Santa Clara Family Health Plan
The Spirit of Care

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Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, July 19, 2017
6:00 PM - 7:30 PM
210 E. Hacienda Avenue
Campbell, CA 95008

AGENDA

1.	**Introduction**	Dr. Lin	6:00	5 min.
2.	**Meeting Minutes**	Dr. Lin	6:05	5 min.
	Review minutes of the April 19, 2017 Utilization Management Committee meeting.			
3.	**CEO Update**	Ms. Tomcala	6:10	10 min.
	Discuss status of current topics and initiatives.			
4.	**Action Items**	Dr. Boris	6:20	10 min.
	a. UM Charter			
	b. Care Coordinator Guidelines	Ms. Castillo		
5.	**Reports (MediCal/SPD, Healthy Kids)**			
	a. Membership	Dr. Robertson	6:30	5 min.
	b. UM Reports 2017	Ms. Castillo	6:35	10 min.
	i. Dashboard Metrics: Turn Around Time (Cal MediConnect/Medi-Cal)			
	a. Follow up item: Summary report on non-compliant MCal TAT			
	ii. Standard Utilization: Metrics PowerPoint			
	iii. June conversion of Xpress to QNXT authorizations for all lines of business			
	c. Interrater Reliability (IRR)	Ms. Castillo	6:45	5 min.
	d. RN Advice Line Policy	Ms. Castillo	6:50	10 min.
6.	**Discussion Items**	Ms. Castillo	7:00	20 min.
	a. RN Advice Line Metrics			
	b. Monthly Stats: Calls made for post hospital discharges for each LOB			
	c. Notice to MD offices: about RN Advice Line			
	d. TAT report: follow up on noncompliant MCal TAT			
7.	Adjournment	Dr. Lin		

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MINUTES

UTILIZATION MANAGEMENT COMMITTEE

April 19, 2017

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

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

ITEM	DISCUSSION	ACTION REQUIRED
I. Introductions Review/Revision/Approval of Minutes	Meeting was started with a Quorum at 6:05 PM. There was a motion to approve the January 18, 2017 minutes by Ali Alkoraishi, MD and second by Dung Van Cai, MD. There was a motion to approve March 22, 2017 minutes by Jeff Robertson, MD, CMO and seconded by Habib Tobaggi, MD.	Minutes approved as presented.

ITEM	DISCUSSION	ACTION REQUIRED
II. CEO Update	Christine Tomcala , CEO discussed the following items: 1. ACA: or Affordable Care Act: currently repeal and replace is uncertain and California is still are at risk of ACA repeal and replace. No one really has the answer. 2. IHSS: payment for services and service decisions will go back to the Santa Clara County system. And the California May budget revise will be clearer on the fiscal impacts. 3. Whole Person Care: SCFHP participated with the county on a second round of applications. The application passed the first hurdle. The primary goal is to help members that can leave LTC and transition to either home or stable housing. 4. DHCS had an annual site visit and audit over the last two weeks. The auditors did an exit conference and SCFHP did very well. The emphasis on compliance and development to P&P's and staff changes has shifted audit compliance positively. The auditors could see the progress and good work. We expect some findings and will share them when they are available. 5. SCFHP is in the middle of implementing QNXT for Medi-Cal LOB. Effective date 7/1/2017.	None.
III. Old Business	HEDIS 2017: Dr. Boris shared the committees requested follow up on the: Specifications for HEDIS for CV Monitoring for people with Cardiovascular Disease and Schizophrenia. The HEDIS specs are provided in the packet and the bullet points were reviewed. Dr. Alkoraishi noted that only Cholesterol lab completion is looked at and the levels are not part of the HEDIS review.	Committee appreciated the follow up.
IV. Action Items	a. Ms. Castillo Manager UM presented the 2017 UM Work plan: Ms. Castillo reviewed the UM Work plan in detail. SCFHP has 24 areas of monitoring for UM activities. The CAHPS and provider satisfaction were removed from the UMC work plan for 2017 as they are reviewed in the QIC. b. Ms. Castillo UM Manager presented the 2016 UM Program Evaluation: She highlighted these areas: a. Monitoring of quality of service is completed through the dashboard on a monthly basis and brought to the committee quarterly. The IRR will now be bi-annually and it will start next week. Member and Provider experience will be provided in the QIC and removed for 2017. For scope and safety of Care, SCFHP was to assess communication between members and providers within 30 days. At the time we did not have the systems to capture this info. In 2017 on QNXT conversion we	Motion was moved by Dr. Alkoraishi to approve the 2017 UM Work plan and the 2016 UM Program Evaluation: the motion was seconded by Dr. Robertson. All were in favor.

