



**Date:** April 8, 2021  
**Meeting Place:** Join Microsoft Teams Meeting  
 +1 323-475-1528 : Conference ID: 275 544 35#

**Meeting Time:** 7:30AM - 9:00 AM

**Members Present:** Fiona Donald, MD *Chief Medical Officer, SFHP*; Edward Evans *SFHP Member Advisory Committee Member*; Jackie Lam, MD *Medical Director and QI Director Northeast Medical Services*; Ann Valdes, MD *Chief Healthcare Officer, Healthright 360*; Lukejohn Day, MD *Chief Medical Officer, Zuckerberg San Francisco General Hospital*; Irene Conway *SFHP Member Advisory Committee Member*; Albert Yu, MD, MPH, MBA *Chief Health Information Officer, San Francisco Department of Public Health*; Claire Horton, MD *Chief Medical Officer, San Francisco Health Network*

**Staff Present:** Ravid Avraham, MD *Associate Medical Director*; Sean Dongre *Manager, Provider Relations*; Abby Ealy *Provider Credentialing Coordinator*; Yves Gibbons Sr. *Manager, Access & Care Experience*; Edward Cho *Provider Relations Specialist*; Se Chung *Health Services Administrative Specialist*; Paul Velasco Sr. *Manager, Systems Administration ITS*; Matija Cale, RN *Director, Clinical Operations*; Nicole Ylagan *Program Manager, Access & Care Experience*; Suu Htaung *Policy Analyst*, Amy Petersen Sr. *Manager, Access & Care Experience*; Lisa Ghotbi *Director, Pharmacy*

Topic		Follow-up [if Quality Issue identified, Include Corrective Action]	Resolution, or Closed Date [for Quality Issue, add plan for Tracking after Resolution]
<b>Call to Order</b>	Meeting called to order at 7:31 AM with a quorum. <ul style="list-style-type: none"> <li>Fiona Donald's first QIC meeting as SFHP CMO.</li> <li>Roll Call.</li> </ul>		

<b>Follow Up Items</b>	<p>Announcements/Plan Updates:</p> <ul style="list-style-type: none"> <li>• Medical Rx Transition: delayed until approximately summer 2021. Update from State in May 2021. Pharmacy benefit to continue to stay with SFHP. DMHC is also reviewing the acquisition under new anti-trust laws.</li> <li>• CalAIM: is the 5 -year Medical waiver that will start in 2022. Some changes to benefits structure including the inclusion of major organ transplants, implementation of new care management and targeted population health programs (ECM Enhanced Care Management).</li> </ul>	On-going.	n/a
<b>Consent Calendar</b>	All in favor to approve consent calendar.		<p>Approved:</p> <ul style="list-style-type: none"> <li>• Review of December 2020 Minutes</li> <li>• UM Committee Minutes - October 2020; November 2020; December 2020</li> <li>• Q3 2020 ED Report</li> <li>• Q4 2020 Grievances Report</li> <li>• Q4 2020 Appeals Report</li> <li>• Q4 2020 QI Scorecard Summary</li> <li>• Annual FSR Report</li> <li>• Q4 2020 PQI Report</li> </ul>
<b>Quality Improvement</b>	<p>• <b>CO-57 Criteria Update</b>  <b>Presented by Matija Cale, RN, MS</b>  Former UM Clinical Criteria Hierarchy:</p> <ol style="list-style-type: none"> <li>1. State/Federal (Medi-Cal/CMS) Criteria</li> <li>2. SFHP internally developed and approved criteria</li> <li>3. MCG Care guidelines</li> <li>4. SFHP CMO or MD consult with MRIoA for additional review</li> </ol> <p>Need for review/reason for change:</p>	None. Review.	

