Santa Clara Family Health Plan
Provider Advisory Council
August 21, 2013
Boardroom

PAC Attendees: Thad Padua, MD, Peter L. Nguyen, DO, Kenneth Phan, MD, Sheri Sager, and Michelle Hugin, MD

Delegated Groups: None

SCFHP Attendees: Matthew Woodruff, Jimmy Lin, MD, Beth Paige, Dr. Jeff Robertson, Vivian Than, Stacy Renteria, Abby Baldovinos, Diane Brown, Scot Bolin, and Vanessa Lagemann

ITEM	DISCUSSION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Meeting Called To Order	Matthew Woodruff, COO acting as Chairperson called meeting to order at 12:25. Dr. Padua will be late to the meeting.	None		
Public Comment	No Public Comment	None		
Review of Minutes	Minutes reviewed and approved	None		
CEO Report	Change in Structure of Health Plan Matt announced Mike Lipman's departure from the Health Plan and the process to have the position in Provider Services filled by the end of September. Until then Matt is heading the Provider Services Department. Primary Care Physician Rate Increase The State had another call on the PCP Rate Increase and how that's going to work and the State is targeting implementation for late fall. Originally the State would postpone the deadline off month to month. Now late fall is the target date. By law they have to have it implemented before December 31st and the rate increase is retroactive to the beginning of this year. All the IPAs and Knox-Keene licensed	None None		

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	Health Plans, such as us, have to attest to the fact that we have passed the extra money we received directly to the physicians. The interesting point that they are still working on and apparently is holding everything up is the employee physicians and there are still questions on the actuary equivalency system for IPA's under capitated arrangements. They have agreed on some but not on all. Committee discussed specialties and the fact this rate increase does not include all specialties. There are only 6 or 7 specialties are included. Essentially when the state comes out with their methodology, if you are a PCP and getting paid capitation, on average you receive X amount of dollars and your capitation is either less or more than this rate increase. If a provider's capitation is less than this rate increase then yes the provider will get a rate increase. If the provider's capitation is more than the State's rate increase then the State does not need give the increase to the provider. Again this rate increase is retroactive the beginning of this year. This rate increase will be for two years. The Committee discussed the Board of Physicians Medical Group's recent decision around reimbursement rates, provider numbers will fluctuate around rate increases and decreases around Medi-Cal and the difficulty it is already to find a provider who will take a Medi-Cal member			

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	Duals Demonstration Update the Dual Demonstration was postponed by the State; it is now effective April 1, 2014. Members will start receiving notifications in January 2014. The Medi-Cal members with long-term support services will begin to transition over July 1st. One of the things the Health Plan has done internally is putting together Q and A information from a provider's standpoint on what they need to know around the Dual Demonstration. These distributed pages are in draft form and are not for publication. Take time to review these, Committee members are welcome to take them with the caveat, please remember these are drafts and they are not for publication. Matt asked Committee members to contact him by phone or email if they have anything to add or to consider revising. Committee discussion on providers answering questions about the process for members who want to apply. There is a list of exclusions on passive enrollment and an opt-out option of the Medicare portion. The Committee discussed the Dual Demonstration's required inter-disciplinary participation for PCP's. The Health Plan will be working with PCP's to assist in coordination of care but it is the PCP's responsibility to be part of the team. Case managers will assist with coordination of services. The Health Plan is having a meeting with providers in South County on September	None		

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	9th. From there the Health Plan will schedule more meetings with providers about the Dual Demonstration in San Jose area. The Health Plan chose South County to get an idea of the questions providers have in a smaller setting. Committee discussion on the Health Plan's role with Medi-Medi members right now and not under a Dual Demonstration program. Matt explained that right now there is no incentive for a Medi-Medi to join our plan, we don't market to them. The only incentive these members would have is care coordination under the Medical Services team in getting the services a member needs. The Health Plan has 7,300 Medi-Medi's that have joined us voluntarily. Diane Brown stated there isn't much case management because Medicare is primary and we don't have anything to do with Medicare right now. The Health Plan tries to do the best we can with one-way communication with the Medicare provider helping the member get in but as far as the Medicare provider getting back to us, that doesn't happen. Our Medical Services team just tries to help the member through this process and this is why the Health Plan is interested in the Dual Demonstration, to have the member's Medicare and Medi-Cal under us so we can make bigger strides around the member's care. Under the Dual Demonstration the goal is care coordination and enhanced benefits for members with monetary savings for government.			

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	Dr. Kenneth Phan asked about any money to the Health Plan from the State for managing the Dual Demonstration members. Yes and no, as far as the care team coordination for the members there is supposedly going to be a billable rate for that but the Health Plan does not know what the reimbursement is at this time. Yes there is a care management fee and no the Health Plan does not know what that dollar amount is. On January 1st with the Medi-Cal expansion assume 35,000 members in total - 60% to the Health Plan and 40% to Blue Cross. The Health Plan is predicting the majority of these members will be adults but we do not have a breakdown of children vs. adults. Dr. Peter Nguyen and Dr. Jimmy Lin discussed providers who illegally charge members for services. Matt responded the Health Plan is aware of a set of providers that charge members for services and report members to collection agencies. When the Health Plan threatens to report the provider to the State because it is illegal to charge a Medi-Cal member, then the provider stops charging the member for awhile then they start up again. Dr. Nguyen wants to know why the Health Plan does not terminate the provider's contract. Matt explained most of the time the provider is needed in that area for Medi-Cal members. It's a difficult decision but not ideal as the provider knows he or she can get away with it. Also some of the responsibility is with the member to file a complaint with the			

