12/2021)

Year-Month	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12
Medi-Cal	248,007	251,004	253,252	256,490	259,202	261,287
Cal MediConnect	9,029	9,266	9,428	9,570	9,679	9,820
Total	**257,036**	**260,270**	**262,680**	**266,060**	**268,881**	**271,107**

Source: iCAT (1/3/2020)

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

Inpatient Utilization: Medi-Cal –SPD DOS 1/1/2020 – 12/31/2020

Source: MCL Enrollment & QNXT Claims and Encounter Data (Run Date:1/11/2021)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2020-Q1	1,059	16.04	5,865	5.54
2020-Q2	819	12.28	4,318	5.27
2020-Q3	762	11.42	3,774	4.95
2020-Q4	533	7.98	2,653	4.98
Total	3,173	11.92	16,610	5.23

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

Inpatient Utilization: Medi-Cal –SPD DOS 1/1/2019 – 12/31/2019

Source: MCL Enrollment & QNXT Claims and Encounter Data (Run Date:1/25/2021)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2019-Q1	1,037	15.40	5,761	5.56
2019-Q2	1,006	14.96	5,399	5.37
2019-Q3	1,027	15.39	5,451	5.30
2019-Q4	1,063	15.91	5,501	5.18
Total	4,133	15.41	22,112	5.35

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

Inpatient Utilization: Medi-Cal – Non-SPD DOS 1/1/2020 – 12/31/2020

Source: MCL Enrollment & QNXT Claims and Encounter Data (Run Date:1/11/2021)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2020-Q1	2,506	4.44	11,031	4.40
2020-Q2	2,076	3.56	7,788	3.75
2020-Q3	2,383	3.90	9,592	4.03
2020-Q4	1,503	2.38	6,222	4.14
Total	8,468	3.54	34,633	4.09

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

Inpatient Utilization: Medi-Cal – Non-SPD DOS 1/1/2019 – 12/31/2019

Source: MCL Enrollment & QNXT Claims and Encounter Data (Run Date:1/25/2021)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2019-Q1	3,573	5.38	16,132	4.51
2019-Q2	3,468	5.28	17,244	3.97
2019-Q3	3,691	5.68	17,404	4.71
2019-Q4	3,367	5.18	15,282	4.53
Total	14,099	5.38	66,062	4.68

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

Inpatient Utilization: Cal MediConnect (CMC)
DOS 1/1/2020 – 12/31/2020

Source: CMC Enrollment & QNXT Claims Data (Run Date:1/11/2021)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2020-Q1	518	21.08	3,337	6.44
2020-Q2	358	13.88	2,156	6.02
2020-Q3	454	16.65	2,542	5.60
2020-Q4	296	10.38	1,481	5.00
Total	1,626	15.32	9,516	5.85

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

Inpatient Utilization: Cal MediConnect (CMC)
DOS 1/1/2019 – 12/31/2019

Source: CMC Enrollment & QNXT Claims Data (Run Date:1/25/2021)

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2019-Q1	507	22.55	3,337	5.67
2019-Q2	471	20.69	2,156	5.47
2019-Q3	437	18.74	2,542	5.32
2019-Q4	457	17.12	1,481	5.83
Total	1,872	20.24	9,516	5.58

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

Medi-Cal Inpatient Utilization

2020

	Medi-Cal Population		
Measure	**Non-SPD**	**SPD**	**Total**
Discharges / 1,000 Member Months	3.54	11.92	4.38
ALOS	4.09	5.23	4.40

2019

	Medi-Cal Population		
Measure	**Non-SPD**	**SPD**	**Total**
Discharges / 1,000 Member Months	5.38	15.41	6.31
ALOS	4.69	5.35	4.84

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

Inpatient Readmissions: Medi-Cal

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 1/1/2019 – 12/31/2020

2020

LOB	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1,2,3]
MC - 2020	5,070	898	17.71%

2019

LOB	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1,2,3]
MC - 2019	5,758	1,140	19.80%

[1] A lower rate indicates better performance.
[2] Only for members aged 18-64 in Medi-Cal.
[3] HEDIS PCR 2019 used. This includes outliers in comparison to PCR 2020.

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

2020

Rate Description	PCR
Count of Index Hospital Stays	1,313
Count of 30-Day Readmissions	210
Actual Readmission Rate	15.99%
NCQA Medicare 50th Percentile	16.39%
SCFHP Percentile Ranking	>50th

2019

Rate Description	PCR
Count of Index Hospital Stays	1,366
Count of 30-Day Readmissions	194
Actual Readmission Rate	14.20%
NCQA Medicare 50th Percentile	16.39%
SCFHP Percentile Ranking	>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.