	<p>Medi-Cal criteria are rarely updated. MCG criteria are nationally recognized, updated frequently and used by other sister plans.</p> <p>Updated UM Clinical Criteria Hierarchy:</p> <ol style="list-style-type: none"> <li>1. SFHP internally developed and approved criteria (genital gender confirmation services, non-genital gender confirmation services, EPSDT private duty nursing)</li> <li>2. MCG Care Guidelines</li> <li>3. State/Federal (Medi-Cal/CMS) Criteria</li> <li>4. SFHP CMO or MD consult with MRIOA for additional review.</li> </ol> <p>Updated criteria has been sent to DMHC for review.</p> <p><b>• IHA (Initial Health Assessment) Restart / Telehealth Update Presented by Nicole Ylagan</b></p> <p>-Requirement of Medical contract to do an initial health assessment after 120 days of enrollment.</p> <p>-DHCS has suspended this regulation until the emergency declaration is withdrawn. But now has asked health plans to restart this regulation.</p> <p>-Process: 2 quarters behind, SFHP sends Medical groups a list of new members via secured email and Medical Groups will reach out to members who have not completed an IHA.</p> <p>Proposed schedule for IHA restart:</p> <p>04/21: Medical group receive IHA list of new members (12/1/2019-3/31-2020);</p> <p>07/2021, list for 4/1/2020-6/30/2020;</p> <p>10/2021, list for 7/1/2020-10/31/2020</p>		
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	<p>Dr. Horton: Approximately 40% are in- person. There is a lot of competing demand of in- person. Would like to assess how many enrollees took place before agreeing on schedule.</p> <p>Irene Conway: Does this need to be in person?</p> <p>Nicole Ylagan: No, telehealth is currently accepted; cannot enforce only in person visits.</p> <p>Dr. Valdes: Is this a mandated timeline?</p> <p>Nicole Ylagan: No, we are creating our own timeline.</p> <p>May be good opportunity to align with vaccine efforts and restarting IHA</p> <p>Nicole Ylagan: Action item: collect new enrollee data and revisit QIC (July/Aug/Sept may be a realistic timeframe to review).</p> <p><b>Telehealth Utilization Summary</b></p> <p>Spike in use since Q2 2020.</p> <p>Language utilized: 47% English, 34% Chinese, 12% Spanish.</p> <p>NEMS, DPH COPC and Kaiser; top 3 utilizers.</p> <p>Jade, Hill Physician and Brown &amp; Toland are bottom 3 utilizers.</p> <p>Upcoming provider training on 4/21/21, 5/18/21, and 6/15/21 for “Maximizing telephone and video visit effectiveness during COVID-19”.</p> <p>Dr. Horton: Experiencing more utilization of telephone vs. computer connection. Has been positive overall to reach members who are chronic no show. Hoping that reimbursement will</p>		
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	<p>include telephone telehealth and is looking for advocates for that.</p> <p>Dr. Valdes: Telephone has made a huge difference because a lot of members are homeless and does have access to WIFI and equipment. Possible barrier regarding telephone vs. video reimbursements from State can limit access.</p> <p>Dr. Woo: DPH have been identifying technical and device challenges.</p> <p>Dr. Donald: to take this issue to the DHCS Medical Directors meeting; to show creating barrier/access by not recognizing phone visits.</p> <p><b>• Accessibility Monitoring Annual Update Presented by Yves Gibbons</b></p> <p>QI-05: Monitoring of Accessibility of Provider Services Including: perception of access, appointment access, service wait times, and telephone triage access -Wait time &amp; Triage Telephone Time to answer (standard: 10 min); Telephone Time to return (standard: end of next close of business); office wait time (standard: 30 min); daytime non urgent clinical triage (standard: within 30 min) and after operation hours clinical triage response times. 80% compliance rate required; non-response rate does not contribute to compliance; compliance reflects individual PCP site and clinics. Highlight: all medical groups reached 80% compliance for Time</p>		
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	<p>to Answer and Office Wait Time. SFHP also reached 80% compliance for Time to Return. Third year surveying for this standard.</p> <p>Increase 74% in 2019 and 98% in 2020 in overall SFHP After Hours Triage compliance</p> <p>Yves Gibbons: Would like some additional input regarding What contributes to consistent triage availability during and after business hours? What works well and barriers in providing telephone triage?</p> <p>Irene Conway: MAC members have overall had a good experience with during business hours and after business hours triage. The PCP office or on call MD was able to look up previous records vs. Teledoc would not have access to past history.</p> <p>Are patients surveyed or only providers?</p> <p>Yves Gibbons: This is only for provider offices. SFHP has a Member Satisfaction Survey.</p> <p>Appointment Access Elements</p> <p>-Primary, Specialty, Behavioral Health, Ancillary Care. First available appointment time for each area. 80% rate required for compliance. If under 80%; CAP (Corrective Action Plan) is sent. Seven days to respond to survey; non-response does not contribute to compliance; 50% response rate required, under 50%; CAP is sent.</p> <p>Highlights: All provider groups reached 80% routine &amp; prenatal appointments, routine behavioral health psychiatry appointments,</p>		
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	<p>and for MRI &amp; Physical Therapy appointments.</p> <p>High Impact Specialty saw an increase in urgent and routine appointments.</p> <p>Eleven new surveyed specialists. Majority of medical groups achieved 80% for routine appointments.</p> <p>How to improve Specialty urgent Appointment times? How do you distinguish between Urgent and Non-urgent (Routine) appointments?</p> <p>Dr. Horton: to check with SFZGH to see how they are handling specialty care appointments.</p> <p><b>• COVID-19 Vaccine Update</b>  <b>Presented by Dr. Fiona Donald</b></p> <p>SFHP covers 1 in 6 San Franciscans.</p> <p>SFHP goals were to support SFDPH in efforts to allow equitable vaccine access to impacted communities; aligned communications with COVID Command regarding vaccine availability; supported outreach and scheduling for vaccine appointment for SFHP members and populations served by SFHP providers including in house support workers, and Healthy San Francisco residents; continue to address barriers to access hesitancy; SFHP has updated it website to show to access the vaccine.</p> <p>Upcoming work: Addressing barriers to the vaccine (transportation has been identified as a barrier and SFHP has been</p>		
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	looking into a rideshare and taxi voucher program); development and monitoring of vaccine data.		
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QI Committee Chair's Signature & Date \_\_\_\_\_