ITEM	DISCUSSION	ACTION REQUIRED
	will complete this. c. Review SCFHP UM Guideline Recommendations: Dr. Boris presented the recommendation to retire the list of guidelines (see insert in the UM packet) and convert some to procedures and/or use the industry standard MCG criteria which is updated on an ongoing basis. In addition, the hierarchy of criteria outlines the use of MCG where available. Questions were answered on the recommendations: for example the Wheelchair guidelines are specifically outlined by Medicare in Noridian guidelines and Medi-Cal has a specific APL which SCFHP will follow. Therefore Wheelchairs requests will be reviewed against Noridian for Medicare and procedures matching the APL for Medi-Cal. Dr. Vemuri asked about the Gender Identity disorders, and there is a specific DHCS APL on this item and SCFHP has a procedure to follow. Dr. Robertson explained that the current stand-alone guidelines were not being kept up and that there are national and state guidelines (MCG or APL's from DHCS to follow). d. Behavioral Health Care Coordinator Guidelines Ms. Holm presented the BH guidelines. Licensed clinicians and care coordinators function in BH to assist with building and approving authorizations based on guidelines. SCFHP is asking for approval of page 14 BH CC guidelines. Approved. Moved Cai Seconded Tobaggi e. Review & Approval of CM.09 Nurse Advice Line Policy: Ms. Carlson reviewed the Nurse Advice line policy. Dr. Alkhoraishi asked if the RN advice line phone number is on the member/patient card. Ms. Carlson stated: Yes. Dr. Tobaggi asked about office staff telling the member to call the RN line before routine appointment questions. And the members agreed that this practice would be appropriate. Ms. Carlson agreed to bring to the next UMC the stats on RN advice line. And to develop with provider services a fax blast about the uses of RN advice line and its availability.	Motion was made by Dr. Alkoraishi and seconded by Dr. Cai to accept the recommendations for the guidelines retirement. All were in favor. The motion was moved by Dr. Cai and seconded by Dr. Tobaggi. All were in favor. Dr. Cai moved to approve the policy and it was seconded by Dr. Dinh. All were in favor. Ms. Carlson to bring RN advice line stats to next meeting and to develop with Provider services a notice to providers.

ITEM	DISCUSSION	ACTION REQUIRED
V. Standing Reports	a. Membership report updated: MCal approx. 5k MCal lives lost from 2016 to current. We are looking at reasons why. There is some anecdotal information about increase in the number of non-renewals for fears of new immigration policies...	None
	b. UM Reports 2017 i. Turn Around Time (Cal MediConnect/Medi-Cal) a. Dr. Boris reviewed the Turn-Around Time (TAT) reports from the combined dashboard. The month of March had slight decrease in TAT in Medi-Cal, this will be reviewed for causes. And starting in 2017, the CMC TAT stats are to be at a goal of 100% compliance. Dr. Boris will be reviewing the Medicare Medicaid Plan monitoring standards for confirmation.	TAT informational only. Ms. Castillo to bring back root cause for low TAT's in March.
	ii. Standard Utilization Metrics a. Dr. Boris reviewed the entire PowerPoint on UM metrics. Of note: starting in 4th quarter of 2016, the UM team did biweekly meetings on inpatients which resulted in the decreases seen in the readmission rates for CMC 13.6% to 11.26% and for Medi-Cal SPD 24.52% to 19.78%. b. Ms. Carlson stated that the Case Management team also has started outreach to all network 1 discharge patients.	Information Pull Cal Duals metrics's for comparison Information only
	c. Quarterly Quality Monitoring in accordance to procedure HS. 04.01 report (1st Quarter 2017) a. Ms. Carlson presented the quality quarterly monitoring report. The UM team is selecting in accordance to the policy 30 charts for review each quarter on denials. It is noted that TAT is mostly compliant, however denial reasons need improvement. Ms. Carlson and Ms. Castillo are working on template language for denials.	Ms. Carlson to bring stats on the number of successful calls by CM. Information only. Ms. Carlson and Ms. Castillo are preparing template language for denials.
	d. LTSS Ops Report a. Ms. Anderson presented the LTSS operations report. Noted are the following: there are approx. 8800 members in IHSS in Medi-Cal and 2900 in CMC. CBAS is at its near capacity with almost 600 member for both CMC and Medi-Cal. MSSP is also at near capacity with approx. 280 members. i. The committee members asked about how many CBAS centers there are: the answer is 5 b. Of the 527 members reviewed in LTC, 379 received a face to face, 46 were identified for transition and 11 successfully transitioned to the community. Stable housing is the number one need.	Informational.

ITEM	DISCUSSION	ACTION REQUIRED
	Un-agenda items: Dr. Tobaggi: was requesting information on the provider handbook for new providers. Dr. Robertson: every new provider gets a manual with facts and information. Ms. Tomcala: the provider manual is in need of some re-write which is in the works.	
VI. Adjournment	Meeting adjourned at ____7:45 PM__	
NEXT MEETING	The next meeting is scheduled for Wednesday, July 19, 2017, 6:00 PM	

Prepared by:

_____ Date _____
Caroline Alexander
Administrative Assistant

Reviewed and approved by:

_____ Date _____
Jimmy Lin, M.D.
Committee Chairperson

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Santa Clara County Health Authority

Utilization Management Committee Charter

Purpose

The Utilization Management Committee shall provide oversight of the SCFHP plan for effective utilization review and management of inpatient and outpatient resources in a manner that is efficient, cost effective and promotes the highest quality of care in the community.

The Committee reports to the the Quality Improvement committee (QIC). Signed minutes of the Committee are presented to the QIC by the Chair or designee.

Members

The Utilization Management Committee shall have a sufficient number of members to provide the necessary expertise and work effectively as a group. Membership shall include primary and specialty care providers with a specialty mix that reflects the health care needs of the populations of the SCFHP membership, including behavioral health. Members are appointed by the CEO, and include the plan CMO or designated medical director. All members, including the Chair, serve 2 year terms which may be renewed at the discretion of the Plan, provided that members have met the requirements set forth in this charter.