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 – Q1 2021

Santa Clara Family Health Plan

Cal MediConnect Compliance Dashboard	Jan	Feb	Mar	Q1 2021
CONCURRENT ORGANIZATION DETERMINATIONS				
# of Concurrent Requests Received	**5**	**153**	189	**347**
# of Concurrent Review of Authorization Requests (part C) completed within five (5) working days of request	**5**	**153**	188	**346**
% of Concurrent Review of Authorization Requests (part C) completed within five (5) working days of request	**100.0%**	**100.0%**	**99.5%**	**99.7%**
# of Concurrent Notifications Sent	**5**	**153**	189	**347**
# of Concurrent Initial Determination Notification (part C) sent to Provider/Member within five (5) working days of request	**5**	**153**	189	**347**
% of Concurrent Initial Determination Notification (part C) sent to Provider/Member within five (5) working days of request	**100.0%**	**100.0%**	**100.0%**	**100.0%**
PRE-SERVICE ORGANIZATION DETERMINATIONS				
Standard Part C				
# of Standard Pre-Service Prior Authorization Requests Received	554	502	669	**1,725**
# of Standard Pre-Service Prior Authorization Requests (part C) completed within five (5) working days	550	501	665	**1,716**
% of Standard Pre-Service Prior Authorization Requests (part C) completed within five (5) working days	**99.3%**	**99.8%**	**99.4%**	**99.5%**
# of Standard Pre-Service Prior Authorization Notifications Sent	554	502	669	**1,725**
# of Standard Pre-Service Prior Authorization Notification (part C) sent to Provider/Member within five (5) working days of request	550	502	669	**1,721**
% of Standard Pre-Service Prior Authorization Notification (part C) sent to Provider/Member within five (5) working days of request	**99.3%**	**100.0%**	**100.0%**	**99.8%**
Expedited Part C				
# of Expedited Pre-Service Prior Authorization Requests Received	283	244	345	**872**
# of Expedited Pre-Service Prior Authorization Requests (part C) completed within sevety-two (72) hours	283	220	333	**836**
% of Expedited Pre-Service Prior Authorization Requests (part C) completed within seventy-two (72) hours	**100.0%**	**90.2%**	**96.5%**	**95.9%**
# of Expedited Prior Authorization Notifications Sent	283	244	345	**872**
# 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	281	229	335	**845**
% 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	**99.3%**	**93.9%**	**97.1%**	**96.9%**
POST SERVICE ORGANIZATION DETERMINATIONS				
# of Retrospective Requests Received	66	51	69	**186**
# of Retrospective Requests (part C) completed within thirty (30) calendar days	66	51	69	**186**
% 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	6	18	13	**37**
# of Standard Prior Authorization Requests (part B drugs) completed within sevety-two (72) hours of request	6	18	13	**37**
% 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	6	18	13	37
# of Standard Prior Authorization Notification (part B drugs) sent within seventy-two (72) hours of request	4	18	13	35
% of Standard Prior Authorization Notification (part B drugs) sent within seventy-two (72) hours of request	**66.7%**	**100.0%**	**100.0%**	**94.6%**
# of Expedited Prior Authorization (part B drugs) Requests Received	12	19	8	**39**
# of Expedited Prior Authorization requests (part B drugs) completed within twenty-four (24) hours of request	12	18	8	**38**
% of Expedited Prior Authorization requests (part B drugs) completed within twenty-four (24) hours of request	**100.0%**	**94.7%**	**100.0%**	**97.4%**
# of Expedited Prior Authorization (part B drugs) Notifications Sent	12	19	8	**39**
# 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	12	19	8	**39**
% 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™

