Santa Clara
Family Health Plan

The Spirit of Care

UTILIZATION MANAGEMENT COMMITTEE
WEDNESDAY, JANUARY 18, 2017
AGENDA
6:00 PM – 7:30 PM

I. Review/Revision/Approval of Minutes — **Jimmy Lin, MD, Chair** — **5 min**

a. Introductions
b. Approval of October 19, 2016 Minutes

II. CEO Update — **Christine Tomcala, CEO** — **5 min.**

III. Old Business — **Jeff Robertson, MD/Lily Boris, MD** — **5 min.**

a. Readmission Analysis

IV. Action Items — **20 min.**

a. Review of Policies — **Jana Alegre**
   i. HS.01 Prior Authorization
   ii. HS.02 Medical Necessity Criteria
   iii. HS.03 Appropriate Professionals
   iv. HS.04 Denial Notification
   v. HS.05 Evaluation of New Tech
   vi. HS.06 Emergency Services
   vii. HS.07 Clinical Practice Guidelines
   viii. HS.08 Second Opinion
   ix. HS.09 Interrater Reliability
   x. HS.10 Financial Incentive
   xi. HS.11 Informed Consent
   xii. HS.12 Preventive Health Guidelines

b. Adopt Hierarchy of UM Criteria-HS.02 — **Jana Alegre**

c. UM Program Description 2017 — **Sandra Carlson**

V. Reports (MediCal/SPD, Healthy Kids) — **20 min.**

a. Membership — **Jeff Robertson, MD**

b. UM Reports 2016 — **Lily Boris, MD**

   i. Turn Around Time (Cal MediConnect/Medi-Cal)
   ii. Standard Utilization Metrics
   iii. Specialty Referral Tracking (attached procedure and results)

c. Mental Health Update **Sherry Holm**
   i. Behavioral Health Utilization Data
   ii. ABA Utilization Data

d. Committee Membership/Charter **Jeff Robertson, MD**

VI. Adjournment **Jimmy Lin, MD**

<u>Next Meeting:</u> Wednesday, April 19, 2017

Santa Clara Family Health Plan

The Spirit of Care

MINUTES

UTILIZATION MANAGEMENT COMMITTEE

October 19, 2016

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	N
Ngon Hoang Dinh, DO	Head and Neck Surgery	Y
Indira Vemuri, MD	Pediatrics	Y
Dung Van Cai, MD	OB/GYN	Y
Habib Tobaggi, MD	Nephrology	N
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 Alegre	Utilization Management Manager	Y
Sandra Carlson	Health Services Director	Y
Caroline Alexander	Administrative Assistant	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. Introductions Review/Revision/Approval of Minutes	Meeting called to order by chair at 6:10 p.m. Introduced Sandra Carlson, Health Services Director to the group. The minutes of the July 20, 2016 meeting were approved as presented.	
II. CEO Update	Ms. Tomcala presented the update for Santa Clara Family Health Plan. Plan is busy preparing for NCQA accreditation and upcoming CMS audit. Opened the floor for questions.	
III. Old Business	Dr. Boris gave an update on the audit findings for the Utilization Management department, as well as the response to the corrective action plan. There were three findings for the Utilization Management Department. Findings included the following: • The Plan did not have a 2015 UM Program and Work Plan -- Corrected • The Plan did not demonstrate a consistent systemic process, such as inter-rater reliability (IRR) studies or other	

ITEM	DISCUSSION	ACTION REQUIRED
	methods, for ensuring consistent application of UM guidelines by all UM decision makers -- Corrected • The Plan did not have an established and systemic process to track all specialty referrals that require medical prior authorizations to their completion, including out of network referrals – In process in accordance to our current policy	
IV. Action Items	a. Final Medi-Cal Prior Authorization Grid for implementation January 1, 2017 Ms. Alegre presented a summary of changes to the Medi-Cal Prior Authorization Grid. Reformatted list to match MediCare list and make easier to read. Inpatient admissions, SNF, LTC will require prior authorization. Outpatient surgery section: removed Hemodialysis, which does not require prior authorization unless out of area. Added gender reassignment surgery. Non contracted providers require prior authorization. Organ transplants, Behavioral Health remained the same. In conjunction with Pharmacy Department, revised drug prior authorization list. Removed Oncology prior authorization requirement. Removed Oncology drugs from prior authorization list. New Grid will be effective January 1, 2017 and be published to the website. Will notify providers via FAX blast there is a new prior authorization grid. Discussion opened to the floor. Dr. Robertson clarified DME section of grid. After motion duly made, seconded, Medi-Cal Prior Authorization Grid was approved as presented.	

ITEM	DISCUSSION	ACTION REQUIRED
V. Standing Reports	a. Membership Dr. Robertson presented an update on membership. Of note between August and September, Healthy Kids population reduced by 1200 due to State slowly decreasing Healthy Kids population. This was due to rolling over Healthy Kids into Medi-Cal. 1300 went into Medi-Cal in September, 300 left Healthy Kids in October. Increased Medi-Cal enrollment in October. Gained 2400 Medi-Cal members in October. Medi-Cal membership is 274,000 and Cal Medi-Connect is 7,800 as of October. Grand Total as of October is 282,000 members. Growth is steady in membership. Distribution amongst networks has remained relatively constant. Working with providers to promote Cal Medi-Connect program. b. UM Reports 2016 – see attached PowerPoint i. Quarterly: CMC and Medi-Cal Dr. Boris presented the report on Inpatient Utilization for Medi-Cal Non-Seniors and Persons with Disabilities (SPD), Medi-Cal SPD, Cal MediConnect, as well as Inpatient Readmissions for the above mentioned populations, respectively. Will do more data analysis and trending, as well as analysis by network for future reporting. Also presented Frequency of Selected Procedures for Medi-Cal population, as well as Medi-Cal Behavioral Health Metrics. ii. Turn Around Time Dr. Boris presented the Dashboard for June 2016 through August 2016. For all Lines of Business, the goal in each area is 95%. For Cal MediConnect the non urgent pre-service requirement is review within 14 calendar days. Percent reviewed within 14 calendar days increased from 79% in June to 97% in August. Expedited requirement is review within 72 hours. Percent reviewed within 72 hours increased from 69% in June to 81% in August. Retrospective Review is to be reviewed within 30 calendar days. 100% were completed within this time frame. For Medi-Cal Standard non urgent requirement is review within 5 business days. Range from June to August has been 95 to 97%. For expedited review, the requirement is 72 hours turnaround. As of August, percentage reviewed in 72 hours is 94%, just slightly below the goal of 95%. Concurrent review not available currently because of our systems. Should be available once Medi-Cal is moved into QNXT system. Decision needs to be made within 24 hours of the request. Retrospective review is to be completed within 30 calendar days of request. As of August, 90% were reviewed within this timeframe. Volume is 1,000 requests per month for Medi-Cal. And CMC requests are also approximately 1000 / month for about 8000 patients.	

ITEM	DISCUSSION	ACTION REQUIRED
VI. Adjournment	Meeting adjourned at 7:05 p.m.	
NEXT MEETING	The next meeting is scheduled for Wednesday, January 18, 2017, 6:00 PM	

Prepared by:

_____ Date _____

Caroline Alexander
Administrative Assistant

Reviewed and approved by:

_____ Date _____

Jimmy Lin, M.D.
Committee Chairperson

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Prior-authorization/Org determinations**	**Policy No.:**	HS.01
Replaces Policy Title (if applicable):	Prior Auth for Non-Delegated SCFHP Mbrs. MLTSS and Specialit y ProgramsPrior Auth Process REDLINE Prior Authorization Process Continuity of Care Policy Out of Network Out of Area Referrals	**Replaces Policy No. (if applicable):**	UM002_07 UM002_09 UM002_08 UM031_04 UM033_04
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define consistent processes and guidelines for conducting prior authorization / org determinations.

II. Policy

A. Santa Clara Family Health Plan has developed, maintains, continuously improves and annually reviews a Utilization Management Program. The UM Program Description and written procedures addresses required functions to support the consistent application of criteria.

B. Prior Authorization is not required for Emergency Services (including Emergency Behavioral Health Services), Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

1. The Plan applies the prudent layperson or reasonable person's interpretation of what may be considered an emergent condition. A policy regarding coverage of emergency services is maintained, revised and reviewed annually and as needed.

C. Prior Authorization is not required for inpatient admissions for stabilization after emergency room treatment

D. Prior authorization is required for inpatient admissions and post stabilization admission in and out-of-network

1. A member or member's representative can initiate prior authorization requests. In this case, the request is processed the same as a provider service request.

E. The Plan utilizes standardized criteria for medical necessity determinations and maintains a policy that is reviewed annually.

F. The Plan has established turn-around times for each line of business which is monitored for compliance

    1. Decisions are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services. In addition, all decisions are clearly documented.

G. The plan allows for new members to continue services with out of network providers for a defined period of time in order to facilitate a smooth transition of care into the plan's network.
H. The Plan maintains a protocol regarding Continuity of Care for both medical and behavioral health services.
I. Out of Area requests are processed in accordance to the Plan's Continuity of Care protocol for
J. medical and behavioral health
K. Members and providers have access to the Utilization Management Department at least eight hours a day during normal business hours of at least 8:30 a.m. to 5:00 p.m. Pacific Time. The Nurse Line is available after hours for timely authorization of Covered Services that are Medically Necessary and to coordinate transfer of stabilized members in the emergency department, if necessary.

    1. The Plan gathers all relevant information in order to make a prior authorization determination. This includes considerations outside of the clinical information such as support system, other resources and location.

L. The Plan maintains a policy and procedure for allowing members access to a second opinion
M. The Plan maintains a policy on denials and denial notification
N. The Pan maintains a policy on requiring use of appropriate/qualified professionals for UM functions such as
    1. Licensed vs. non-licensed functions
    2. Specialist requirements (BH, Pediatrics, other)

O. The Plan maintains policy and procedures to make certain that members have equal access to new technology or new uses of current treatment modalities through an established policy for the evaluation of new technology.

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, Benefits, IT, Provider and Member Services, outside community resources and providers.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN Signature Sandra Carlson Name Health Services Director Title January 15, 2017 Date	Jeff Robertson MD Signature Jeff Robertson, MD Name Chief Medical Officer Title January 15, 2017 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 1/18/2017**	

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

A. Criteria is based on sound clinical evidence to make utilization decisions
B. Criteria is specific to procedures
C. Criteria is used to evaluate the necessity of medical and behavioral healthcare decisions
D. In addition to the UM hierarchy of guidelines, the plan is licensed to use MCG™ guidelines (formerly known as Milliman Care Guidelines®) to guide utilization management decisions
E. The criteria is reviewed and adopted at least annually by the UM Committee
    1. This includes external physicians, both primary care providers and specialists (including pediatric and behavioral health specialists) in developing, adopting, and reviewing criteria
F. The criteria takes into account individual member needs and the local delivery system
G. The Plan annually defines the hierarchy of application of criteria for each line of business
H. The plan defines the availability of criteria and states in writing how practitioners can obtain UM criteria and how the criteria is made available to the practitioners and members upon request
I. The plan evaluates the consistency with which health care professionals involved with any level of applying UM criteria in decision making and takes appropriate corrective actions to improve areas of non-compliance at least annually

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

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

2. When SCFHP discloses medical necessity criteria to the public, the criteria includes the following disclosure: "The materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

III. Responsibilities

Health Services reviews annually and submits criteria, policies and procedures to the medical officer and UM/QIC for approval.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN Signature Sandra Carlson Name Health Services Director Title January 18, 2017 Date	Jeff Robertson, MD Signature Jeff Robertson, MD Name Chief Medical Officer Title January 18, 2017 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 1/18/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Appropriate Use of Professionals**	**Policy No.:**	HS.03
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To provide clear directives that utilization management activities are carried out by qualified personnel, not limited to but including utilization of licensed healthcare professionals for any determination requiring clinical judgment.