No person who holds a direct financial interest in an affiliated heatlh care entity is eligible for appointment. UMC members shall annually sign a Confidentiality Agreement. Failure to sign the agreement or abide by the terms of the agreement shall result in removal from the committee.

Meetings

Regular meetings of the Utililzation Management Committee shall be scheduled quarterly. Additional special meetings, or meeting cancellations, may occur as circumstances dictate. Committee members must attend at least two meetings per year. Attendance may be in person or via teleconferencing. Teleconferencing shall be conducted pursuant to California Government Code section 54953(d). The presence of a majority of voting members shall constitue a quorum for the transaction of business.

The Committee may invite other individuals, such as members of management, auditors, or other technical experts to attend meetings and provide pertinent information relating to an agenda item, as necessary.

Responsibilities

The following goals and objectives shall serve as a guide with the understanding that the Committee may carry out additional functions as may be appropriate in light of changing business, regulatory, legal and other conditions:

A. Review the Utilization Program, Work Plan and Program evaluation annually
B. Provide oversight for review and utilization of inpatient and outpatient services.
C. Verify that utilization management functions meet thestandards and requirements of regulatory and licensing bodies
D. Oversee the adoption and usage of well defined criteria for medical decision making
E. Review utilization reports by selected service for patterns of under and over utilization
F. Promote the delivery of quality patient care in an efficient and cost effective manner

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

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Utilization Management
Care Coordinator Guidelines

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

Care Coordinators may "approve" covered medical service when criteria are met. The Care Coordinator is responsible to document all pertinent information within the approved authorization. Which includes but is not limited to: Accurately and fully completing authorization entry in QNXT. 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

Healthy Kids	Medi-Cal	CalMediconnect
- Check CCS status - Make CCS referral if applicable - Authorize 1 day pending nurse review.	-Check CCS status (if under 21) - Make CCS referral if applicable - Authorize 1 day pending nurse review.	Authorize 1 day pending nurse review

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

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

          In area emergency admission- VHP, Kaiser, PMG, Premier Care-Redirect to Delegated Group
    b. CMC-All emergency admissions, In area and Out of area approve 1 day

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

Utilization Management
Care Coordinator Guidelines

- Palo Alto Medical Foundation- MC only (PAMF authorizes for HK)

***Kaiser-Redirect to group

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

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

4. Acute Rehab-send to nurse for review

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

6. Maternity – Approve 2 days for Vaginal delivery, 4 days for C-Section delivery
    a. Maternity Kick-follow maternity kick entry process for QNXT

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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, Kaiser, PMG, Premier Care – redirect to Network if within month of admission and month after admission.
    d. SCFHP will be financially responsible beginning 3rd month of admission
    e. Medicare primary
        - Without Medicare A-Apply CCG pre approval of 3 days and forward to nurse review for additional days
        - With Medicare A &B-Void notice. Medicare is financially responsible for skilled services with exemptions:
            - Skilled days exhausted (100 days per benefit period)
2. SNF sends Skilled level of care request to SCFHP UM.
3. Coordinator will approve initial 3 days.
4. Coordinator will forward this request to UM nurse for additional days and concurrent review.

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Utilization Management
Care Coordinator Guidelines

Long Term Care

1. Member must be CMC or MediCal assigned to network
    a. Independent Physician's
    b. Palo Alto Medical Foundation- MC only
    c. VHP, Kaiser, PMG, Premier Care-redirect to Network if within month of admission and month after admission.

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

2. SNF sends LTC request to SCFHP UM
3. Coordinator will approve 1 year with complete LTC requirement.
4. Nurse may recommend Last Covered Day to MD if LTC criteria is not met.
5. All LTC Re Authorization will be forwarded to nurse for review.

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Utilization Management
Care Coordinator Guidelines

Bed Hold

LTC and Skilled level of care in SNF:

1. Member must be CMC or Medi-Cal assigned to network
    a. Independent Physician's
    b. Palo Alto Medical Foundation- MC only
    c. VHP, Kaiser, PMG, Premier Care redirect to Network if within month of admission and month after admission.
2. Bed Hold Notification Form is received from Facility
3. Coordinator will enter and approve up to 7 days max per Medi-Cal benefit.

    - Separate authorization will be created for Bed Hold.
    - Existing LTC or skilled auth will be updated with correct DC date.
    - New skilled or LTC auth will be created for the days following the bed hold to continue auth for the level of care.

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Utilization Management
Care Coordinator Guidelines

Home Health

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

2. Covered benefit for all LOB's when medically indicated. Must include:
    a. Plan of care
    b. MD order

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

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

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

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Utilization Management
Care Coordinator Guidelines

CBAS

1. Member can be assigned to any/all networks or **CMC**
   - 7 days business days to process all routine requests
   - 30 days to process retro requests

2. **First referral (Face to Face F2F)** (CPT code: H2000) is for 3 days for interdisciplinary assessment with program- face to face is scheduled with SCFHP RN prior to authorizing H2000.
   - **F2F (Face to face) H2000 -** Pended until we receive the CEDT. Once the CEDT is received, ok to approve per CCG.