Medi-Cal Compliance Dashboard	Jan	Feb	Mar	Q1 2021
MEDICAL AUTHORIZATIONS - HS COMBINED				
Concurrent Review				
Total # of Concurrent Requests Resolved	5	148	176	329
# of Concurrent Review of Authorization Requests completed within five (5) working days of request	5	147	175	327
% of Concurrent Review of Authorization Requests completed within five (5) working days of request	100.0%	99.3%	99.4%	99.4%
Routine Authorizations				
Total # of Routine Prior Authorization Requests Resolved	814	913	1,149	2,876
# of Routine Prior Authorization Requests completed within five (5) working days of request	813	908	1,147	2,868
% of Routine Prior Authorization Requests completed within five (5) working days of request	99.9%	99.5%	99.8%	99.7%
Expedited Authorizations				
Total # of Expedited Prior Authorization Requests Resolved	149	130	155	434
# of Expedited Prior Authorization Requests completed within seventy-two (72) hours of request	149	129	155	433
% of Expedited Prior Authorization Requests completed within seventy-two (72) hours of request	100.0%	99.2%	100.0%	99.8%
Retrospective Review				
Total # of Retrospective Requests Resolved	353	274	304	931
# of Retrospective Requests completed within thirty (30) calendar days of request	353	274	304	931
% 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	1337	1336	1628	4,301
# Member Notification of UM decision in writing within two (2) working days of the decision.	1335	1326	1610	4,271
% Member Notification of UM decision in writing within two (2) working days of the decision.	99.9%	99.3%	98.9%	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	1305	1307	1607	4,219
% Provider Notification of UM decision by telephone, facsimile or electronic mail and then in writing within twenty-four (24) hours of making the decision	97.6%	97.8%	98.7%	98.1%

Santa Clara Family Health Plan™

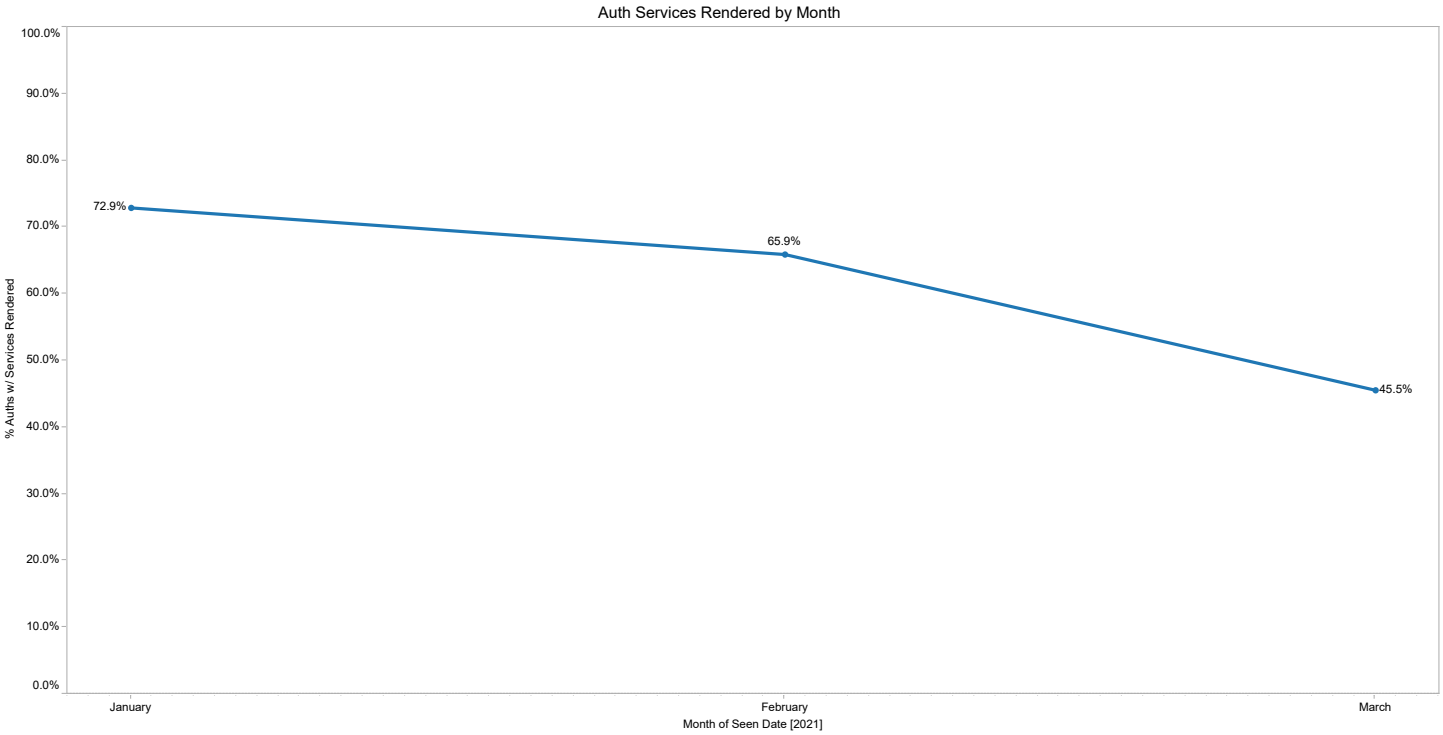
Cal MediConnect and Medi-Cal Quarterly Referral Tracking