II. Policy

A. Santa Clara Family Health Plan's Health Services Department carries out various utilization management activities which require different levels of licensure or expertise.
B. The Plan specifies the type of personnel responsible for each level of UM decision making which includes:
    - Non-licensed staff may apply established and adopted UM approval guidelines that do not require clinical judgment.
    - Only qualified licensed healthcare professionals assess clinical information used to support UM decisions.
    - Only a physician, designated behavioral health practitioner or pharmacist may make a medical necessity denial decision.

C. Licensed professionals supervise all medical necessity decisions and provide day to day supervision of assigned UM staff.
D. Non-licensed and licensed staff receive training and daily supervision.
E. The Plan maintains written job descriptions with qualifications for practitioners who review denials based on medical necessity which addresses education, training, experience and current appropriate clinical licensure.
F. SCFHP maintains a fulltime Medical Director and Chief Medical Officer. Each maintain an un-restricted physician license in the state of California.
G. The Plan requires that each UM denial file includes the reviewer's handwritten signature, initial, unique electronic signature, identifier or a signed / initialed note by the UM staff person attributing the denial decision to the professional who reviewed and decided the case.

H. The plan maintains written procedures for using board certified consultants to assist in making medical necessity determinations which documents evidence of the use of the consultants when applicable.
I. The Plan maintains a Policy prohibiting financial incentives for UM decisions, including incentives to deny requests or to encourage underutilization.

III. Responsibilities

Health Services follows appropriate professionals supported by Human Resources for licensing verification and Provider Network Management monitoring of the professional licensing organizations.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

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Sandra Carlson, RN	Jeff Robertson, MD
Signature	Signature
Sandra Carlson	Jeff Robertson, MD
Name	Name
Health Services Director	Chief Medical Officer
Title	Title
January 18, 2017	January 18, 2017
Date	Date

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v1		**Utilization Management**	**Approve 1/18/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Denial of Services Notification**	**Policy No.:**	HS.04
Replaces Policy Title (if applicable):	Member Notification about Adverse Medical Service Decisions	**Replaces Policy No. (if applicable):**	UM-01-96
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒Healthy Kids	☒ CMC

I. Purpose

To define Santa Clara Family Health Plan's expectations for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations.

II. Policy

A. The plan maintains strict processes on notification of denial decisions to members and providers. Notification includes verbal and written processes. A procedure is maintained that outlines timeliness guidelines that are followed by Health Services.

B. A mechanism is in place to allow providers to discuss a denial with a physician reviewer prior to appeal. This is documented when such discussions occur.

C. Letters to members for denial, delay, or modification of all or part of the requested service include the following.

1. Approved denial templates are customized to each line of business and filled out appropriately for each member request
2. Specifies the denied or modified service or care requested and provides a clear and concise explanation of the reason(s) for the Plan's decision
3. Specifies the criteria or guidelines used for the Plan's decision
4. Specifies the clinical reason(s) for the Plan's decision
5. If the denial is due to not enough clinical information the letter specifies the information needed and the specific criterion used
6. Advises that members and providers can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
7. The letter is easily understandable for a layperson
8. Provided in the language on the member's plan file
9. Advises that notifications are available in threshold languages upon request
10. Advises that translation services in alternative formats can be requested for members with limited language proficiency

11. The written notification to the requesting provider includes the name of the determining health care professional as well as the telephone number to allow the physician or provider to easily contact the determining health care professional
12. The Plan's written denial notification to members and their treating practitioners contains the following information relevant to the appeal

    i. A description of appeal rights, including the right to submit written comments; documents or other information relevant to the appeal
    ii. An explanation of the appeal process; including members' rights to representation and appeal time frames
    iii. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials
    iv. A description on how to appeal to the Independent Medical Review body appropriate to their line of business (i.e. State DMHC for MediCal, Maximus for Medicare non pharmacy)

III. Responsibilities

Health Services coordinates with both internal and external stakeholders in development, execution, maintenance and revisions to Denial Notifications. This includes but is not limited to collaboration with Quality, Benefits, IT, UM Committee, QIC, providers and community resources.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

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Sandra Carlson, RN Signature Sandra Carlson Name Health Services Director Title January 18, 2017 Date	Signature Jeff Robertson, MD Name Chief Medical Officer Title January 18, 2017 Date

Version Number		Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1		**Utilization Management**	**Approve 1/18/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Evaluation of New Technology**	**Policy No.:**	HS.05
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define Santa Clara Family Health Plan's process used where members have equitable access to new technology or new developments in technology that is determined to be safe and effective as aligned with benefits.

II. Policy

A. The Plan establishes and maintains a formal mechanism for selective evaluation and adoption of new or innovative technologies.
   1. New developments in technology and new applications of existing technology is necessary for inclusion considerations in its benefits plan as allowed, to keep pace with changes in the industry and allow for improved outcomes of medical care.

B. The Plan maintains written processes for evaluating new technology and new applications of existing technologies for inclusion in its benefits, where allowed by payors. Processes will address assessment of new technologies for medical procedures, behavioral health procedures, pharmaceuticals, and devices.

C. The Plan investigates all requests for new technology or a new application of existing technology by using *Up to Date* as a primary guideline to determine if the technology is considered investigational in nature.
   1. *Up to Date* is an evidence-based clinical decision support resource for healthcare practitioners. If further information is needed, the plan utilizes additional sources, including Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This includes medical and behavioral health procedures and devices. Pharmaceuticals are investigated by the Pharmacy and Therapeutics Working Group.

D. If the new technology, pharmaceutical or new application of an existing technology or pharmaceutical is addressed in the above documents, the information is critically evaluated by the Plan's Medical Director at the time of benefit coverage determination with consideration of clinical effectiveness and cost-effectiveness.

E. If the new technology, pharmaceutical or new application of an established technology/pharmaceutical is not addressed in the above documents, the Medical Director's critical evaluation will proceed to conferring with an appropriate specialist consultant for additional information.

F. Once the necessary information has been obtained, it will then be presented to the Technology Assessment or Pharmacy and Therapeutics Working Group, subcommittees of the Medical Advisory Council, to provide a recommendation to the Physician Council regarding coverage by the Plan.
   1. The decision will be based on safety, efficacy, cost and availability of information in published

literature regarding controlled clinical trials.

2. If a decision cannot be made, a committee of specialists may be convened to review the new medical technology/pharmaceutical and make a recommendation to the Medical Advisory Council.
3. Ongoing patient selection criteria processes will be developed at this point to include standards for specific prior authorization requirements and financial specifications to product manufacturers or vendors.

III. Responsibilities

Health Services coordinates efforts with internal stakeholders to ensure new technology is assessed for regulatory appropriateness and efficacy. Benefit changes are coordinated with IT and compliance.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

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First Level Approval	Second Level Approval
Sandra Carlson, RN	Jeff Robertson, MD
Signature Sandra Carlson, RN	Signature Jeff Robertson, MD
Name Director of Health Services	Name Chief Medical Officer
Title 01/18/2017	Title 1/18/2017
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	**Original**	**Utilization Management**	**Approve 1/18/2017**	

Santa Clara
Family Health Plan

Policy Title:	**Emergency Services**	**Policy No.:**	HS.06
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define coverage of Emergency Medical Conditions and Urgent Care services.

II. Policy

A. Emergency Services are available and accessible within the service area 24 hours-a-day, seven (7) days-a-week
B. The Plan maintains contracts with behavioral health practitioners and facilities to provide services to members that require urgent or emergent Behavioral Healthcare for crisis intervention and stabilization
C. SCFHP includes ambulance services for the area served to transport the member to the nearest 24-hour emergency facility with physician coverage
D. The Plan does not require prior authorization for access to Emergency Services
E. The Plan applies prudent layperson language to define emergency department access and assesses each case on the presenting symptoms or condition that steered the member to the Emergency Department
F. No authorization is required for emergency services
    i. To screen and stabilize the member
    ii. Should a member be directed to the ED by an agent of SCFHP (i.e.: contracted PCP or specialist, nurse advice line, customer service, etc.) then the ED service will be approved regardless of prudent layperson language
G. In the occasion where an Emergency Department visit was to be denied, that denial must be made by a physician reviewer (except in administrative circumstances such as the claimant was not a member at the time of service)
H. It is the policy of SCFHP to allow 24-hour access for members and providers to obtain timely authorization for medically necessary care where the member has received emergency services and the care has been stabilized but the treating physician feels that member may not be discharged safely
I. SCFHP does not require prior authorization for the provision of emergency services and care necessary to stabilize the member's medical condition
J. The Plan will not deny reimbursement of a provider for a medical screening examination in the Emergency Department
K. If the Plan and the treating provider disagree about the need for post-stabilization care, then the Plan provider will personally take over the care of the patient within a reasonable amount of time for post-stabilization care or the Plan will have another hospital agree to accept the transfer of the member

L. The Plan makes the Emergency Department utilization management processes available to all facilities, including non-contracting hospitals by
    i. posting on the Plan website for public view
    ii. providing the number on the membership card

M. All ED practices are considered at least annually

III. Responsibilities

Health Services collaborates internally with benefits, compliance and IT to ensure that emergency services are covered.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

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First Level Approval	Second Level Approval
Sandra Carlson, RN	
Signature	Signature
Sandra Carlson	Jeff Robertson, MD
Name	Name
Health Services Director	Chief Medical Officer
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January 18, 2017	January 18, 2017
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v1	**Original**	**Utilization Management**	**Approve 1/18/2017**	

Santa Clara
Family Health Plan

Policy Title:	**Clinical Practice Guidelines**	**Policy No.:**	HS07
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define the manner of a consistent process for development and revisions of Clinical Practice Guidelines.

II. Policy

A. Santa Clara Family Health Plan (SCFHP) uses Clinical Practice Guidelines to help guide practitioners to make decisions about appropriate health care for specific clinical circumstances and behavioral healthcare services. These guidelines are based on up to date evidence and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field.

B. SCFHP adopts at least two medical based and two behavioral health based clinical practice guidelines.

C. The guidelines are reviewed and updated at least every two years by the Utilization Management Committee (UMC).

D. The CPGs are available for viewing on the provider web page of the health plan website, are available in the Provider Manual and are available upon request.

E. In addition to the Clinical Practice Guidelines, The Plan adopts preventive health guidelines for the following:
   1. Care for children up to 24 months old
   2. Care for children 2-19 years old
   3. Care for adults 20-64 years old
   4. Care for adults over 65 years old

F. SCFHP annually measures performance against at least two important aspects of the disease management programs

G. SCFHP annually evaluates provider adherence to CPGs and Preventive Health Guidelines through analysis demonstrating a valid methodology to collect data.
The QI Department analyzes pertinent HEDIS scores and claims data.
The analysis includes quantitative and qualitative analysis or performance.