3. **Second referral (Reassessment)** (CPT code: S5102) goes for 6 months and is determined by RN based on qualifications provided by the assessment with the provider.
   - **Reassessment S5102 –** Compare against previous assessment, if not changes and no hospitalizations, document in Control# diary notes and approve per CCG in Event Tab.

Utilization Management
Care Coordinator Guidelines

Hearing Aid

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

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

3. Current Audiology exam done by an Audiologist

Santa Clara Family Health Plan

Utilization Management
Care Coordinator Guidelines

Hearing Aid – Repair

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

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

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

Utilization Management
Care Coordinator Guidelines

Non-Emergency Transportation

1. Member can be assigned to any/all networks all Lines of Business
2. Non emergency Out of Area ground transportation-Approve x 1.
3. Non emergency Air transportation-Forward to nurse for review.

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Utilization Management
Care Coordinator Guidelines

Behavioral Health Treatment (BHT) Guidelines

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

Santa Clara Family Health Plan Membership Report

	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06
AM	**107**	**107**	**107**	**106**	**105**	**103**	**105**	**105**	**104**
Santa Clara Family Health Plan	107	107	107	106	105	103	105	105	104
HK	**2,662**	**2,458**	**2,581**	**2,585**	**2,780**	**2,752**	**2,794**	**2,757**	**2,732**
Palo Alto Medical Foundation	45	42	50	51	68	75	81	82	82
Physicians Medical Group	729	697	709	686	737	715	728	717	737
Premier Care	160	149	144	146	145	143	163	161	164
Santa Clara Family Health Plan	224	220	272	296	339	342	349	335	339
Valley Health Plan	1,504	1,350	1,406	1,406	1,491	1,477	1,473	1,462	1,410
MC	**271,627**	**271,186**	**269,893**	**268,008**	**268,360**	**267,437**	**267,199**	**265,711**	**265,649**
Kaiser	27,372	27,261	27,573	27,038	27,139	27,202	27,280	26,993	27,177
Network 00	10,278	10,302	10,343	10,281	10,708	10,826	10,893	10,893	10,995
Palo Alto Medical Foundation	7,558	7,635	7,501	7,375	7,440	7,459	7,566	7,528	7,550
Physicians Medical Group	48,929	49,190	48,966	48,819	48,830	48,473	48,329	48,123	48,116
Premier Care	16,646	16,757	16,786	16,694	16,650	16,605	16,573	16,476	16,492
Santa Clara Family Health Plan	15,495	15,729	15,695	16,150	16,085	16,256	16,523	16,613	16,703
Valley Health Plan	145,349	144,312	143,029	141,651	141,508	140,616	140,035	139,085	138,616
CMC	**7,801**	**7,583**	**7,546**	**7,527**	**7,598**	**7,622**	**7,567**	**7,545**	**7,543**
Santa Clara Family Health Plan	7,801	7,583	7,546	7,527	7,598	7,622	7,567	7,545	7,543
Grand Total	**282,197**	**281,334**	**280,127**	**278,226**	**278,843**	**277,914**	**277,665**	**276,118**	**276,028**

March 2017 Dashboard report for Medi-Cal:

Summary:

18 authorizations were found to be non compliant with regulatory TAT.

17 Urgent and 1 Routine.

4 were entered late by coordinator.

1 request sent via connect and was addressed late.

11 auths were within compliance but IT report captured as non compliant.

Steps done:

1. Staff education on TAT
2. UM management frequent monitoring on incoming request and auth entry.
3. UM folders are locked to have limited access in moving and deleting files.
4. Connect is deactivated and waiting on Health X launch.
5. IT report on data integrity.

authorizationid	OrgDetermType	authtype	acuity	dispositiondesc	DetailStatus	seendate	DeterminationDate	TAT	TAT_Compliance	YearMonth	
61056	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/1/2017	3/7/2017	4	Non Compliant	201703	entered late
61109	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/3/2017	3/8/2017	3	Non Compliant	201703	Compliant
61194	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/6/2017	3/13/2017	5	Non Compliant	201703	entered late
61195	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/6/2017	3/13/2017	5	Non Compliant	201703	entered late
61204	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/8/2017	3/13/2017	3	Non Compliant	201703	Compliant
61289	Urgent Concurrent	Inpatient	urgent	Urgent	APPROVED	3/14/2017	3/16/2017	2	Non Compliant	201703	Compliant
61299	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/13/2017	3/16/2017	3	Non Compliant	201703	Compliant
61303	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/13/2017	3/16/2017	3	Non Compliant	201703	Compliant
61308	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/14/2017	3/16/2017	2	Non Compliant	201703	Compliant
61329	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/15/2017	3/17/2017	2	Non Compliant	201703	Compliant
61363	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/15/2017	3/20/2017	3	Non Compliant	201703	Compliant
61379	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/15/2017	3/21/2017	4	Non Compliant	201703	entered late
61422	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/17/2017	3/22/2017	3	Non Compliant	201703	Compliant
61427	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/17/2017	3/22/2017	3	Non Compliant	201703	compliant
61429	Non Urgent Preservice / Prior Auth	Outpatient	elective	Routine	APPROVED	3/22/2017	6/16/2017	61	Non Compliant	201703	Connect request. Late decision.
61442	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/20/2017	3/23/2017	3	Non Compliant	201703	compliant
61562	Urgent Concurrent	Inpatient	urgent	Urgent	APPROVED	3/27/2017	3/29/2017	2	Non Compliant	201703	compliant
61708	Urgent Concurrent	Inpatient	emergency	Urgent	APPROVED	3/2/2017	4/4/2017	23	Non Compliant	201703	entered late