Minutes are considered final only with approval by the QIC at its next meeting.



# Emergency Room Visit / Prescription Access Report

## 4<sup>th</sup> Quarter 2020

### San Francisco Health Plan Medi-Cal LOB

**Goal:**

Evaluate access to medications prescribed pursuant to an emergency room visit and determine whether any barriers to care exist.

**Methodology:**

All claim and encounter records for an emergency room visit (without an admission) during a calendar quarter are evaluated and consolidated into a unique record of each emergency room (ER) visit date by member. These unique ER visits are analyzed by ER facility site and member count (see Tables 1A & 1B). Top diagnoses were evaluated for reason of ER visit (see Table 2). A review of the pharmacy locations where members filled their prescriptions within 72 hours of discharge was assessed to reflect any medication barriers (see Table 3).

**Findings:**

#### Section 1 - ER Visits

In 4Q2020, 7,659 members had 12,570 ER visits, averaging 1.64 ER visits per member, which decreased from the previous quarter (1.94). This reflects an ER visit by approximately 5.5% of the SFHP Medi-Cal membership within the quarter, which decreased from 6.4% previously. Visits by ER facility and the number of Member ER visits decreased compared to the previous quarter (12,570 and 7,156 respectively).

**Table 1A: Visits by ER Facility**

ER Facility	ER Visits
ZSFG – ACUTE CARE	5,085
UCSF MEDICAL CENTER	1,672
ST FRANCIS MEMORIAL	1,505
CPMC MISSION BERNAL CAMPUS	1,209
CPMC PACIFIC CAMPUS	806
ST MARYS MEDICAL CENTER	432
CPMC PACIFIC CAMPUS-OUTPATIENT AND ER	407
CPMC DAVIES CAMPUS-ACUTE	395
CHINESE HOSPITAL	307
KAISER HOSPITAL SF	220
Other ED Facilities	542
<b>TOTAL</b>	<b>12,570</b>

**Table 1B: Member ER Visits**

# ER Visits	Member
1	4,769
2	1,615
3	566
4	258
5	132
6	101
7	44
8	33
9	34
10	19
11+	88
<b>TOTAL</b>	<b>7,659</b>

## **Section 2 - Top Diagnoses**

Of the 12,570 ER visits in 4Q2020, 5,947 visits (51%) resulted in a medication (from ER or pharmacy) within 72 hours of the ER Visit and 5,788 (49%) did not. Not all ER visits warranted medication treatment (i.e. chest pain, abdominal pain or altered mental status). Overall, the distribution of top ER visits by diagnoses category is shown in Table 2. Head injury became a top diagnosis which may be related to increased violence in the community. Suicidal ideations remain a top diagnosis from 2Q2020 which may relate to COVID-19 shelter in place.