Member satisfaction and grievances are tracked and reported to the Quality Improvement Committee (QIC)at least annually and acted upon as recommended by the QIC.

III. Policy Reference

HS.07 Clinical Practice Guidelines

IV. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Sandra Carlson	Signature Jeff Robertson, MD
Name Director of Health Services	Name Chief Medical Officer
Title January 18, 2017	Title January 18, 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		**Utilization Management**	**1/18/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	Second Opinion	**Policy No.:**	HS.08
Replaces Policy Title (if applicable):	Second Opinion Policy and Procedure	**Replaces Policy No. (if applicable):**	UM-30-96; UM036_01
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	□ CMC

I. Purpose

To define the process of obtaining second opinions and member access to a second opinion by appropriate healthcare professionals as appropriate.

II. Policy

A. A request for a second opinion may be initiated by a member or a treating healthcare provider of a member
B. The member Evidence of Coverage provides all members with notice of the policy regarding the manner in which a member may receive a second medical opinion.
C. The Plan provides or authorizes a second opinion by an appropriately qualified health care professional, if requested by a member or participating health professional.
D. When the member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness would be detrimental to the enrollee's ability to regain maximum function, the Plan will authorize or deny the second opinion request within 72 hours.
E. When the member's condition is non-urgent, the Plan authorizes or denies the second opinion requests in an expeditious manner not to exceed the usual UM policy.
F. The member may choose from any provider from any independent practice association or medical group within the network of the same or equivalent specialty to provide the second opinion
G. If the member requests a second opinion from an out-of-network specialist which is approved by the Plan, the Plan shall incur the cost for the second opinion beyond the applicable co-pays due by the member, if any.
H. The Plan shall notify the member of any denial for a second opinion in writing. If an expedited request, the member will be notified in alignment with established UM procedures. When the request is denied, notifications are made to the member and provider with an explanation of the reason of the decision, a description of the criteria or guidelines used and clinical reason for the decision regarding medical necessity denials. Any written communication to a physician or other health care provider of a denial, delay or modification of a request includes the name of the deciding Medical Director or CMO along with contact information. Information on how to file a grievance or appeal is included.

III. Responsibilities

Health Services follows the Second Opinion policy and procedure as directed, works collaboratively with internal and external departments including Quality, Benefits, IT, Providers and community services.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A.

V. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN Signature	 Signature
Sandra Carlson Name	Jeff Robertson, MD Name
Health Services Director Title	Chief Medical Officer Title
January 18, 2017 Date	January 18, 2017 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Utilization Management	Approve 1/18/2017	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**InterRater Reliability**	**Policy No.:**	HS.09.01
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To standardize Santa Clara Family Health Plan (SCFHP) InterRater Reliability (IRR) testing. The plan's intent is that UM staff demonstrates accurate and consistent application of medical necessity criteria and guidelines.

II. Policy

SCFHP evaluates the consistency with which clinical and non-clinical staff involved with any level of applying UM criteria in decision making at least annually. When a staff member is found to be not proficient, corrective measures are pursued.

I. Medical/Behavioral Health/Pharmaceutical
   A. Cases
      1. Up to 10 hypothetical cases are presented:
         a. Approved and denied Prior Authorization requests
         b. Requiring non-clinician and/or clinician review
         c. Outpatient and Inpatient services

III. Review
   1. Identical cases are distributed to each reviewer
   2. The reviewer completes the review as if it was a real time review, documenting on paper worksheet (*see attachment A, IRR worksheet*).
   3. Each worksheet is graded and assigned a score. Total score plus percentage is calculated. (*see attachment B, scoring document*)
   4. 85% is considered a passing score.
      a. Below Proficient (<85%)
         i. An individualized corrective action plan will be implemented with the employee's direct clinical manager and the employee. The plan includes the following.
            a) Oversight of employee determinations as appropriate
            b) Training in the area identified to be deficient
            c) Re-testing after training complete to ensure compliance
            d) Coaching and observation as appropriate
            e) Repeat of process as needed

IV. Records

POLICY

All results and internal Corrective Action Plans (CAPS) remain confidential and are maintained within Health Services and are reported to the QIC.

V. Policy Reference

N/A

VI. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN Signature Sandra Carlson Name Health Services Director Title January 18, 2017 Date	Jeff Robertson Signature Jeff Robertson, MD Name Chief Medical Officer Title January 18, 2017 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original	Utilization Management	1/18/2017	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**UM Financial Incentives (Prohibition of)**	**Policy No.:**	HS.10
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To provide clear directives prohibiting financial incentives for Utilization Management decisions.

II. Policy

A. SCFHP does not reward decision makers or other individuals for UM decisions. Providers and members are notified of this policy through the Member Handbook/Provider Manual via web-site.

1. The Plan at no time provides financial or other incentives for UM decisions. UM approvals and denial decisions are based strictly on the appropriateness of care or service and existence of coverage.
2. The Plan never specifically rewards practitioners or other individuals to deny, limit, or discontinue medically necessary covered services.
3. The Plan does not encourage decisions that result in underutilization of care or services.
4. SCFHP Staff and Providers are notified annually of the Plan policy of prohibition for financial or other incentives for UM decisions.

III. Responsibilities

All internal, contracted staff and vendors involved with UM activities are notified of the policy prohibiting financial incentives for UM decisions. IT and Benefits ensure the appropriate criteria/benefits are in place for appropriate decision making. Compliance/QA activities monitor.

IV. References

3 Way Contract. (2014). *Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services*.

NCQA Guidelines. (2016, Februrary 22). Washington, DC, U.S.A. UM4;Elemement G

Technical Assistance Guide; Utilization Management; Routine Medical Survey UM-001. (2015, October 27). *Department of Managed Healthcare; Division of Plan Surveys*. California, United States: California

V. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN Signature Sandra Carlson Name Health Services Director Title January 18, 2017 Date	Jeff Robertson MD Signature Jeff Robertson, MD Name Chief Medical Officer Title January 18, 2017 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Utilization Management	Approve 1/18/2017	

POLICY

Santa Clara
Family Health Plan

Policy Title:	Informed Consent	**Policy No.:**	HS.11
Replaces Policy Title (if applicable):	Informed Consent Policy	**Replaces Policy No. (if applicable):**	PPQI-04C
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To standardized Santa Clara Family Health Plan's (SCFHP) provider requirements for obtaining, documenting and storing informed member consent.

II. Policy

SCFHP recognizes that it is necessary for members to be aware of risks and benefits of treatment and options available. It is Plan policy that members be well informed and that consent for certain high risk procedures/services as well as reproductive health services be obtained and properly recorded and stored in the member medical record.

III. Responsibilities

Health Services developed and maintains the policy on Informed Consent. The Utilization Management Committee adopts and reviews the policy. Provider Relations and Marketing provide information to members and providers via the web site. Quality Improvement reviews medical records for necessary documentation.

IV. References

DHCS Renewed Contract; Exhibit A, Attachment 4, Medical Records, 6) Knox Keene**§ 1363.02.** Reproductive health services information; statement

V. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN Signature	 Signature
Sandra Carlson Name	Jeff Robertson, MD Name
Health Services Director Title	Chief Medical Officer Title
January 18, 2017 Date	January 18, 2017 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 1/18/2017**	

Santa Clara
Family Health Plan

Policy Title:	**Preventive Health Guidelines**	**Policy No.:**	HS.12
Replaces Policy Title (if applicable):	Pediatric Preventive Health Service Adult Preventive Health	**Replaces Policy No. (if applicable):**	QM003_02 QM004_02
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To standardize Santa Clara Family Health Plan's (SCFHP) Preventive Health Guideline adoption, promotion and management.

II. Policy

SCFHP guidelines are intended it help clinicians, practitioners and members make informed decisions about appropriate preventive health care. This includes guidelines for perinatal care, children up to 24 months, 2-19 years, adults 20-64 years, or 65 or more years old.

The Utilization Management Committee (UMC) reviews and adopts preventive health guidelines that define standards of practice as they pertain to promoting preventive health services. Whenever possible, guidelines are derived from nationally recognized sources. They are based on scientific evidence, professional standards or in the absence of the availability of professional standards, an expert opinion. The preventive health guidelines are reviewed and updated at least every two years and more frequently when updates are released by the issuing entity. The Plan expects its practitioners to utilize the adopted guidelines in their practices, and recognizes the inability of the guidelines to address all individual member circumstances.

III. Responsibilities

The Preventive Health Guidelines are developed by health services utilizing nationally recognized sources The Guidelines are reviewed at least bi-annually... Guidelines are available to providers and members on the Plan website,

IV. References

28 CCR 1300.70(b) (2) (G) (5)
28 CCR 1300.70(b) (2) (H)
NCQAStandardsQI7ElementB

V. Approval/Revision History

First Level Approval	Second Level Approval
Sandra Carlson, RN Signature Sandra Carlson Name Health Services Director Title January 18, 2017 Date	Signature Jeff Robertson, MD Name Chief Medical Officer Title January 18, 2017 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Utilization Management**	**Approve 1/18/2017**	

Santa Clara
Family Health Plan

Policy Title:	**Hierarchy of UM Criteria by Line of Business**	**Policy No.:**	HS125
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	Utilization Management	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	X Medi-Cal	X Healthy Kids	X CMC

I. Purpose

SCFHP utilizes clinical UM guidelines that serve as one of the sets of guidelines for coverage decisions. SCFHP is also licensed to use MCG™ guidelines (formerly known as Milliman Care Guidelines®) to guide utilization management decisions. This may include but is not limited to decisions involving pre-certification, inpatient review, level of care, discharge planning and retrospective review. SCFHP utilizes the following guidelines in the order presented to make coverage decisions.

Benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the clinical UM guidelines. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law. A clinical UM guideline does not constitute plan authorization, nor is it an explanation of benefits.

II. Policy

In order to meet state and federal requirements, Santa Clara Family Health Plan (SCFHP) has developed a hierarchy of criteria for UM decisions by Line of Business.
The Utilization Management (UM) program implements a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and actively pursues identified opportunities for improvement. The UM program ensures that:

- Members receive the appropriate quantity and quality of health care services
- Service is delivered at the appropriate time
- Members receive the appropriate quantity and quality of health care services
- Service is delivered at the appropriate time

For authorization purposes, a requested service or medical equipment is approved if it is a covered benefit and is determined to be medically necessary.

In order to achieve appropriate and standardized decisions, the UM program processes requests using the systematic and consistent application of utilization management criteria. Clinical care decisions are determined by the SCFHP's qualified, experienced UM team using evidence based guidelines developed and approved by the Utilization Management Committee. For medical necessity determinations, the Alliance utilizes evidence based medical necessity criteria in a decision hierarchy.

III. Responsibilities

The SCFHP hierarchy of criteria for UM decisions by LOB is listed below. Plan clinical staff are educated on the hierarchy of decisions by their managers.