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Utilization Management Committee (UMC)

July 2017

UMC Goals and Objectives

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

Inpatient Utilization: Medi-Cal – Non-SPD
4/1/2016 –3/31/2017

Source: Medi-Cal Enrollment & Xpress Claims/Encounter Data

Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2016 Q2	2,347	3.6	10,016	4.27
2016 Q3	2,506	3.7	9,780	3.90
2016 Q4	2,276	3.3	9,508	4.18
2017 Q1	2,389	3.6	9,903	4.15
Total	9,518	3.6	39,207	4.12

Inpatient Utilization: Medi-Cal – SPD
4/1/2016 –3/31/2017

Source: Medi-Cal Enrollment & Xpress Claims/Encounter Data

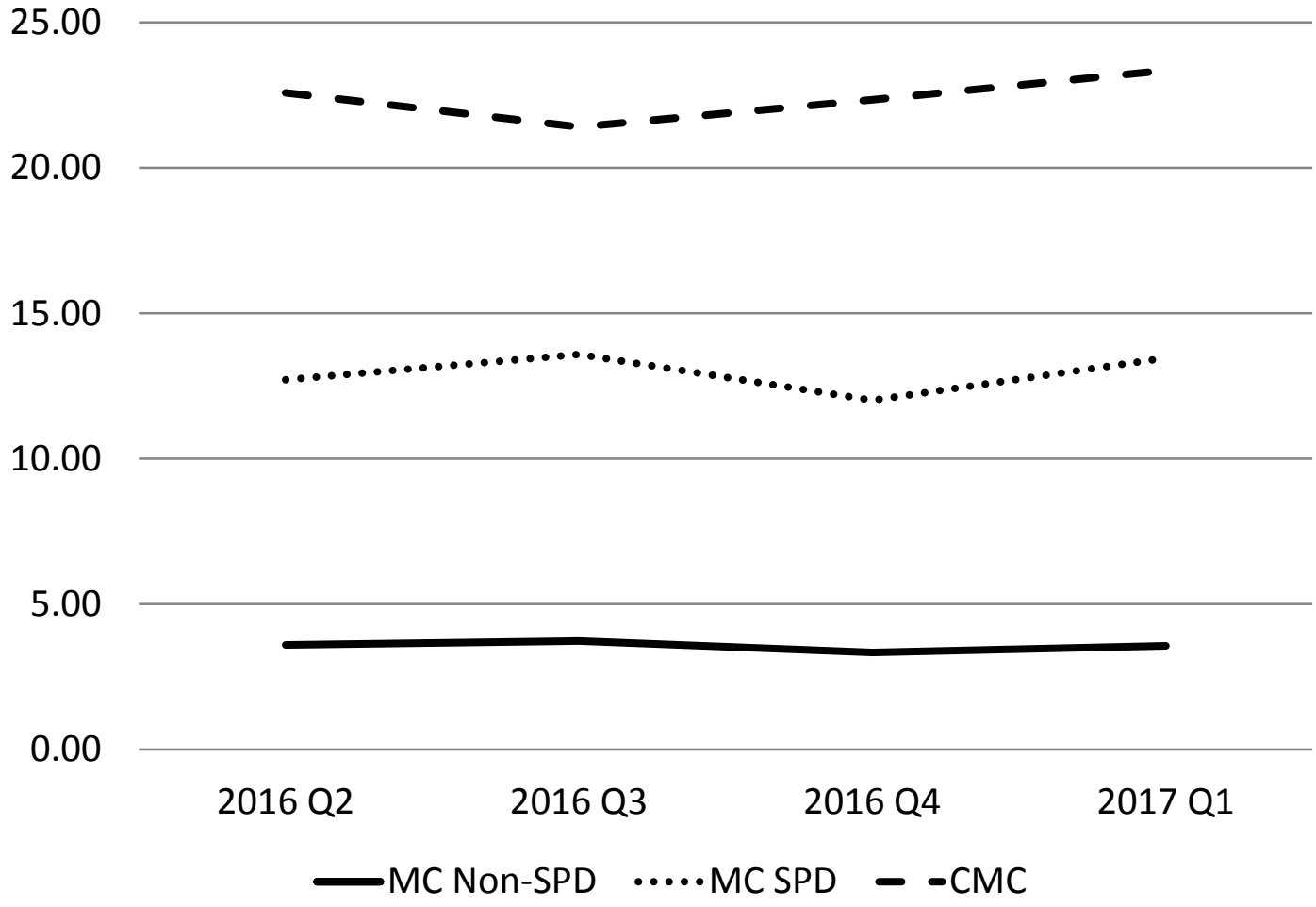
Quarter	Discharges	Discharges / 1,000 Member Months	Days	Average Length of Stay
2016 Q2	759	12.7	4,752	6.26
2016 Q3	840	13.6	4,198	5.00
2016 Q4	763	12.0	4,642	6.08
2017 Q1	865	13.5	4,457	5.15
Total	3,227	12.9	18,049	6.43