**Table 2: Percent ER Visits by Diagnoses (4Q2020)**

<b>Top Diagnoses Categories</b>	<b>ICD10</b>	<b>ER Visits</b>	<b>% of Visits</b>
Chest pain	R07.xx	1,133	9.65%
Abdominal pain	R10.xx	608	5.18%
Shortness of breath	R06.02	229	1.95%
Headache	R51.9	157	1.34%
Altered mental status	R41.82	141	1.20%
Head Injury Unspecified	S09.90	138	1.18%
Fever Unspecified	R50.9	119	1.01%
Dizziness and Giddiness	R42	117	1.00%
Suicidal Ideations	R45.851	114	0.97%
COVID-19	U07.1	114	0.97%
Cough	R05	89	0.76%
Other Stimulant Abuse Uncomplicated	F15.10	86	0.73%
Low Back Pain	M54.5	81	0.69%
All Other Diagnoses		8,609	73.36%
<b>TOTAL</b>		<b>11,735</b>	<b>100.0%</b>

## **Section 3 - Pharmacy Location**


For the members filling a prescription from a Pharmacy within 72 hours of their ER visit date, a further analysis evaluated the location of the pharmacy relative to where the member received emergency care and the hours of operation for these pharmacies. Of the 4,389 member visits to a pharmacy after an ER discharge, the top 16 most utilized pharmacies are reported in Table 4. One 24-hour pharmacy in San Francisco was top utilized. Access to a pharmacy after an ER visit can occur throughout the day and would not be limited to only after-hours. In this analysis, member visits are defined as unique days that prescriptions are filled for a member per unique pharmacy.

**Table 3. Pharmacies where Members obtained Rx within 72 hours of an ER Visit**

Pharmacy	Hours of Operation	Mbr Visits	% of Visits
SF General (1001 Potrero Ave)	9AM – 8PM M-F, 9AM-1PM Sat	441	9.70%
Walgreens 3711 (1189 Potrero Ave)	8AM – 10PM M-F, 8AM – 9PM Sat-Sun	383	7.41%
Walgreens 1327 (498 Castro St)	24 Hours	222	4.79%
Walgreens 5487 (5300 3rd St)	8AM – 9PM	214	6.33%
Walgreens 4609 (1301 Market St)	8AM – 9PM	200	4.00%
Chinese Hospital (845 Jackson St)	8AM – 7PM M-F, 9AM-5PM Sat-Sun	133	1.92%
Walgreens 4231 (2690 Mission St)	9AM-9PM M-F, Sat 9AM-5PM, Sun 10AM-6PM	124	2.55%
Walgreens 3185 (825 Market St)	8AM – 9PM M-F, 9AM – 5PM Sat, 10AM – 6PM Sun	124	3.67%
Daniels Pharmacy	9AM-6:30PM	118	2.97%
Walgreens 7150 (965 Geneva Ave)	9AM – 9PM	105	2.27%
Walgreens 1626(2494 San Bruno Ave)	9AM-9PM M-F, Sat 9AM-5PM, Sun 10AM-6PM	101	2.24%
Scriptsite Pharmacy (870 Market St)	9:30AM-5:30PM M-F	96	2.29%
Walgreens 9886 (3400 Cesar Chavez)	9AM-9PM M-F, Sat 9AM-5PM, Sun 10AM-6PM	90	2.08%
Walgreens 13666 (1300 Bush St)	8AM-10PM	88	3.32%
Walgreens 4558 (300 Gough St)	8AM – 9PM M-F, 9AM – 5PM Sat, 10AM – 6PM Sun	76	2.36%
Walgreens 1120 (4645 Mission St)	9AM-9PM M-F, Sat 9AM-5PM, Sun 10AM-6PM	87	2.36%
All Other Pharmacy Locations		1632	38.1%
<b>TOTAL</b>		<b>4,389</b>	<b>100.0%</b>

**Summary:**

No barrier to pharmacy access during after-hours was identified in this quarter. ER utilization was lower in 4Q2020 compared to 3Q2020 (12,570 visits versus 13,865) with each member utilizing the ER at 1.64 visits, which is lower than the previous quarter (1.94). About 51% of ER visits received a medication (from ER or pharmacy) within 72 hours of the ER visit, slightly lower than last quarter (53%). Appropriate prescription fills were seen in all four key diagnoses category. Monitoring of member access to medication treatment after an ER visit will continue.