UM Criteria :	Medi-Cal/Healthy Kids	CMC Medicare
Outpatient (all)	1. Title 22, Medi-Cal FFS for review of the code for coverage determination and guidelines (when available) 2. MCG Guidelines (Milliman) 3. SCFHP UM approved policies 4. Consensus statements and nationally recognized standards of practice (if no other guidelines available)	1. Local Coverage Determinations 2. National Coverage Determinations 3. MCG Guidelines (Milliman) 4. Consensus statements and nationally recognized standards of practice (if no other guidelines available)
Inpatient	1. Title 22, Medi-Cal FFS for review of the code for coverage determination and guidelines (when available) 2. MCG Guidelines (Milliman)	1. Local Coverage Determinations 2. National Coverage Determinations 3. MCG Guidelines (Milliman)
California Home Medical Equipment (DME Vendor)	1. Title 22, Medi-Cal FFS for review of the code for coverage determination and guidelines (when available) 2. MCG Guidelines (Milliman) 3. Consensus statements and nationally recognized standards of practice (if no other guidelines available)	1. Local Coverage Determinations 2. National Coverage Determinations 3. MCG Guidelines (Milliman) 4. Consensus statements and nationally recognized standards of practice (if no other guidelines available)

IV. References

None.

V. Approval/Revision History

Version Number	Change (Original/Reviewed/Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original	UM/P&P	**Originated January 13, 2016**	

Santa Clara Family Health Plan

Utilization Management Program Description

2017

Introduction

Santa Clara Family Health Plan (SCFHP) has implemented a Utilization Management (UM) Plan consistent with Medicare regulations, the National Committee for Quality Assurance (NCQA) standards and the California Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) requirements to consistently measure and monitor processes to improve the effectiveness, efficiency, and value of care and services provided to the members of SCFHP.

The UM program description is reviewed and approved by the SCFHP Utilization Management Committee (UMC) annually. SCFHP may provide recommendations for Quality Improvement (QI) activities to improve the comprehensive UM program. A SCFHP chief medical officer or medical director is involved in UM activities, including implementation, supervision, oversight and evaluation of the UM Program. To assess the effectiveness of the UM program and to keep UM processes current and appropriate. SCFHP annually evaluates the UM Program for:

- The program structure, scope, processes, and information sources used to determine benefit coverage and medical necessity.
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioners in the program.
- Member and provider experience data

Santa Clara Family Health Plan (SCFHP) Background

Santa Clara Family Health Plan (SCFHP) is a local, public, not-for-profit health plan dedicated to improving the health and well-being of the residents of Santa Clara County. Our mission is to provide high quality, comprehensive health care coverage for those who do not have access to, or are not able to purchase, good health care at an affordable price. Working in partnership with providers, we act as a bridge between the health care system and those who need coverage. We do this by offering comprehensive, affordable medical, dental and vision coverage through our health insurance programs:

Medi-Cal, Cal MediConnect and Healthy Kids (Medi-Cal is a public insurance program, Cal MediConnect is a program for people with both Medi-Cal and Medicare, and Healthy Kids is a locally funded insurance program).

Since 1997, SCFHP has partnered with providers to deliver high-quality health care to our members. Through dedication to integrity, outstanding service, and care for our community, we work to ensure that everyone in our county can receive the care they need for themselves and for their families. We currently serve over 250,000 residents of Santa Clara County. For the Cal MediConnect Line of Business we serve approximately 9,000 members.

Section I. Program Objectives & Principles

A. The purpose of the SCFHP Utilization Management (UM) Program is to objectively monitor and evaluate the appropriateness of utilization management services delivered to members of the SCFHP. The UM Program addresses the following information about the UM structure:

1. Guides efforts to support continuity and coordination of medical services
2. Defines UM staff members' assigned activities, including the defining of the UM staff that has the authority to deny medical necessity coverage
3. Addresses process for evaluating, approving and revising the UM program and supporting policies and procedures
4. Defines the UM Program's role in the QI Program, including how SCFHP collects UM information and uses it for QI related activities
5. Improve health outcomes
6. Support efforts that are taken to continuously improve the effectiveness and efficiency of healthcare services

B. The SCFHP maintains the following operating principles for the UM Program:

1. UM decisions are made on appropriateness of care and service, as well as existence of benefit coverage
2. Appropriate processes are used to review and approve provision of medically necessary covered services and are based on the SCFHP policies and procedures through established criteria
3. The SCFHP does not financially reward clinicians or other individuals for issuing denials of coverage, care, or service
4. The SCFHP does not encourage UM decisions that result in under-utilization of care by members
5. Members have the right to:
    a) Participate with providers in making decisions about their individual health care
    b) Discuss candidly with providers the appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage

Section II. Program Structure

A. Program Authority

1. Board of Supervisors and the Board of Directors

The Santa Clara County Board of Supervisors appoints the Board of Directors (BOD) of the SCFHP, a 12-member body representing provider and community partner stakeholders. The BOD is the final decision making authority for all aspects of the SCFHP programs and is responsible for approving the Quality Improvement and Utilization Management Programs. The Board of Directors delegates oversight of Quality and Utilization Management functions to the SCFHP Chief Medical Officer (CMO) and the Quality Improvement Committee (QIC) and provides the authority, direction, guidance, and resources to enable SCFHP staff to carry out the Utilization Management Program. Utilization Management oversight is the responsibility of the Utilization Review Committee (UMC). Utilization Management activities are the responsibility of the SCFHP staff under the direction of the Chief Medical Officer.

2. Committee Structure

The Board of Directors appoints and oversees the QIC, which, in turn, provides the authority, direction, guidance, and resources to the Utilization Management Committee (UMC) to enable SCFHP staff to carry out the Quality Improvement and Utilization Management Programs.

SCFHP UMC meets quarterly in accordance with the SCFHP bylaws and more frequently when needed. Committee meeting minutes are maintained summarizing committee activities and decisions, and are signed and dated. The QIC Committee provides oversight, direction and makes recommendations, final approval of the UM Program.

B. UM Committee

1. Composition, roles, goals, meetings, and additional information will be found in the UM Committee Charter.

2. Responsibilities of the UM Committee

a) Develop, maintain, and execute an effective utilization review and management plan (the Plan) to manage the use of hospital resources in a manner that is efficient and cost effective.
b) The Director of Utilization Review shall review the Plan annually and revise it as necessary.
c) Provide oversight for review and utilization of:
   i. Ancillary services
   ii. Medical necessity of admissions
   iii. Extended length of stay and high cost cases
   iv. Cases of non-covered stays
   v. Short stay inpatient stays
   vi. Observation cases.

d) Verify that utilization management functions meet the standards and requirements of all licensing and regulatory agencies, accrediting bodies, third party payers, and external review agencies.
e) Verify that admissions and discharges are appropriate using well defined criteria.
f) Review and analyze data from the hospital-wide best practice/pathway activities, case mix index, denials, appeals/recoveries, and other sources and make recommendations for actions based on the findings.
g) Establish and approve criteria, standards, and norms for pre-admission reviews, continued stay reviews, and assist in continuing modification of such criteria, standards, and norms.
h) Recommend changes in patient care delivery if indicated by analysis of review findings.
i) Promote the delivery of quality patient care, according to criteria set by the Medical Staff, in an efficient and cost-effective manner.
j) Refer quality concerns identified during the review process to the Enterprise Director of Quality and Patient Safety and/or Risk Management for evaluation and action.

Promote the delivery of quality patient care, according to criteria set by the medical staff, in an efficient and cost-effective manner.

3. Conflict of Interest

No person who holds a direct financial interest in an affiliated health care entity is eligible for appointment to the Utilization Management Committee. For purposes of this policy, SCFHP does not consider employment by the Plan to constitute a direct financial interest in an affiliated entity. No committee member may participate in the review of a case in which either he or she or any of his or her professional associates have been professionally involved, except to provide additional information as requested. Refer to policy and procedure # QI.01 Conflict of Interest.

C. The Quality Improvement Committee

1. Functional responsibilities for the UM Program
   a) Annual review, revision and approval of the UM Program Description
   b) Oversight and monitoring of the UM Program, including:
   c) Review and approval of the sources of medical necessity criteria
   d) Recommend policy decisions
   e) Monitor for over and under-utilization of health services
   f) Design and implement interventions to address over and under-utilization of health services
   g) Guide studies and improvement activities
   h) Oversight of annual program evaluation and review
   i) Review results of improvement activities, HEDIS measures, other studies and profiles and recommend necessary actions

D. Health Services Department

The Health Services Department at the SCFHP is responsible for coordination of programs including the UM Program. The Utilization Management Department staff administer the UM Program. Non-clinical staff may receive and log utilization review requests in order to ensure adequate information is present. Some utilization requests are automatically approved by the care coordinator (non-clinical staff). Appropriately qualified and trained clinical staff uses evidenced based criteria or generally accepted medical compendia and professional practice guidelines to conduct utilization reviews and make UM determinations relevant to their positions (potential denials are referred to licensed physician and pharmacist reviewers). The CMO and Medical Director, conduct reviews that require additional clinical interpretation or are potential denials. The medical directors apply medical necessity criteria that are reviewed and adopted on an annual basis. The CMO or qualified designee is the only staff that makes medical necessity and coverage denial decisions.

1. Communication Services

The UM Staff shall provide the following communication services for members and practitioners:

a) UM personnel are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. The UM Department normal business hours are Monday through Friday, 8:30am to 5:00pm pacific time zone
b) Telephone lines are staffed with professionals who have access to most information/resources needed to provide a timely response. Callers have the option of leaving a voice mail message either during or after business hours
c) UM staff can receive inbound communication regarding UM issues after normal business hours. These calls are returned promptly the same or next business day. Staff is also a resource for other Plan Departments for UM and Case Management questions
d) UM staff are identified by name, title and organization name when initiating or returning calls regarding UM issues
e) The Department has both local and toll-free telephone and telefax numbers and offers TDD/TTY services for deaf, hard of hearing or speech impaired members. Language assistance/interpretation is also available for members to discuss UM issues
f) Language assistance for members to discuss UM issues is available at no cost to the member
g) SCFHP provides members with 24 hour access to the Nurse Advice Line for information regarding wellness/prevention and to assist members with the following:
    1. Determine whether to seek care
    2. Determine the most appropriate level of care for their condition
    3. Obtain answers to questions about medication
    4. Obtain information about providers
    5. Obtain information about non-urgent illnesses or injuries
    6. Apply self-care prior to a health care visit
    7. Receive bi-lingual or translation services

2. Roles

a) Chief Medical Officer (CMO)

The Chief Medical Officer is a physician who holds an active, unrestricted California license and is designated with responsibility for development, oversight and implementation of the UM Program. The CMO serves as the chair of the QIC, and makes periodic reports of committee activities, UM Program activities and the annual program evaluation to the BOD. The CMO works collaboratively with SCFHP community partners to continuously improve the services that the UM Program provides to members and providers.

b) Medical Directors

The Medical Directors are licensed physicians with authority and responsibility for providing professional judgment and decision making regarding matters of UM. Medical Director responsibilities include, but are not limited to, the following:

1. Support processes where medical decisions are rendered by, and are not influenced by fiscal or administrative management considerations. The decision to deny services based on medical necessity is made only by Medical Directors
2. Ensure that the medical care provided meets the standards of practice and care
3. Ensure that medical protocols and rules of conduct for plan medical personnel are followed
4. Develop and implement medical policy.
5. A medical director is designated to be involved with UM activities, including implementation, supervision, oversight and evaluation of the UM program
6. Any changes in the status of the CMO or Medical Directors shall be reported to Department of Health Care Services (DHCS) within ten calendar working days of the change.
7. The SCFHP may also use external specialized physicians to assist with providing specific expertise in conducting reviews. These physicians hold current, unrestricted licenses in the state of California and are board certification by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) in specific areas of medical expertise. The CMO is responsible for managing access and use of the panel organization of specialized physicians. An example of external specialist physicians would be psychiatry or psychology for making determinations regarding mental health care.