Inpatient Utilization: Cal MediConnect (CMC)
4/1/2016 –3/31/2017

Source: CMC Enrollment & QNXT Claims Data

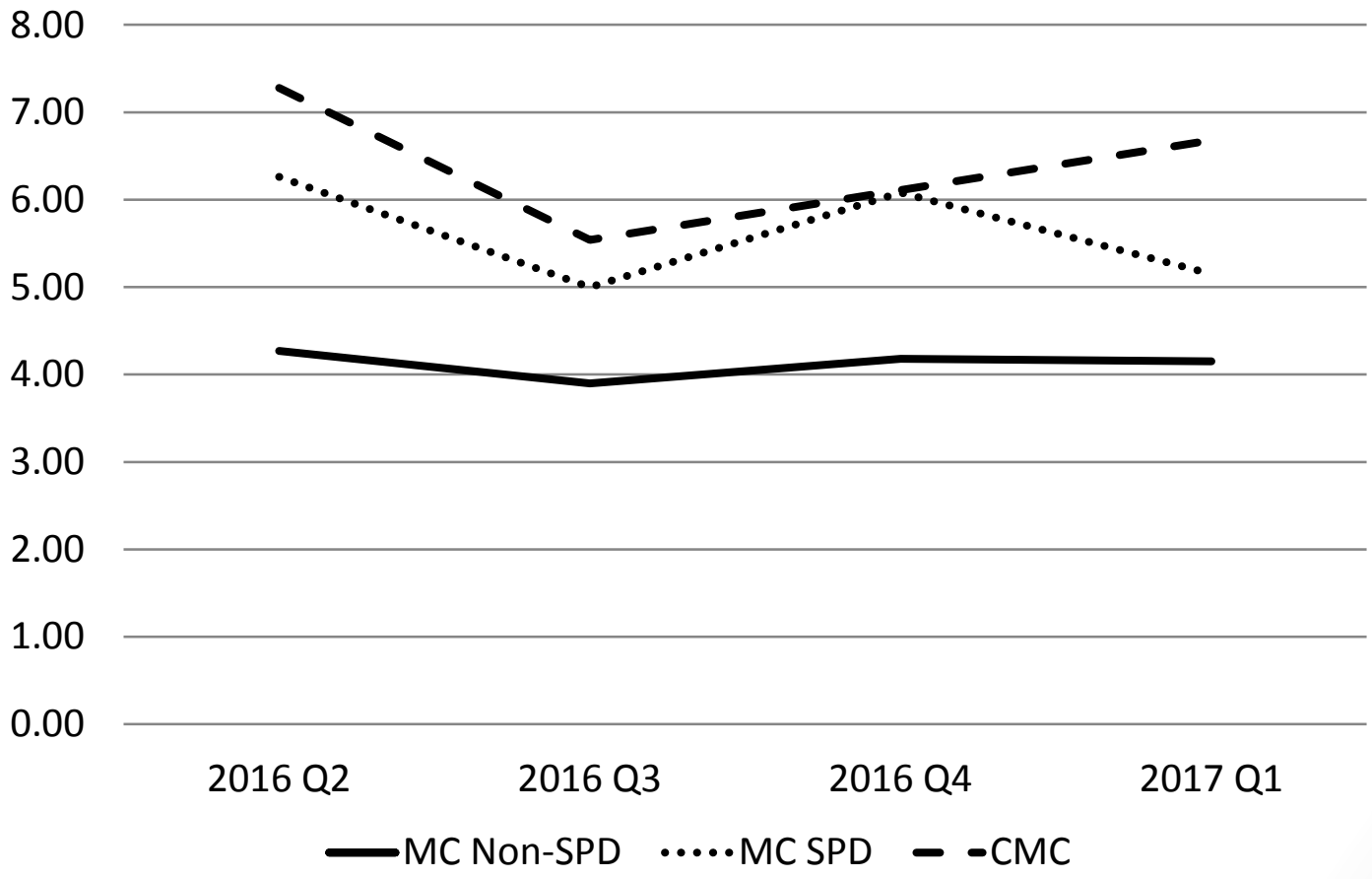
Quarter	Discharges	Discharges / 1,000 Members per Year	Days	Average Length of Stay
2016 Q2	541	271.0	3,938	7.28
2016 Q3	491	256.9	2,722	5.54
2016 Q4	490	268.1	2,996	6.11
2017 Q1	514	280.2	3,431	6.6
Total	2,036	269.0	13,087	6.20

SCFHP Medi-Cal & Cal MediConnect
Discharges / 1,000 Member Months (MM)
4/1/2016 – 3/31/2017



Statewide Inpatient Admissions per 1,000 MM as of March 2016:
SPD – 34
Dual – 31
ACA – 8
OLTIC – 2
Other – 4

SCFHP Medi-Cal & Cal MediConnect (CMC)
Average Length of Stay
4/1/2016 – 3/31/2017



Medi-Cal Inpatient Utilization
NCQA Medicaid Benchmark Comparisons
4/1/2016 – 3/31/2017

	Medi-Cal Population		
Measure	**Non-SPD**	**SPD**	**Total**
Discharges / 1,000 Member Months	3.55	12.94	4.35
NCQA Medicaid Percentile Rank[1]	<10th	>75th	<10th
ALOS	4.12	5.59	4.49
NCQA Medicaid Percentile Rank[2]	>50th	>90th	>50th