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Cal MediConnect	CBAS	Retro Request	7	5	0	2	28.6%
		Routine - Extended Service	16	16	0	0	0.0%
		Routine - Initial Request	2	2	0	0	0.0%
	CUSTODIAL	Retro Request	105	101	0	4	3.8%
		Routine - Extended Service	1	1	0	0	0.0%
		Routine - Initial Request	30	25	0	5	16.7%
	DME	Member Initiated Org Determi..	8	3	0	5	62.5%
		Member Initiated Org Determi..	5	4	0	1	20.0%
		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 - Ro..	8	6	0	2	25.0%
		Non Contracted Provider - Urg..	1	1	0	0	0.0%
		Retro Request	5	1	0	4	80.0%
		Routine - Extended Service	2	1	0	1	50.0%
		Routine - Initial Request	185	112	0	73	39.5%
		Urgent - Extended Service	1	1	0	0	0.0%
		Urgent - Initial Request	20	14	0	6	30.0%
	HomeHealth	Operational PA	75	37	0	38	50.7%
		Retro Request	7	4	0	3	42.9%
		Routine - Extended Service	13	9	0	4	30.8%
		Routine - Initial Request	14	5	0	9	64.3%
		Urgent - Extended Service	189	75	0	114	60.3%
		Urgent - Initial Request	184	99	0	85	46.2%
	HOSPICE	Non Contracted Provider - Ret..	3	3	0	0	0.0%
		Non Contracted Provider - Ro..	2	1	0	1	50.0%
	Inpatient	Non Contracted Provider - Ro..	2	2	0	0	0.0%
		Routine - Extended Service	2	2	0	0	0.0%
		Routine - Initial Request	507	496	0	11	2.2%
		Urgent - Initial Request	13	13	0	0	0.0%
	InpatientAdmin	Routine - Initial Request	1	1	0	0	0.0%
	InpatientPsych	Routine - Initial Request	2	0	0	2	100.0%
	OP-BehavioralGr	Care Coordinator Initiated Org..	3	3	0	0	0.0%
		Non Contracted Provider - Ro..	1	0	0	1	100.0%
	OP-Behavorial	Care Coordinator Initiated Org..	2	1	0	1	50.0%
		Non Contracted Provider - Ret..	2	1	0	1	50.0%
		Non Contracted Provider - Ro..	2	0	0	2	100.0%
	OPHospital	Member Initiated Org Determi..	8	4	0	4	50.0%
		Member Initiated Org Determi..	7	3	0	4	57.1%
		Member Rep Initiated Org Det..	3	3	0	0	0.0%
		Member Rep Initiated Org Det..	2	2	0	0	0.0%
		Modified original request – Se..	1	1	0	0	0.0%
		Non Contracted Provider - Ro..	23	11	0	12	52.2%
		Non Contracted Provider - Urg..	9	3	0	6	66.7%
		Retro Request	13	10	0	3	23.1%
		Routine - Extended Service	17	7	0	10	58.8%
		Routine - Initial Request	502	143	0	359	71.5%
		Urgent - Extended Service	1	0	0	1	100.0%
		Urgent - Initial Request	232	97	0	135	58.2%
	OPHospitalGr	Member Initiated Org Determi..	5	1	0	4	80.0%

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Cal MediConnect	OPHospitalGr	Member Initiated Org Determi..	5	4	0	1	20.0%
		Retro Request	2	1	0	1	50.0%
		Routine - Extended Service	9	4	0	5	55.6%
		Routine - Initial Request	154	77	0	77	50.0%
		Urgent - Extended Service	4	2	0	2	50.0%
		Urgent - Initial Request	52	35	0	17	32.7%
	SkilledNursing	Care Coordinator Initiated Org..	2	2	0	0	0.0%
		Operational PA	37	33	0	4	10.8%
		Retro Request	7	6	0	1	14.3%
		Routine - Initial Request	15	14	0	1	6.7%
		Urgent - Initial Request	66	66	0	0	0.0%
	Transportation	Member Initiated Org Determi..	3	1	0	2	66.7%
		Member Initiated Org Determi..	2	1	0	1	50.0%
		Member Rep Initiated Org Det..	2	1	0	1	50.0%
		Retro Request	3	0	0	3	100.0%
		Routine - Initial Request	48	17	0	31	64.6%
Grand Total			**2,656**	**1,595**	**0**	**1,061**	**39.9%**