c) Health Services Director and UM Manager

Deleted: Manager

The Health Services Utilization Manager is responsible for the day to day management of the UM department, the overall UM Department operations and for coordination of services between departments. These responsibilities include:

1. Develop and maintain the UM Program in collaboration with the Medical Director and Health Services Managers including Behavioral Health Manager(s) and Long Term Support Services(LTSS) Management staff
2. Coordinate UM activities with the Quality Department and other SCFHP units.
3. Maintain compliance with the regulatory standards.
4. Monitor utilization data for over and underutilization.
5. Coordinate interventions with the Health Services Medical Director and staff to address under and over utilization concerns when appropriate.
6. Monitor utilization data and activities for clinical and utilization studies.
7. Maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans and community partners, sharing information about requirements and successful evaluation strategies
8. Implement a yearly UM program evaluation and member and provider satisfaction surveys

d) UM Operations Supervisor

Responsible for the daily operational management of the Utilization Management Department activities, such as: authorization processing, letter creation, provider outreach and education and supervising staff productivity, training and development., daily supervision of non-clinical Utilization Care Coordination and data entry staff.

e) Pharmacy Director

The Pharmacy Director, or designee, is a licensed pharmacist (Pharm. D.) responsible for coordinating daily operations, and revewing and managing pharmacy utilization reports to identify trends and patterns. The Director provides clinical expertise relative to the Pharmacy, Quality, and Utilization Management components of SCFHP plan management, including Member and Provider Services, and Claims operations. The scope of responsibilities of the Pharmacy Services Director includes:

1. Render pharmaceutical service decisions (approve, defer, modify or deny) pursuant to criteria established for the specific line of business by the CMO and the SCFHP Pharmacy and Therapeutics Committee or generally accepted medical compendia and professional practice guidelines
2. Assure that the SCFHP maintains a sound pharmacy benefits program.
3. Manage the SCFHP Medication Formulary on an ongoing basis
4. Manage the Drug Utilization Review program

5. Monitor compliance with delegation requirements and the performance of the Pharmacy Benefits Management firm's services
6. Provide clinical expertise and advice for the on-going development of pharmacy benefits.
7. Review medication utilization reports to identify trends and patterns in medication utilization
8. Develop and manage provider and client education programs to improve medication prescribing patterns and to increase patient compliance
9. Ensure compliance with Federal and State regulatory agencies
10. Manage the contract with, and delegated activities of, the pharmacy benefits management organization

f) Utilization Review Nurses

Licensed, Registered nurses are responsible for the review and determinations of medical necessity coverage decisions. Nurses may provide prospective, concurrent and retrospective inpatient or outpatient medical necessity coverage determinations using established and approved medical criteria, tools and references as well as their own clinical training and education. Utilization Review Nurses also work collaboratively with case managers and assist with member discharge planning. All cases that do not satisfy medical necessity guidelines for approval are referred to a Medical Director for final determination. The CMO or Medical Directors are available to the nurses for consultation and to make medical necessity denials.

g) Nurse Case Managers

Case management services at the SCFHP are licensed registered nurses responsible for the case management for selected members with complex medical conditions. Case managers, in collaboration with the treatment team and with family members when appropriate, coordinate and facilitate the provision of appropriate medical services and available resources to meet the member's individual needs and promote quality, cost-effective outcomes. Please refer to the Case Management Program for additional information. The scope of responsibilities of Nurse Case Mangers includes:

1. Assists members, providers and facilities with transitions of care
2. Identifies targeted behaviors and assists participant members in moving through stages of change.
3. Reviews participant's functional status, formal and informal family support system, determining participant's desired outcome of care and needs for participant education
4. Develops and facilitates implementation of a care plan addressing the total healthcare needs of the participants. This is the Interdisciplinary Care Plan (ICP)
5. Identifies participant barriers to accessing health care services
6. Functions as part of the multi-disciplinary treatment team, facilitating communications with primary managing physician and other members of the

condition management team. Initiates the Interdisciplinary Care Team (ICT) process with the member, primary care physician, and others at the request of the member

h) Non-Clinical Staff

Non-clinical staff in multiple roles perform a variety of basic administrative and operational functions. Clinical staff provides oversight to the non-clinical staff.
Roles and responsibilities include:

1. Care Coordinators process selected approvals that do not require clinical interpretation, and complete intake functions with the use of established scripted guidelines.
2. Health Services Administrative Assistant assists with mailings and data collection

i) Behavioral Health Staff

1. Medical Director or CMO
   i. Reviews denials, changes in requested service.
      a) If there is a change in the authorization request for a behavioral health related inpatient or partial hospitalization stay for a member, this is considered a denial. The denial will be reviewed by the SCFHP MD or CMO who shall consult with a SCFHP psychiatrist as needed.
   ii. Involved in the implementation of the behavioral health care aspects of the UM Program
   iii. Establishes UM policies and procedures relating to behavioral healthcare
   iv. Reviews and decides UM behavioral healthcare cases
   v. Participates in UM Committee meetings

2. Psychiatrist
   i. SCFHP contracts with a board certified psychiatrist to provide consultation and participation in the following
   ii. Implementation of the behavioral health care aspects of the UM Program
   iii. Establishing UM policies and procedures related to behavioral healthcare
   iv. Participates in UM Committee meetings
   v. Development and approval of behavioral health criteria
   vi. Review and decides UM behavioral healthcare cases
   vii. Oversight of UM referrals and cases

3. Behavioral Health Program Manager
   i. The BH Program Manager is a BH clinician and has responsibility to facilitate the review of all referrals to the BH department for appropriate triage and assignment.

The priority for assignment will be for psychiatrically hospitalized members, frequent emergency room (medical and psychiatric ER), emergent or urgent situations of a life-threatening nature, care coordination with Specialty Mental Health members. All other referrals from internal and external sources will be prioritized as staff time is available.

ii. The BH Program Manager is responsible to oversee Quality Improvement monitoring to continuously assess application of utilization management criteria, turn-around-times, appropriate level of care, etc. The Program Manager Drives compliance with behavioral health related HEDIS measures to support member access to preventive services and management of chronic conditions.

4. Behavioral Health Case Manager
   i. The BH case manager will review all psychiatric hospitalizations and partial hospitalizations for medical necessity and to provide coordination of care upon discharge. The BH case manager will contact the hospital case manager to ensure that a plan is developed for aftercare. If the hospitalization is reviewed retrospectively, the BH case manager will contact the member or member's parents to arrange for coordination of aftercare.

j) Pharmacy Staff

SCFHP staff is composed of clinical pharmacists, pharmacy technicians and a medical director. The Plan staff roles and responsibilities include but are not limited to:

i. Review of all prior authorization requests for non-formulary medication therapy
ii. Review of all pharmacy appeals
iii. Delegation oversight of the Pharmacy Benefit Manager
iv. Quality Improvement monitoring to continuously assess application of criteria, turn-around-times, step therapy, etc.
v. Provides education to the contracted network staff as necessary
vi. Drives compliance with medication related HEDIS measures to support member access to preventive services and management of chronic conditions

E. UM Program Evaluation

1. Annual Evaluation

Members of the UM Program management team annually evaluate and update the UM Program to ensure the overall effectiveness of UM Program objectives, structure, scope and processes. The evaluation includes, at a minimum:

a) Review of changes in staffing, reorganization, structure or scope of the program
b) Analysis of annual aggregated data related to UM processes and activities
c) Resources allocated to support the program
d) Review of completed and ongoing UM work plan activities
e) Assessment of performance indicators
f) Review of delegated arrangements activities
g) Recommendations for program revisions and modifications

The UM management team presents a written program evaluation to the QIC. The QIC reviews and approves the UM Program evaluation on an annual basis. The review and revision of the program may be conducted more frequently as deemed appropriate by the QIC, CMO, CEO, or BOD.

The QIC's recommendations for revision are incorporated into the UM Program description, as appropriate, which is reviewed and approved by the BOD and submitted to DHCS, CMS on an annual basis.

F. Quality Improvement Integration

The UM Program includes a wide variety of quality assurance activities to support positive member outcomes and continuous quality improvement. The CMO guides these activities in collaboration with the Director of Compliance with the oversight of the QIC. Performance results are analyzed and reviewed with opportunities for improvement identified for intervention and performance management.

1. Quality Improvement UM Program activities:

a. HEDIS measurement and reporting
b. Under and Over Utilization monitoring as exampled by:
    1. Readmission rates
    2. Access to preventive health services
    3. Bed days
    4. Length of Stay
c. Appeal, denial, deferral, modification and grievance monitoring
d. Provider profile measurement
e. Potential quality issue referrals
f. Quality Improvement Work Plan indicators
g. Quality improvement projects
h. Inter-rater reliability assessments
i. Focused ad hoc analyses
j. Regulatory compliance
k. Delegation oversight
l. Member and provider satisfaction with the UM process
m. Member and provider education
n. Member notifications for denial reason
o. UM Turn-around-times

p. Nurse Advice Line utilization and trends
q. Monitoring of groups with shared savings/capitation agreements
    1. SCFHP monitors groups with CAP agreements for under-utilization so that members receive optimal care regardless of risk agreement with provider group or plans.

2. UM Data Sources

Sources are used for quality monitoring and improvement activities, including those both directly administered by SCFHP and their delegates

a. Claims and encounter data
b. Medical records
c. Medical utilization data
d. Behavioral Health utilization data
e. Pharmacy utilization data
f. Appeal, denial, and grievance information
g. Internally developed data and reports
h. Audit findings
i. Other clinical or administrative data

Actual unit cost and utilization rates by treatment type category are compared to budgeted and benchmark figures. If any significant over or underutilization trend is noted, additional, more detailed reports are reviewed. Reports are structured so that they are available on a patient specific, provider or group specific, service specific, or diagnosis specific basis. Data can be reported in summary or at an individual claim level of detail. The utilization reporting system allows for focused problem identification and resolution.

SCFHP's Pharmacy Benefit Coordinator routinely monitors and analyzes pharmacy use in each product line to detect potential underutilization and overutilization. Pharmacy utilization is also monitored by individual physicians and across practice and provider sites. Appropriate clinical interventions and/or other strategies are implemented when required and monitored for effectiveness.