[1] NCQA Medicaid 50th percentile = 6.82
[2] NCQA Medicaid 50th percentile = 4.10

Medi-Cal SPD & CMC Inpatient Utilization
MCG & NCQA Medicare Benchmark Comparisons
4/1/2016 – 3/31/2017

	Discharges / 1,000 Members per Year	Days / 1,000 Members per Year	ALOS
SCFHP Population			
Medi-Cal SPD	155.3	868.8	5.59
CMC	269.0	1,728.9[1]	6.43
MCG Medicare Plans			
Loosely Managed	258.7	1,406.9	5.44
Moderately Managed	214.8	1,078.7	5.02
Well Managed	171.0	750.6	4.39
NCQA Medicare Mean	218.7	1,213.1	5.29

[1] A 5% sample of 2015 Medicare FFS data for dual eligible members in 6 CCI counties showed inpatient days / 1,000 = 2,502.6

Inpatient Readmissions: Medi-Cal – Non-SPD

Source: All Cause Readmissions (ACR) data for 4/1/2016 – 3/31/2017 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1, 2]
2016 Q2	1,186	199	16.78%
2016 Q3	1,189	186	15.64%
2016 Q4	1,084	158	14.58%
2017 Q1	851	142	16.69%
Total	4,310	685	15.89%

[1] A lower rate indicates better performance.

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

Inpatient Readmissions: Medi-Cal – SPD

Source: All Cause Readmissions (ACR) data for 4/1/2016 – 3/31/2017 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1]
2016 Q2	513	134	26.16%
2016 Q3	588	145	24.66%
2016 Q4	509	114	22.40%
2017 Q1	422	101	23.93%
Total	2,032	494	24.31%

[1] A lower rate indicates better performance.

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

Inpatient Readmissions: Cal MediConnect (CMC)

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 4/1/2016 – 3/31/2017 measurement period

Quarter	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Actual Readmission Rate[1, 2]
2016 Q2	286	40	13.99%
2016 Q3	332	45	13.55%
2016 Q4	369	43	11.65%
2017 Q1	248	23	9.27%
Total	1,235	151	12.23%

[1] A lower rate indicates better performance.

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

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

Source: HEDIS Plan All-Cause Readmissions (PCR) data for 4/1/2016 – 3/31/2017 measurement period

Rate Description	Ages 18 – 64 (PCR-A)	Ages 65+ (PCR-B)
Count of Index Hospital Stays	320	912
Count of 30-Day Readmissions	41	109
Actual Readmission Rate	12.81%	11.95%
NCQA Medicare 50th Percentile	16.78%	13.07%
SCFHP Percentile Ranking	>75th	>75th

[1] A lower rate indicates better performance.

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

Frequency of Selected Procedures: Medi-Cal

Source: HEDIS data for 4/1/2016 – 3/31/2017 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Tonsillectomy				
Male & Female, Age 0-9	188	0.27	0.62	↓
Male & Female, Age 10-19	68	0.10	0.27	↓
Hysterectomy, abdominal				
Female, Age 15-44	18	0.03	0.13	↓
Female, Age 45-64	23	0.07	0.27	↓
Hysterectomy, vaginal				
Female, Age 15-44	12	0.02	0.12	↓
Female, Age 45-64	25	0.08	0.19	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 4/1/2016 – 3/31/2017 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Cholecystectomy, open				
Male, Age 30-64	0	0.00	0.02	↓
Female, Age 15-44	2	0.00	0.01	↓
Female, Age 45-64	2	0.01	0.03	↓
Cholecystectomy, closed (laparoscopic)				
Male, Age 30-64	45	0.10	0.27	↓
Female, Age 15-44	155	0.25	0.63	↓
Female, Age 45-64	76	0.24	0.62	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 4/1/2016 – 3/31/2017 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Back Surgery				
Male, Age 20-44	6	0.02	0.24	↓
Female, Age 20-44	10	0.02	0.16	↓
Male, Age 45-64	35	0.13	0.56	↓
Female, Age 45-64	26	0.08	0.49	↓
Mastectomy				
Female, Age 15-44	13	0.02	0.02	↔
Female, Age 45-64	22	0.07	0.14	↓
Lumpectomy				
Female, Age 15-44	39	0.06	0.12	↓
Female, Age 45-64	76	0.24	0.37	↓

Frequency of Selected Procedures: Medi-Cal, Cont.

Source: HEDIS data for 4/1/2016 – 3/31/2017 measurement period

Procedure	Number of Procedures	Procedures / 1,000 Member Months	NCQA Medicaid 50th Percentile	SCFHP Comparison to Benchmark
Bariatric Weight Loss Surgery				
Male, Age 0-19	0	0.00	0.00	↔
Female, Age 0-19	0	0.00	0.00	↔
Male, Age 20-44	3	0.01	0.01	↔
Female, Age 20-44	31	0.07	0.05	↑
Male, Age 45-64	5	0.02	0.01	↑
Female, Age 45-64	16	0.05	0.05	↔

Medi-Cal Behavioral Health Metrics

Source: HEDIS data for 4/1/2016 – 3/31/2017 measurement period

Measure	Rate	NCQA Medicaid 50th Percentile	SCFHP Percentile Rank
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	36.87%	42.19%	<50th
Continuation & Maintenance Phase	29.41%	52.47%	<10th
Antidepressant Medication Management			
Acute Phase Treatment	62.33%	53.40%	>75th
Continuation Phase Treatment	41.19%	38.06%	>50th
Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia	50.00%	80.00%	<10th

Santa Clara
Family Health Plan
The Spirit of Care

Questions?