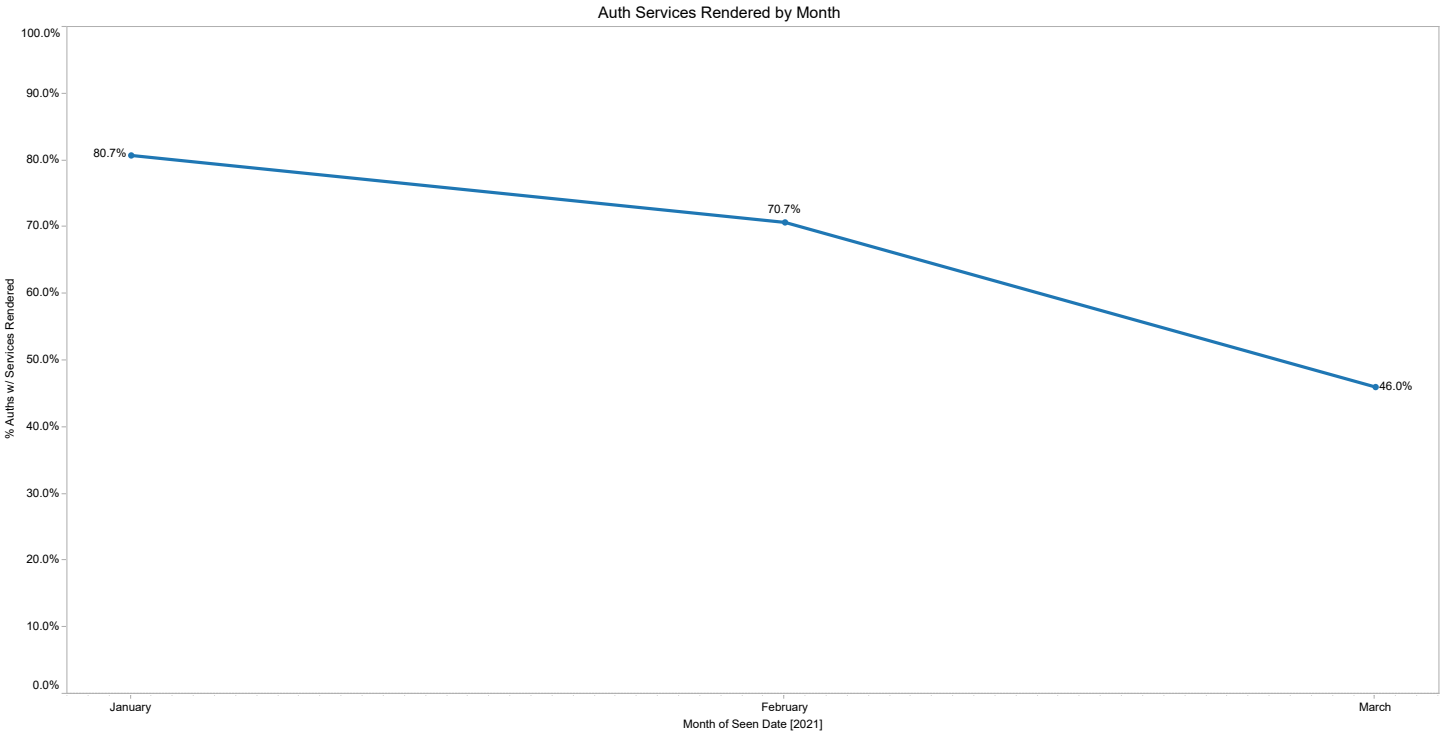

Auth Services Rendered by Month
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
% Auths w/ Services Rendered
72.9%
65.9%
45.5%
January
February
March
Month of Seen Date [2021]