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	State and that is part of the problem too as some people are not willing to go through that process. The Bridge starts April.			
Medical Services	<u>Implementation of Lifecare Solutions</u> Dr. Jeff Robertson gave the Medical Services follow-up report on the Lifecare Solutions implementation. The Health Plan's one source capitated DME provider for a majority of our networks, excluding Kaiser and Valley Health Plan. This is a single source provider for much of the Health Plan's DME and this simplifies our process with cost containment and excellent customer service. The Health Plan has had a 90 day transition period from when the RFP bid was awarded to implementation starting September 3rd. There was a reminder memo sent out to providers, most of you got it. Once September 3rd comes there may be individual providers who may have protests about this. It doesn't cover all DME; it just covers the large volume items which are listed in the reminder memo. Sherri Sager spoke about the huge issue LPCH has on DME for pediatric patients as it delays the release of kids from the hospital because kids would be at home if the DME was provided for properly. It would save money by getting the kids out of the hospital and home with appropriate DME. Diane Brown responded Lifecare Solutions is a CCS provider	Dr. Robertson will give a follow-up report on implementation.	Dr. Robertson	October 10, 2013

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	and a lot of the pediatric patients are CCS eligible. The Health Plan does not see a lot of utilization or encounter data on these items for pediatric patients under CCS. The Health Plan does know that Lifecare Solutions is taking care of a lot of kids in Santa Clara County. Dr. Robertson stated Sherri needs specialized items and this implementation is not going to solve that problem. We will let the Committee how implementation goes after September 3rd. <u>HEDIS</u> The second item is HEDIS and Vanessa Lagemann has a Powerpoint presentation to go over the data extraction and collection. It's very important for us to maintain or improve our scores. Vanessa reviews the presentation with the Committee. Dr. Peter Nguyen's complaint of SCFHP is not letting member's self-refer to Weight Watchers even though its Health Plan policy. Health education referral form is bouncing back. Diane will look into that. Matt explained to the Committee the presentation is not an access issue, it is the Health Plan working with the provider community about documenting services. Sherri asked is it just data collection and how to document services vs. how much is it	None Diane Brown will look into self referring members to Weight Watchers	D. Brown	October 10,2013

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	a provider not providing the service? It's both. Dr. Robertson and Diane answer the numbers should stay the same with small increases but when it's a big swing up or a big swing down then it is data collection. The Blue Cross results will be at the next meeting as they will be released in September.	Blue Cross results will be disclosed	V. Lagemann	October 10, 2013
Compliance	<u>Grievance Report</u> Beth Paige reviewed the grievance reports with the Committee. The first report has the total number of grievances for the first and second quarter to give you an idea of the numbers. The next report is the grievances per 1,000 member requested by the Committee for each IPA- we de-identified the IPAs. 1 grievance per 1,000 members is the standard. The ones that are above the standard do have smaller assigned membership populations. Beth has the grievance committee is currently reviewing the assigned membership numbers for each network. The next slide is the types of grievances i.e. complaints from members, appeals - which are denials, quality of care, a quality of service grievance is "my doctor was rude to me", "my transportation vendor is picking me up late" Sherri Sager explained an issue between LPCH and Valley, members who live in north county are being referred to specialty care at Valley after getting care from LPCH for years before. Beth agreed her department has received complaints around this issue. Matt stated the Health Plan will not get into	None		

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	contract dispute. It's a continuity of care issue and disruptive to patient/provider relationship. This has to do with LPCH moving their primary care to Gardner Family Health Network. In an indirect way this does impact the Health Plan, members can choose to go to Blue Cross and not deal with LPCH or Valley.			
Provider Services	CME Topics Melinda Shaw reviewed the CME topics listed on the agenda as well as additional ones inserted in the binder tab. The Health Plan has budgeted for three CME's this year looking at October, February and May. Our last CME was just touching 100 providers. The Committee reviewed the topics. Matt would like to have another good CME year like last year when providers had input in the topics. The Health Plan can send out the topics for a vote to the Committee members. The Committee members present like US Healthcare System with Dr. Levitt and the Cost Containment CME. Matt suggested the third topic be something around Medicare with the Dual Eligible population in May.	Provider Services to send out CME topics to vote on.	Melinda	October 10, 2013
IT/Claims Issues	Mis-directed Claims Matt gave the Committee an update on the misdirected claims issue. We have set up a process that when a claim comes to us that should have gone to an IPA or another network the Health Plan is to forward the claim to the correct payor.	None		

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	Electronic Claims The electronic claims submission update. We have one provider that refused to submit claims electronically to the health plan. 278C Electronic Authorizations Good feedback with partners but with our IT team also working on the Dual Demonstration and the audit we just started up again with testing. Right now there is a 60 day lag that needs to be compliant with our 90 day claim turnaround.	None None		
	PAC Calendar Matt addressed the issue of changing the day of the week for the PAC Meetings. Expect an e-mail about what day of the week works well for you. We will need to have at least one more meeting to end this year. We will not have a meeting in September. Based on the voting the Health Plan will determine the day of the week and the subsequent calendar for 2014.	Matt to notify committee day of the week and the calendar for 2014 after all members have an opportunity to vote.	Matt	October 10,2013
Adjournment	Adjourned at 1:50 pm			

Signature:_____ **Date:**_____