Santa Clara
Family Health Plan

InterRater Reliability Summary
2017

1. In accordance with Policy HS.09, the 1st bi-annual Calendar Year 2017, Santa Clara Family Health Plan (SCFHP) scheduled IRR testing is complete. This is required twice a year. IRR testing is scheduled for SCFHP Fall and Spring calendar. In accordance with NCQA/DHCS, DMHC guidelines, and SCFHP policy, 10 random cases are developed to test all of our Utilization Management (UM) staff. Our UM staff consist of non-licensed Care Coordinators (CC)/Support Specialist (SS), RN/LVN, and Medical Directors (MD).
2. In the calendar year 2017, SCFHP updated the policy from individual testing to group testing to provide support to our staff.

   a. Positive feedback received from the majority of SCFHP UM staffs during the Fall testing cycle.
3. It is the policy of SCFHP to monitor the consistency and accuracy of review criteria applied by all reviewers - physicians and non-physicians - who are responsible for conducting Utilization Management reviews and to act on improvement opportunities identified through this monitoring.
4. The Chief Medical Officer will review and approve the assessment report of decision making performance of staff responsible for conducting Utilization Management reviews for medical staff. The report results and recommendations for improvement will be presented annually to the Utilization Management Committee.
5. The Plan classifies reviews into one of two performance categories: Proficient (80% - 100% of the records are in compliance with the review criteria); Not proficient (below 80% in compliance) Scores below 80% require increased focus by Supervisors/Managers with actions described in Policy/Procedure HS.09/HS.09.01 or an individual corrective action plan.

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

Reviewer	Percent Score	Pass/Failed
1	100	Pass
2	100	Pass
3	100	Pass
4	100	Pass
5	100	Pass
6	100	Pass
7	100	Pass
8	100	Pass
9	100	Pass
10	100	Pass

11	100	Pass
12	100	Pass
13	100	Pass
14	100	Pass
15	100	Pass

Findings indicate that all staff performed as Proficient. There were no CAP's.
The next testing cycle is scheduled for Spring 2017.

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Nurse Advice Line**	**Policy No.:**	HS.13
Replaces Policy Title (if applicable):	Nurse Advice Line	**Replaces Policy No. (if applicable):**	UM 111_01
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To describe Santa Clara Family Health Plan's (SCFHP) Nurse Advice Line services.

II. Policy

SCFHP's Nurse Advice Line is available 24 hours a day, seven days a week with immediate telephonic access to a California Licensed Registered Nurse to assist with a multitude of varying member health care needs. Members have access to support for a broad range of health related questions, including acute and chronic disease triage, education or prevention. Members are advised regarding accessing care and the most appropriate level of care, based on their inquiries. Follow-up with members is arranged as needed, which may include health plan case management services.

Nurse Advice Line services include the use of TDD equipment to handle the needs for deaf/hard of hearing individuals, and also Language Line Interpretation services for member languages other than English.

Additional details are provided in SCFHP's Procedure CM.09.01.

III. Responsibilities

Multiple departments at SCFHP maintain responsibilities related to the Nurse Advice Line. Health Services and Customer Service provides member follow-up as appropriate. Marketing maintains information regarding the Nurse Advice Line on the Plan web site. Quality Improvement and Delegation Oversight tracks and monitors the Nurse Advice Line for trends, performance and member satisfaction.

IV. References

NCQA 2016

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Sandra Carlson, RN	Signature Jeff Robertson, MD
Name Director of Medical Management	Name Chief Medical Officer
Title 04/14/2017	Title 04/14/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1.0	**Original**			

CMC member Optum's 24 hour Nurse Advice Line Stats

November 2016	8 calls received
December 2016	7 calls received
January 2017	14 calls received
February 2017	4 calls received
March 2017	9 calls received
April 2017	24 calls received
May 2017	12 calls received
June 2017	17 calls received

Call types vary in nature for issues such as: *Dizziness/Lightheadedness/Vertigo, Hip problems, Back problems, Headache, rectal bleeding, Nosebleeds, Urinary problems, Weakness/Fatigue, Allergic Reaction, Fever/Chills > 12 yrs of age, Abdominal Pain, Neurological symptoms.*

Disposition types vary in nature to include advice to members instructing them to: *Call 911, Home treatment, Seek Care today, Contact your PCP.*

Optum provides a 24/7/365 centralized toll-free Nurse Advice Line (NAL) number to all CMC members. Inbound calls are received by non-clinical staff who handle all non-clinical and/or informational calls. Calls clinical in nature are transferred to an Optum Nurse. Optum's NAL is supported by the HealthWise clinical guidelines. Optum's NAL program has translation services for multiple languages and is TDD/TTY for people with hearing impairments.

Optum is able to incorporate issues that are triaged by a Nurse, into Care Plans for members enrolled in one of their Disease Management or Complex Case management programs. A 24 hour follow up call is initiated for all calls requiring Nurse triage.