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		1	1	0	0	0.0%
		Retro Request	46	44	0	2	4.3%
		Routine - Extended Service	39	38	0	1	2.6%
		Routine - Initial Request	4	4	0	0	0.0%
	CONT OF CARE	Routine - Extended Service	1	0	0	1	100.0%
		Urgent - Initial Request	1	1	0	0	0.0%
	CUSTODIAL	Non Contracted Provider - Ret..	1	1	0	0	0.0%
		Non Contracted Provider - Ro..	5	4	0	1	20.0%
		Reopening CMC	2	2	0	0	0.0%
		Retro Request	566	546	0	20	3.5%
		Routine - Extended Service	1	1	0	0	0.0%
		Routine - Initial Request	192	147	0	45	23.4%
	Dental	Routine - Initial Request	29	21	0	8	27.6%
		Urgent - Initial Request	11	5	0	6	54.5%
	DME	Non Contracted Provider - Ret..	14	6	0	8	57.1%
		Non Contracted Provider - Ro..	9	3	0	6	66.7%
		Non Contracted Provider - Urg..	3	3	0	0	0.0%
		Operational PA	5	5	0	0	0.0%
		Retro Request	7	5	0	2	28.6%
		Routine - Extended Service	1	0	0	1	100.0%
		Routine - Initial Request	244	142	0	102	41.8%
		Urgent - Extended Service	2	2	0	0	0.0%
		Urgent - Initial Request	33	27	0	6	18.2%
	HomeHealth	Non Contracted Provider - Ret..	1	0	0	1	100.0%
		Operational PA	18	9	0	9	50.0%
		Retro Request	2	0	0	2	100.0%
		Routine - Initial Request	3	1	0	2	66.7%
		Urgent - Extended Service	13	1	0	12	92.3%
		Urgent - Initial Request	27	14	0	13	48.1%
	HOSPICE	Non Contracted Provider - Ret..	14	12	0	2	14.3%
		Non Contracted Provider - Ro..	2	2	0	0	0.0%
		Non Contracted Provider - Urg..	3	0	0	3	100.0%
		Retro Request	1	0	0	1	100.0%
	Inpatient	Non Contracted Provider - Ro..	3	3	0	0	0.0%
		Retro Request	3	2	0	1	33.3%
		Routine - Initial Request	491	464	0	27	5.5%
		Urgent - Initial Request	13	12	0	1	7.7%
	InpatientAdmin	Urgent - Initial Request	1	0	0	1	100.0%
	OP-BehavioralGr	Non Contracted Provider - Ro..	5	4	0	1	20.0%
		Retro Request	16	15	0	1	6.3%
		Routine - Extended Service	108	77	0	31	28.7%
		Routine - Initial Request	2	0	0	2	100.0%
		Urgent – RN review; Expedite..	1	1	0	0	0.0%
	OP-Behavorial	Routine - Extended Service	5	3	0	2	40.0%
		Routine - Initial Request	33	7	0	26	78.8%
	OPHospital	Non Contracted Provider - Ret..	4	2	0	2	50.0%
		Non Contracted Provider - Ro..	25	11	0	14	56.0%
		Non Contracted Provider - Urg..	9	3	0	6	66.7%
		Operational PA	2	0	0	2	100.0%

Referral Tracking Report

LOBRollupN..	Template	Disposition	Total # of Auths	# Auth Services Rendered within 90 days	# Auth Services Rendered After 90 days	# Auth Services Not Rendered	% Auths w/ No Services Rendered
Medi-Cal	OPHospital	Retro Request	12	7	0	5	41.7%
		Routine - Extended Service	46	15	0	31	67.4%
		Routine - Initial Request	374	148	0	226	60.4%
		Urgent - Extended Service	3	1	0	2	66.7%
		Urgent - Initial Request	145	75	0	70	48.3%
		Urgent – RN review; Expedite..	1	1	0	0	0.0%
	OPHospitalGr	Non Contracted Provider - Ro..	12	11	0	1	8.3%
		Operational PA	1	0	0	1	100.0%
		Retro Request	13	11	0	2	15.4%
		Routine - Extended Service	114	52	0	62	54.4%
		Routine - Initial Request	431	169	0	262	60.8%
		Urgent - Extended Service	14	6	0	8	57.1%
		Urgent - Initial Request	89	65	0	24	27.0%
		Urgent – RN review; Expedite..	2	1	0	1	50.0%
	SkilledNursing	Operational PA	15	14	0	1	6.7%
		Retro Request	4	3	0	1	25.0%
		Routine - Initial Request	24	21	0	3	12.5%
		Urgent - Initial Request	48	43	0	5	10.4%
	Transportation	Operational PA	1	0	0	1	100.0%
		Retro Request	16	12	0	4	25.0%
		Routine - Extended Service	1	0	0	1	100.0%
		Routine - Initial Request	346	86	0	260	75.1%
Grand Total			**3,734**	**2,392**	**0**	**1,342**	**35.9%**


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
80.7%
70.7%
46.0%
January
February
March
Month of Seen Date [2021]