3. Utilization Management Performance Monitoring

a. Areas to monitor

The Director of Health Services monitors the consistency of the UM staff in handling approval, denial and inpatient decisions. Turnaround time of UM decisions, including verbal and written notification is also monitored. CMO and Medical Director decisions are periodically reviewed by a physician for consistency of medical appropriateness determinations. Telephone service, as related to the percentage of calls that go into the hold queue, abandonment rate and average speed of answer is tracked. Additional monitoring of the Utilization Management Program is performed through comments from the Member Satisfaction Survey, the Physician and Office Manager Satisfaction Survey, Case Management Member Satisfaction Survey, and the quarterly appeals reports Product-line specific, high level, summary cost and utilization data is reviewed and analyzed monthly but not limited to the following areas:

1. Discharges/1,000
2. Percentage of members receiving any mental health service
3. Hospital outpatient services/1,000
4. ED visits/1,000 (not resulting in admission)
5. Primary Care visits/1,000
6. Specialty Care visits/1,000
7. Prescription Drug services
8. Denials
9. Deferrals
10. Modifications
11. Appeals

Actual unit cost and utilization rates by treatment type category are compared to budgeted and benchmark figures. If any significant over or underutilization trend is noted, additional, more detailed reports are reviewed. Reports are structured so that they are available on a patient specific, provider or group specific, service specific, or diagnosis specific basis. Data can be reported in summary or at an individual claim level of detail. The utilization reporting system allows for focused problem identification and resolution.

The Plan's Pharmacy Benefit Manager routinely monitors and analyzes pharmacy use in each product line to detect potential underutilization and overutilization. Pharmacy utilization is also monitored by individual physicians and across practice and provider sites. Appropriate clinical interventions and/or other strategies are implemented when required and monitored for effectiveness.

b. Access to UM Staff

Utilization and Case Management staff is available Monday through Friday (excluding holidays) from 8:30 a.m. to 5:00 p.m. to answer questions regarding UM decisions, authorization of care and the UM program. The Department has both local and toll-free telephone and telefax numbers and offers TDD/TTY services for deaf, hard of hearing or speech impaired members. Language assistance/interpretation is also available for members free of charge to discuss UM issues. Telephone lines are staffed with professionals who have access to most information/resources needed to provide a timely response. Callers have the option of leaving a voice mail message either during or after business hours. These calls are returned promptly the same or next business day. Staff is also a resource for other Plan Departments for UM and Case Management questions.

G. Appeal Procedures

The SCFHP maintains procedures by which a member, authorized representative and provider can appeal a UM organization determination that results in a denial, termination, or limitation of a covered service. The UM Program procedure for appeals includes provisions for timely and appropriate

notification of pre-service, post-service and expedited appeals along with an option for external level review. Appeals are administered in accordance with SCFHP policies and procedures, and regulatory standards.

Detailed information about SCFHP appeal policies and procedures are in the following documents:

- HS.01 - Prior Authorization Process
- MED-UM-0037 – HS.01.XX
- MED-CGR-0001 through MED-CGR-0011 - Member Grievance and Appeals

H. Delegation of Utilization Management Activities

When SCFHP delegates Utilization Management decisions or other UM related activities, the contractual agreements between the SCFHP and this delegated group specify the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities to the SCFHP, how performance is evaluated; and corrective action plan expectations, if applicable. The SCFHP conducts a pre-contractual evaluation of delegated functions to assure capacity to meet standards and requirements. The SCFHP's Delegation Oversight Manager is responsible for the oversight of delegated activities. Delegate work plans, reports, and evaluations are reviewed by the SCFHP and the findings are summarized at QIC meetings, as appropriate. The Delegated Oversight Manager monitors all delegated functions of each of our delegates through reports and regular oversight audits. The QIC annually reviews and approves all delegate UM programs. Depending on the delegated functions the audit may include aspects of the following areas: utilization management, credentialing, grievance and appeals, quality improvement and claims.

As part of delegation responsibilities, delegated providers must:

- Develop, enact, and monitor a UM Program description that addresses all State, Federal, health plan and accreditation requirements.
- Provide encounter information and access to medical and behavioral health records pertaining to SCFHP members.
- Provide a representative to the QIC.
- Submit quarterly reports, annual evaluations, and work plans.
- Cooperate with annual audits and complete any corrective action judged necessary by the SCFHP.

SCFHP does not delegate the management of complaints, grievances and appeals. SCFHP conducts a pre-delegation review to measure resources of the potential delegate

Section III. Program Scope, Processes & Information Sources

The UM Program consists of comprehensive and systematic functions, services, and processes that provide care management to members, and include medical necessity determinations regarding the appropriateness of health care services in accordance with definitions contained in the member certificate of coverage. The UM Program also encompasses delegated utilization management functions, activities, and processes for behavioral health and pharmacy services.

A. Clinical Review Criteria

The Utilization Management Program is conducted under the administrative and clinical direction of the Chief Medical Officer and UM Committee. Therefore, it is SCFHP's policy that all medical appropriateness and necessity criteria are developed, and approved by the physician entities prior to implementation. Part of this review process may also include input from appropriate participating subspecialists. As part of the review of the Utilization Management Program, all criteria are reviewed and updated as needed, but no less than annually. Providers are advised annually that criteria are available upon request. Internally developed criteria and a general list of services that require prior authorization are also available on SCFHP's web site. MCG® criteria are available to providers through request with the UM Department. The individual needs of the member and the resources available within the local delivery system are considered when applying Utilization Management criteria.

1. Adoption of criteria

When adopting Medical Necessity Criteria, SCFHP (with direct oversight by the Chief Medical Officer) will:

a. Have written UM decision-making criteria that are objective and based on medical evidence
b. Have written policies for applying the criteria based on individual needs
c. Have written policies for applying the criteria based on an assessment of the local delivery system
d. Involve appropriate practitioners in developing, adopting and reviewing criteria
e. Annually review the UM criteria and the procedures for applying them, and updates the criteria when appropriate

2. **Hierarchy of criteria**

Utilization review determinations are derived from a consistently applied, systematic evaluation of utilization management decision criteria. The criteria are selected based on nationally recognized and evidence-based standards of practice for medical services and are applied on an individual needs basis. Primary criteria used for utilization review decisions are from Local Coverage Determinations (LCD); Noridian and National Coverage Determinations (NCD);MCG. A hierarchy of criteria for UM decision is used (listed below).

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UM Criteria	Medi-Cal/Healthy Kids	CMC Medicare
Outpatient (all)	A. Title 22, Medi-Cal FFS for review of the code for	A. Noridian Medicare Portal

UM Criteria	Medi-Cal/Healthy Kids	CMC Medicare
	coverage determination and guidelines (when available) B. MCG Guidelines (Milliman) C. SCFHP UM approved policies D. Consensus statements and nationally recognized standards of practice (if no other guidelines available)	B. Local Coverage Determinations (Medicare Coverage Data Base, 2016) C. National Coverage Determinations D. MCG Guidelines (Milliman) E. Consensus statements and nationally recognized standards of practice (if no other guidelines available)
Inpatient	A. Title 22, Medi-Cal FFS for review of the code for coverage determination and guidelines (when available) B. MCG Guidelines (Milliman)	A. Local Coverage Determinations B. National Coverage Determinations C. MCG Guidelines (Milliman)
California Home Medical Equipment (DME Vendor)	A. Title 22, Medi-Cal FFS for review of the code for coverage determination and guidelines (when available) B. MCG Guidelines (Milliman) C. Nationally recognized standards of practice (if no other guidelines available)	A. Local Coverage Determinations B. National Coverage Determinations C. MCG Guidelines (Milliman) D. Consensus statements and nationally recognized standards of practice (if no other guidelines available)

UM Criteria	Medi-Cal/Healthy Kids	CMC Medicare
Medications	A. Title 22, Medi-Cal FFS for review of the code for coverage determination and guidelines (when available) B. MCG Guidelines (Milliman) C. Nationally recognized standards of practice (if no other guidelines available)	A. Local Coverage Determinations B. National Coverage Determinations C. Micromedex D. Consensus statements and nationally recognized standards of practice (if no other guidelines available)
Investigative or Experimental Devices or Technology **Investigative or Experimental Medication**	A. Title 22, Medi-Cal FFS for review of the code for coverage determination and guidelines (when available) B. MCG Guidelines (Milliman) C. Nationally recognized standards of practice (if no other guidelines available)	A. Up to Date B. Appointed special work group composed of the Medical Director and Board Certified specialists specific to the need of the request C. Reviewed through the P&T Committee or appointed special work group to assess

Other applicable publicly available clinical guidelines from recognized medical authorities are referenced, when indicated. Also when applicable, government manuals, statutes, and laws are referenced in the medical necessity decision making process. The QIC annually reviews the Care Guidelines and criteria and applicable government and clinical guidelines for changes and updates.

Additionally, the SCFHP has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in benefit plans in order to keep pace with changes and to ensure that members have equitable access to safe and effective care.

B. Medical Necessity

The Utilization Management Program is conducted under the administrative and clinical direction of the Chief Medical Officer and the Utilization Management Committee.
Therefore, it is the policy of SCFHP that all medical appropriateness/necessity criteria are developed, reviewed and approved by the physician entities prior to implementation.

Part of this review process may also include input from appropriate participating subspecialists. As part of the review of the Utilization Management Program, all criteria are reviewed and updated as needed, but no less than annually. Providers are advised annually that criteria are available upon request.

Internally developed criteria and a general list of services that require prior authorization are also available on the web site for SCFHP.

Specific MCG criteria are available to providers by contacting the UM Department or the physician reviewer. The individual needs of the member and the resources available within the local delivery system are considered when applying Utilization Management criteria.

Members may request a copy of the medical necessity criteria. When the disclosure of UM criteria is made to the public, the disclosure will be accompanied by the following notice:

> "The materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

The Medicare Model Explanation of Coverage (EOC) defines medically necessary services or supplies as those that are:" 1) Proper and needed for the diagnosis or treatment of your medical condition; 2) Used for the diagnosis, direct care, and treatment of your medical condition; 3) Not mainly for your convenience or that of your doctor; and those that 4) Meet the standards of good medical practice in the local community."

1. Medical Necessity Determinations

Medical necessity determinations are made based on information gathered from many sources. Each case is different. However, these sources may include some or all of the following:

a) Primary Care Physician
b) Specialist physician
c) Hospital Utilization Review Department
d) Patient chart
e) Home health care agency
f) Skilled nursing facility
g) Physical, occupational or speech therapist
h) Behavioral health/chemical dependency provider
i) Patient or responsible family member

The information needed will often include the following:

a) Patient name, ID#, age, gender
b) Brief medical history
c) Diagnosis, co morbidities, complications
d) Signs and symptoms
e) Progress of current treatment, including results of pertinent testing
f) Providers involved with care
g) Proposed services
h) Referring physician's expectations
i) Psychosocial factors, home environment

The Utilization Review Nurses will use this information, along with good nursing judgment, departmental policies and procedures, needs of the individual member and characteristics of the local delivery system, including the availability of the proposed services within the network service area, or case conference discussions with a SCFHP Medical Director, to make a decision.

Deleted: The Utilization Management Coordinator has the authority to approve services based on medical necessity.

If the decision is outside the scope of the Utilization Review Nurse's authority, the case is referred to the Medical Director for a determination. The Medical Director or Pharmacists or designated behavioral health practitioner as appropriate, are the only Plan representatives with the authority to deny payment for services based on medical necessity/appropriateness. Psychiatrists, doctoral-level clinical psychologists, or certified addiction medicine specialists have the authority to deny payment for behavioral health care services based on medical necessity and appropriateness. Alternatives for denied care or services are given to the requesting provider and member and are based on the criteria set used or individual case circumstances. In making determinations based on contract benefit exclusions or limitations, the Member Handbook and Group Services Agreement are used as references.

2. Inter-Rater Reliability

The Referral Management Manager monitors the consistency of the UM/CM staff in handling approval, denial and inpatient decisions. The Inter-Rater Reliability (IRR) testing process evaluates consistent application amongst the Utilization Management (UM) team, including all staff who apply medical necessity criteria, including medical directors, registered and licensed nursing staff, pharmacists, pharmacy technicians, non-clinical staff.

All staff is assessed through the established IRR process at least annually. All new hires are reviewed monthly for the first 90 days and then again at the six-month period and then annually.

C. Timeliness of UM Decisions

SCFHP maintains a policy and procedure (P&P) meeting state and federal regulations/guidelines for meeting timeliness standards of UM decisions and notification. The P&P is reviewed/revised at least annually. Staff is monitored and evaluated on meeting timeliness standards.

D. Clinical Information

When determining coverage based on medical necessity, SCFHP obtains relevant clinical information and consults with the treating practitioner where necessary. The reviewing medical director shall document any consults conducted and will acknowledge the clinical information considered when making a decision to deny, delay or modify a request for service or care.

E. Transplants

It is SCFHP's policy that all requests for organ transplants be reviewed by the Medical Director and Case Manager and the members are directed to the most appropriate Center of Excellence transplant facility for evaluation based on benefits. The Case Manager coordinates with the facility transplant coordinator to send the transplant recommendation to SCFHP, as appropriate, prior to approval by the Plan. Renal and corneal transplants are excluded from SCFHP review. The Plan's determination of medical necessity will be based on the Transplant Team determination, thus providing an outside, impartial, expert evaluation. Once the member has been approved, the member is enrolled in the United Network for Organ Sharing (UNOS). The patient's acceptance into UNOS serves as the Plan's medical necessity determination. All members that are approved for transplant are followed closely by Case Management as well as Paramount's interdepartmental transplant team, consisting of Medical Directors, Case Managers and Financial, Claims and Actuarial representatives. The purpose of the team is to ensure ongoing medical necessity for transplant, employer group high dollar alert (if self-insured), and reinsurance notification and to ensure appropriate claims payment.

F. New Technology Assessment

SCFHP investigates all requests for new technology or a new application of existing technology using the HAYES Medical Technology Directory® as a guideline to determine whether the new technology is investigational in nature. If further information is needed, the Plan utilizes additional sources, including Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This includes medical and behavioral health procedures and devices. Pharmaceuticals are investigated by the Pharmacy and Therapeutics Working Group. If the new technology, pharmaceutical or new application of an existing technology or pharmaceutical is addressed in the above documents, the information is taken into consideration by the Medical Director at the time of benefit determination. If the new technology, pharmaceutical or new application of an established technology/pharmaceutical is not addressed in the above documents, the Medical Director will confer with an appropriate board certified specialist consultant for additional information. This information will be presented to the Technology Assessment or Pharmacy and Therapeutics Committee, subcommittees of the Medical Advisory Council, to provide a recommendation to the physician Council regarding coverage. The decision will be based on safety, efficacy, cost and availability of information in published literature regarding controlled clinical trials. If a decision cannot be made, a committee of specialists may be convened to review the new medical technology/pharmaceutical and make a recommendation to the Medical Advisory Council.

G. Emergency Services/Post Stabilization Care

No referrals are required for treatment of an emergency medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman, or her unborn child, in serious jeopardy
b. Serious impairment to bodily functions
c. Serious dysfunction of any bodily organ or part.

Emergency Room services are also covered if referred by an authorized Plan representative, PCP or Plan specialist. Plan notification (referral) is not required for payment of Emergency Room services for an emergency medical condition.

SCFHP properly arranges for the transfer of members after the member has been stabilized subsequent to an emergency psychiatric or medical condition but the provider believes further medically necessary health care treatment is required and the member cannot be safely discharged.

SCFHP does not require prior authorization for post-stabilization care

- The Plan shall fully document all requests for authorizations and responses to such requests for post stabilization medically necessary care which shall include the date and time of receipt, the name of the health care practitioner making the request and the name of the SCFHP representative responding to the request. All non-contracting hospitals are able to locate a contact number at which the hospital can obtain authorization from the SCFHP by the information on the back of the member's identification card or by the website of the Plan
- SCFHP has mechanisms in place to support that a patient is not transferred to a contracting facility unless the provider determines no material deterioration of the patient is likely to occur upon transfer

H. Determination Information Sources

UM personnel collect relevant clinical information from health care providers to make prospective, concurrent and retrospective utilization review for medical necessity and health plan benefit coverage determinations. Clinical information is provided to the appropriate clinical reviewers to support the determination review process. Examples of relevant sources of patient clinical data and information used by clinical reviewers to make medical necessity and health plan benefit coverage determinations include the following:

1. History and physical examinations
2. Clinical examinations
3. Treatment plans and progress notes
4. Diagnostic and laboratory testing results
5. Consultations and evaluations from other practitioners or providers
6. Office and hospital records

7. Physical therapy notes
8. Telephonic and fax reviews from inpatient facilities
9. Information regarding benefits for services or procedures
10. Information regarding the local delivery system
11. Patient characteristics and information
12. Information from responsible family members

I. Health Services

The scope of health services and activities includes utilization review determinations, referral management, discharge planning, complex case management, and UM documents.

1. Utilization Determinations

Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria. Qualified health care professionals supervise utilization review decisions of assigned UM staff and participate or lead UM staff training. These professionals also monitors all UM staff for consistent application of UM criteria for each level and type of UM decision, monitors all documentation for adequacy and is available to UM staff on site or by telephone. Under the supervision of a licensed medical professional, non-clinical staff collects administrative data or structured clinical data to administratively authorize cases that do not require clinical review.

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Only a Medical Director, with a current California license to practice without restriction, makes medical necessity denial determinations. A Medical Director is available to discuss UM denial determinations with providers, and providers are notified about determination processes in the denial letter.

When applying medical necessity criteria, SCFHP shall

a. Consider individual needs of members
    i. Age
    ii. Comorbidities
    iii. Complications
    iv. Progress of treatment
    v. Psychosocial situation
    vi. Home environment, as applicable
b. Assessment of the local delivery system
    i. Availability of inpatient outpatient and transitional facilities
    ii. Availability of outpatient services in lieu of inpatient services such as surgi-centers vs. inpatient surgery
    iii. Availability of highly specialized services, such as transplant facilities or cancer centers
    iv. Availability of skilled nursing facilities, sub acute care facilities or home care in the organization's service area to support the patient after hospital discharge
    v. Local hospitals' ability to provide all recommended services within the estimated length of stay

In accordance with the DHCS contract only qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made on the basis of medical necessity. Additionally, a qualified physician or pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan medical director, in collaboration with the Plan Pharmacy and Therapeutics Committee (PTC) or generally accepted medical compendia and professional practice guidelines.

UM decisions are not based on the outcome of individual authorization decisions or the number and type of non-authorization decisions rendered. UM staff involved in clinical and health plan benefit coverage determination process are compensated solely based on overall performance and contracted salary, and are not financially incentivized by the SCFHP based on the outcome of clinical determination.

Board certified physician advisors are available to the UM Program for consultation on clinical issues as well as consultation for potential denials. The UM Program maintains a list of board-certified physician specialists identified for consultation and documents their involvement in member authorization and appeal records when appropriate.

For each non-medical necessity denial, the UM Department documents within it's UM system the reason for and the specific benefit provision, administrative procedure or regulatory limitation used to classify the denial. The UM staff references the sources (e.g. Certificate of Coverage or Summary of Benefits) of the administrative denial. The Plan includes this information in the denial notice sent to the member or the member's authorized representative

Decisions affecting care are communicated in writing to the provider and member in a timely manner in accordance with regulatory guidelines for timeliness. Notification communication includes appeal rights and procedures. Member notifications comply with appropriate contractual and regulatory guidance for each member's line of business. Member correspondence about authorization decisions includes a statement in each SCFHP threshold language instructing the member how to obtain correspondence in their preferred language.

The UM Program appeals and reconsideration policies and procedures assure members and providers that the same staff involved in the initial denial determination will not be involved in the review of the appeal or reconsideration. Additionally, there is separation of medical decisions from fiscal and administrative management to assure medical decisions will not be unduly influenced by fiscal and administrative management.

The UM Program includes the following utilization review processes:

a) Prospective Review

Prospective (pre-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted prior to the delivery of a health care service or supply to a member. A prospective review decision is based on the collection of medical information available to the health care provider prior to the time the service or supply is provided.

b) Concurrent Review

Concurrent review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted during a member's ongoing stay in a facility or course of outpatient treatment. The frequency of review is based on the member's medical condition with respect to applicable care guidelines.

c) Retrospective Review

Retrospective (post-service) review is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted after the health care service or supply is provided to a member. A retrospective review decision is based on the medical information available to the health care provider at the time the service or supply was provided.

d) Standing Referrals

SCFHP has established and implemented a procedure by which a member may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, and the plan medical director or his or her designee, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or independent practice association. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the member.

e) Terminal Illness

In the circumstance occur where SCFHP denies coverage to member with a terminal illness, which refers to an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider, SCFHP shall provide to the member within five business days all of the following information:

1. A statement setting forth the specific medical and scientific reasons for denying coverage
2. A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine
3. Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the member to request a conference as part of the plan's grievance system

f) Communications

Decisions to approve, modify, or deny requests by practitioners for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting practitioner verbally as appropriate and in writing. See pages 17 through 21 for notification timelines.

In the case of concurrent review, care shall not be discontinued until the member's treating practitioner has been notified of SCFHP's decision and a care Plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

Communications regarding decisions to approve requests by practitioners prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to practitioners initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for SCFHP's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider to contact the professional responsible for the denial, delay, or modification with ease. Responses shall also include information as to how the member may file a grievance with the Plan.

Communication to members for denial, delay, or modification of all or part of the requested service shall include the following:

a) Be written in a language that is easily understandable by a layperson
b) Specify the specific health care service requested
c) Provide a clear and concise explanation of the reasons for the Plan's decision to deny, delay, or modify health care services. Reason shall be written in layperson terms, easily understandable by the member
d) Specify a description of the criteria or guidelines used for the Plan's decision to deny, delay, or modify health care services
e) Specify the clinical reasons for the Plan's decision to deny, delay, or modify health care services
f) Include information as to how he / she may file a grievance to the Plan
g) Include information as to how he / she may request an independent medical review

g) Referral Management

1. In-network

SCFHP network physicians are the primary care managers for member healthcare services. The network primary care physicians provide network specialist and facility referrals directly to

members without administrative pre-authorization from the UM Program, and primary care physicians may coordinate prior authorization for utilization review on a number of services such as DME, home health, and nutritional supplements. These referrals are primarily for routine outpatient and diagnostic services and are tracked by the UM Program from claims and encounter data. All elective inpatient surgeries and non-contracted provider referrals require prior authorization. The UM Program care management system tracks all authorized, denied, deferred, and modified service requests and include timeliness records. These processes are outlined in the Provider Manual and in internal policies and procedures.

2. Emergency Services

No referrals or prior authorization requests are required for treatment of an emergency medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

i. Placing the health of the individual or, with respect to a
ii. pregnant woman, the health of the woman, or her unborn child,
iii. in serious jeopardy
iv. Serious impairment to bodily functions
v. Serious dysfunction of any bodily organ or part

Emergency Room services are also covered if referred by an authorized Plan representative, PCP or Plan specialist. Plan notification (referral) is not required for payment of Emergency Room services for an emergency medical condition.