Santa Clara Family Health Plan™

Quality Monitoring of Plan Authorizations and Denial Letters

Quality Monitoring of Denial Letters for HS.04.01
1st 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 1st 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 Q1 2021, the dates of service and denials were pulled in April 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. 40% or 12/30 were expedited requests
         - 100% of the expedited authorizations are compliant with regulatory turnaround time of 72 calendar hours
      d. 60% or 18/30 were expedited 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. 77% or 23/30 were medical denials
      f. 23% or 7/30 were administrative denials
      g. 100% were denied by a Medical Director or Pharmacist
      h. 100% or 30/30 of all requests were provided written notifications to both member and provider
      i. 100% or 12/12 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. 83% or 25/30 of the written notifications were readable
         - 1/5 contained medical terminology that was not explained
         - 4/5 had grammatical and punctuation deficiencies
      l. 90% or 27/30 of the written notifications included the rationale for denial
         - 1/3 did not include the criteria or guideline
         - 2/3 included the Member Handbook for the incorrect line of business
      m. 100% or 30/30 of the letters included the criteria or EOC that the decision was based upon.
      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 Treatment

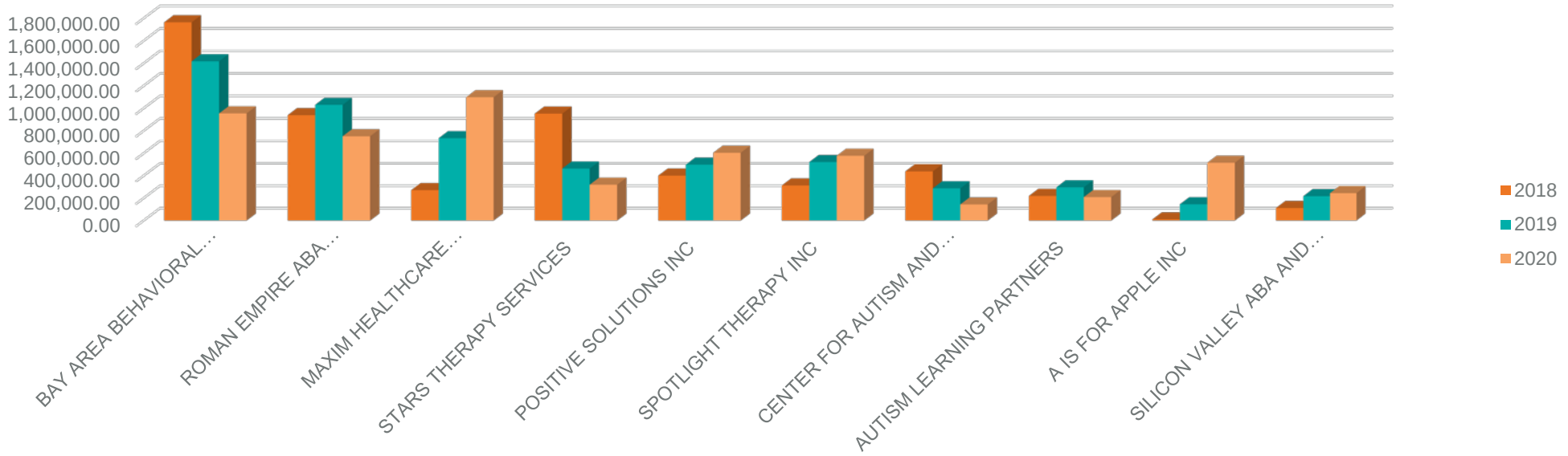
Authorization status*

- **258** approved and currently in treatment
- **0** in treatment under LOA

*AS OF 04/14/2021

Behavioral Health Treatment

Top 10 billing providers



Behavioral Health Treatment

New contracts

Providers	Effective
Center for Social Dynamics	03/01/2021

Behavioral Health

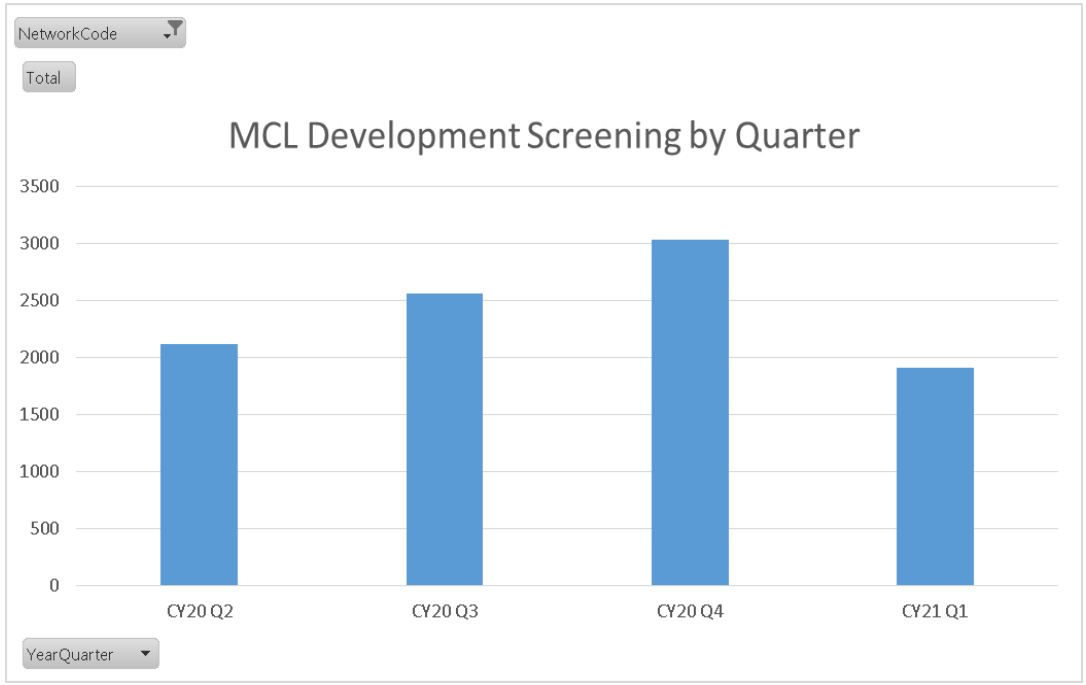
Utilization

- **CMC psychiatric admissions**
  - **9**
  - **1 readmission at Reno Behavioral Health**

- **County Call Center**
  - Not reported

Developmental Screening

Completed screenings by quarter



Developmental Screening

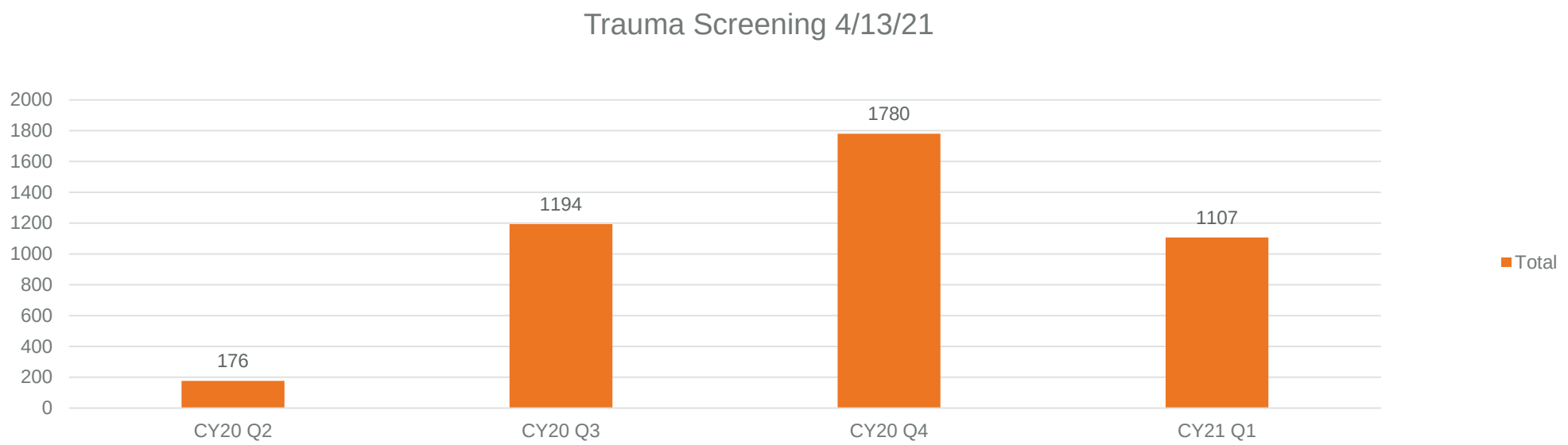
Completed screenings by quarter

2020-Q2	2119
2020-Q3	2564
2020-Q4	3030
2021-Q1	1908
Grand Total 4/13/2021	9621

Developmental Screening

Network	Total Q1
Independent Physicians	87
VHP	695
PAMF	38
PMG	710
Premier	378

Trauma Screening



Trauma Screening

Interventions

- Incentive through 6/30/21 to attest to completion of trauma training on ACEs Aware

- Community support and collaboration