3. Out of Network

Requests for out-of-network Referrals are reviewed individually and determinations are made based on the patient's medical needs and the availability of services within the Provider Network to meet these needs. A physician reviewer shall assess any requests for out of network referrals.

4. Specialist Referrals

The Primary Care Physician (PCP) may request a consultation from a participating specialist physician at any time. No referral is required from SCFHP prior to consultation with any participating specialists.

5. Tertiary Care Services

All referrals to Plan tertiary care centers are reviewed on an individual basis. The member's medical needs and the availability of the requested services within the non-tertiary care network are taken into consideration.

6. Second Opinions

A request for a second opinion may be initiated by a member or a treating healthcare provider of a member, and at no charge to the member. The processing of a request for a second opinion

will be treated with the same criteria for turn-around-time as other UM referral requests. If a second opinion is not available within the Member's network, an out-of-network opinion will be arranged, at no cost other than normal co-payments, to the member. The member Evidence of Coverage provides all members with notice of the policy regarding the manner in which a member may receive a second medical opinion. The second opinion policy is reviewed, revised and approved annually.

7. Predetermination of Benefits/Outpatient Certification

Certain procedures, durable medical equipment and injectable medications are prior authorized. SCFHP uses MCG criteria for Imaging, Procedures and Molecular Diagnostics. When MCG criteria does not exist within SCFHP's purchased products, criteria are developed internally by the Technology Assessment Work Group or Pharmacy and Therapeutics Committee as appropriate. Additionally, potentially cosmetic surgery and other procedures may be reviewed prospectively, at the request of providers and members, to issue coverage determinations.

8. Authorization Tracking

SCFHP tracks a defined sub-set of out-patient authorizations for completion of the authorization to claims paid cycle. This allows for monitoring of possible barriers leading to member non-compliance with prescribed care. In addition, the plan tracks authorizations while in process for timeliness and compliance with regulations and guidelines.

h) Discharge Planning

Discharge planning is a component of the UM process that assesses necessary services and resources available to facilitate member discharge to the appropriate level of care. UM nurses work with facility discharge planners, attending physicians and ancillary service providers to assist in making necessary arrangements for member post-discharge needs. Behavioral health case managers will work with psychiatric hospital facilities to facilitate member discharge to the most appropriate level of care and community case management.

i) Intensive Case Management

In accordance with the DHCS contract, primary care physicians provide basic case management services. The SCFHP provides case management for a select number of the Cal MediConnect population and works with a vendor for the majority of the CMC cases. Care is coordinated

between the SCFHP and the vendor to ensure collaboration of the multi-disciplinary care team and effective member management. Complex and Intensive case management services assist members to close gaps in care, establish action plans, set clinical condition treatment progress goals, improve medication adherence, and reduce the risk of hospitalization. Complex and case management services also involve opportunities to match the content of medical management to the changing risk levels and needs of individual members.

j) UM Documents

In addition to this program description other additional documents important in communicating UM policies and procedures include:

1. The Provider Manual provides an overview of operational aspects of the relationship between the SCFHP, providers, and members. Information about the SCFHP's UM Program is included in the provider manual. In addition the Provider Manual describes how providers may obtain a copy of the clinical guidelines used to make medical determinations.
2. The Provider Manual and the web site also provide information about services/procedures requiring pre-authorization. Changes and updates are communicated to providers via faxed communications, newsletters, bulletins and the website.
3. Provider Bulletin is a monthly newsletter distributed to all contracted provider sites on topics relevant to the provider community and can include UM policies, procedures, and activities.
4. Evidence of Coverage (EOC) documents are distributed to members based on their product line. Members have the right to submit a complaint or grievance about any plan action, and the Evidence of Coverage document directs members to call the Customer Service phone number to initiate complaints or grievances involving UM issues and actions. Member complaints or grievances are documented in the data system and forwarded to the UM unit for follow-up response. The SCFHP Grievance and Appeal unit coordinates with the UM unit on appropriate responses to member complaints or grievances.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the UM Program information is available on the SCFHP website.

J. Behavioral Health Management

SCFHP provides access to all standard Medicaid based fee-for service benefits, including applicable Behavioral Health services. Behavioral Health utilization management practices are in compliance with parity requirements of Medicaid managed care rules and the Affordable Care Act

SCFHP members receive comprehensive behavioral health and substance abuse services according to their specific benefit package. SCFHP Medi-Cal members obtain mental health and substance use

disorder services primarily through the Santa Clara County Behavioral Health Department (CBHD). The Severely Mentally Ill (SMI) population will be referred through the County Call Center to County Mental Health Clinics, Federally Qualified Healthcare Clinics or Community-Based Organizations. The CBHD will be responsible for payment of services to those who are determined by the CBHD to be SMI. The non-SMI diagnoses will be considered Mild to Moderate and referrals will also be through the County Call Center to the FQHC clinics. Santa Clara Family Health Plan will be responsible for payment for those services.

Cal Medi-Connect (CMC) members will be treated the same as Medi-Cal members and referred through the County Call Center. The difference in terms of payment for CMC members is that the professional services for psychiatry, psychology and Licensed Clinical Social Work services are to be billed to SCFHP under the member's Medicare benefit. The Mild to Moderately diagnosed members will also be referred through the County Call Center and SCFHP is responsible for payment. Members may contact their County Call Center, or receive physician referral within the member's medical home. SCFHP maintains procedures for primary care providers to coordinate care and services for members in need of behavioral health services including, but not limited to, all medical necessary services across the behavioral health provider network.

1. **Behavioral Health Integration**

   The SCFHP uses a variety of mechanisms that ensure behavioral health services and management processes are actively integrated into the UM Program and include

   a) A behavioral healthcare practitioner is involved in quarterly HCQC meetings to support, advise and coordinate behavioral healthcare aspects into UM Program policies, procedures and processes.
   b) A behavioral healthcare practitioner participates as a member of the UM interdisciplinary care team. The UM interdisciplinary care team consists of a Medical Director, Registered Nurse, Pharmacist and Behavioral Healthcare practitioner. The team meets routinely to perform member case reviews. The interdisciplinary care team evaluates topics such as access, availability, health management systems, practice guidelines, clinical and service quality improvement activities, member satisfaction, continuity and coordination of care, and member's rights and responsibilities.
   c) The SCFHP routinely receives clinical reports from Santa Clara County Behavioral Health Department, which are reviewed by the Manager of Behavioral Health Department.
   d) SCFHP participates in quarterly operational meetings with the CBHD to review and coordinate administrative, clinical and operational activities.

2. **Santa Clara County Behavioral Health Care Services**

   a) Specialty behavioral health services for Medi-Cal members, excluded from the SCFHP contract with DHCS, are coordinated under a Memorandum of Understanding executed with SCFHP. This is a carve-out arrangement for behavioral health management with the State of California directly overseeing and reimbursing the behavioral health services provided to Medi-Cal members.

3. The referral procedure for SCFHP members includes

a) SCFHP Primary Care Providers (PCPs) render outpatient behavioral health services within their scope of practice.
b) PCPs refer the members to Santa Clara County Behavioral Health Department for evaluation and coordination of medically necessary specialty behavioral health services by the Access Team, including inpatient psychiatric care.
c) PCPs refer members to qualified Medi-Cal providers for the provision of services not covered by CBHD.
d) Members may contact the County Call Center to be referred to providers of Mild to Moderate services under Medi-Cal or Healthy Kids coverage

K. Pharmacy Management

1. Scope

a) SCFHP delegates pharmacy utilization management activities in the Cal MediConnect line of business to the pharmacy benefit management company MedImpact. MedImpact possesses a UM program that manages pharmacy services under the delegated arrangement. Overall UM Program oversight is performed by the Chief Medical Officer or designee with supporting policies and procedures reviewed and approved by the Quality Improvement Committee. The Chief Medical Officer and the Director of Pharmacy (a licensed pharmacist) are responsible for operational and clinical management of the pharmacy UM program. The scope of the UM Program encompasses all processes performed by MedImpact. These processes include: intake and triage services, authorization guideline development, implementation of UM formulary tools and medication utilization review determinations. The Pharmacy and Therapeutics Committee provides oversight for evidence-based, clinically appropriate UM guideline criteria. Guidelines are developed in conjunction with review of peer-reviewed literature with consideration for such factors as safety, efficacy and cost effectiveness, and also with the input evaluation of external clinical specialists appropriate to the subject matter. An annual review process and ad hoc assessments support the development of guidelines that are current with the latest advancements in pharmaceutical therapy. The UM Program is evaluated annually and submitted to the Utilization Management Oversight Committee for approval. This evaluation includes, but is not limited to: medication UM activities, UM structure and resources, measures to assess the quality of clinical decisions, overall effectiveness of the UM Program and opportunities for UM Program improvement.

b) Pharmacy Benefit Manager

MedImpact staff, who are delegated to perform pharmacy utilization management services and activities, involve both clinical and administrative personnel. The PBM Staff roles and responsibilities include, but are not limited to:

i. Medical Directors are licensed physicians with oversight of the UM Program, and also provide consultation services.
ii. Clinical Pharmacist Reviewers are licensed pharmacists with responsibility to perform utilization management services.
iii. Prior Authorization Clerks perform administrative functions such as data entry and generating reports.
iv. Prior Authorization Coordinators review medication requests based on MedImpact criteria as approved by SCFHP.
v. Prior Authorization Customer Service Representatives perform intake functions and triage customer inquiries.
vi. Research Coordinators contact provider offices to request additional information to compete a prior authorization request.

L. Long Term Support Services

SCFHP has established and implemented guidelines for Long Term Services and supports authorizations for services in this area. The LTSS Case Manager coordinates with the UM Department, community resources, and health plan partners to identify care needs and ensure access to appropriate services to achieve positive health outcomes.

M. Confidentiality

SCFHP has written policies and procedures to protect a member's personal health information (PHI). The Health Services Department collects only the information necessary to conduct case management services or certify the admission, procedure or treatment, length of stay, frequency and duration of health care services. We are required by law to protect the privacy of the member's health information. Before any PHI is disclosed, we must have a member's written authorization on file. Within the realm of utilization review and case management, access to a member's health information is restricted to those employees that need to know that information to provide these functions. A full description of SCFHP's Notice of Privacy Practices may be found on our website at: www.scfhp.com.

N. Annual Evaluation

The Health Services Department is responsible for developing an annual evaluation of the Utilization Management Program to identify strengths and areas for improvement. The written evaluation compares auditing results, utilization reports, quality indicators, survey results, and initiatives and priorities from previous years. Additionally, the Director of Health Services will have processes in place to trigger quarterly reports used for evaluating the efficiency and effectiveness of the Utilization Management Plan throughout the year.

In coordination and collaboration with the UM Medical Director, the Director of Quality Improvement, the UM and QI Committees and the Chief Medical Officer, and Quality Management Committee, the Case Management Department implements identified opportunities for improvement that foster and promote positive change in the case management of SCFHP members. The Director of Case Management is responsible for submitting the department's annual Case Management Plan with incorporated strategies for improvement.

O. Interdepartmental collaboration

SCFHP departments collaborates to prevent conflicting information and to align member self-management tools, member education and information provided to the member.