 <p><b>SAN FRANCISCO HEALTH PLAN™</b></p>	<p><b>Utilization Management Committee (UMC)</b> <b>19 January 2021</b></p>	
<p><b>Meeting called by:</b></p>	<p>Matija Cale</p>	
<p><b>Type of meeting:</b></p>	<p>Mandatory – Monthly Recurring</p>	<p><b>Recorder: K. M. McDonald</b></p>
<p><b>Present:</b></p>	<p><b><u>Clinical Operations</u></b> Matija Cale, Monica Baldzikowski; SeDessie Harris, Tamsen Staniford; Kirk McDonald; April Tarpey; Morgan Kerr; Ravid Abraham; Jim Glauber</p> <p><b><u>Pharmacy</u></b> Ralph Crowder, Lisa Ghotbi</p>	<p><b><u>Compliance</u></b> Betty DeLos Reyes Clark</p> <p><b><u>Access and Care Experience</u></b> Ralph Custodio</p>
<p><b>Not Present:</b></p>	<p>Tony Tai; Heather Thomson, Maxine Casey; Fiona Donald, Crystal Garcia, Kandice Voelker, Amy Petersen</p>	
<p><b>Quorum (details after the <i>Action Items</i> section below)</b></p> <p><b>January Meeting: Full quorum</b></p>	<ul style="list-style-type: none"> <li>• Chief Medical Officer, MD (Jim Glauber)</li> <li>• Senior Manager, Prior Authorization, RN</li> <li>• Program Manager, Utilization Management, PhD</li> <li>• Manager, Pharmacy, RPh.</li> <li>• Director, Clinical Operations, RN</li> <li>• Director, Pharmacy, Pharm.D.</li> <li>• UM Nurse Manager, Prior Authorizations, RN</li> <li>• Manager, Concurrent Review and Care Transitions, RN</li> </ul> <hr/> <p>Not Present:</p>	
<p><b>Documents Presented:</b></p>	<p>Draft_Minutes_UMC_Dec_v1.4.21 UPDATED____Draft_Agenda_UMC_Jan_v1.7.21 UM Director Dashboard_Dec 2020_01 15 21 Jesse_Jan-2020_Appeals_v1.14.21</p>	

**Agenda**

	Topic	Brought By	Time	MINUTES
1.	Standing Items: <ul style="list-style-type: none"> <li>• Approval of minutes</li> <li>• Action Items review</li> <li>• Parking lot review</li> <li>• Medical/Pharmacy Directors' Dashboards (ad hoc discussion – odd months only: Jan, March, May, July, Sept. Nov)</li> </ul>	Monica/SeDessie	1:00 – 1:05	<ul style="list-style-type: none"> <li>• Draft December minutes – Approved by Quorum.</li> <li>• Director's Dashboard               <ul style="list-style-type: none"> <li>○ Reviewed the Subacute Days table                   <ul style="list-style-type: none"> <li>▪ Drop in SNF days</li> </ul> </li> <li>○ Discussed the status of migrating some tables to the Tableau platform.</li> <li>○ Reviewed the PA tables                   <ul style="list-style-type: none"> <li>▪ The turn-around-time (TAT) dashboard is being revised. Essette currently tolls TAT by hours rather than by days.</li> <li>▪ Given the staff shortage, increase in team working with 5-day authorizations. This is creating a false negative for the TAT metrics.</li> <li>▪ Will be formally requesting IT Team this week to assist in correcting this issue (see action item below).</li> <li>▪ There has been an increase in the number of requests to extend the authorization end dates.                       <ul style="list-style-type: none"> <li>• Averaging 5 requests per week.</li> <li>• Approving all authorizations now through 30 June 2021.</li> </ul> </li> </ul> </li> </ul> </li> <li>• Action Items</li> </ul>
2.	<ul style="list-style-type: none"> <li>• Medical/Pharmacy Appeals: Upheld and Overturned</li> <li>• Independent Medical Review (IMR)</li> <li>• State Fair Hearings (SFH)</li> </ul>	<ul style="list-style-type: none"> <li>• Monica</li> <li>• Ralph Crowder</li> <li>• Kandice/Betty</li> </ul>	1:05 – 1:10	<ul style="list-style-type: none"> <li>• UM – Appeals 0               <ul style="list-style-type: none"> <li>○ Upheld appeals - 0</li> <li>○ Overturned appeals - 0</li> </ul> </li> <li>• Pharmacy – Appeals - 3               <ul style="list-style-type: none"> <li>○ Upheld appeals - 1</li> <li>○ Overturned appeals – 2                   <ul style="list-style-type: none"> <li>▪ MA201217001 – need to follow-up Dr. Kim Murphy regarding blood vs. urinary ketone monitoring.</li> <li>▪ No change to process or policies for the following appeals:                       <ul style="list-style-type: none"> <li>• MA201123001</li> <li>• MA201214001</li> </ul> </li> </ul> </li> </ul> </li> </ul>

				<ul style="list-style-type: none"> <li>Compliance <ul style="list-style-type: none"> <li>IMR - 1</li> <li>SFH – 1</li> <li>Consumer Complaint – 2 <ul style="list-style-type: none"> <li>Advair and Soolantra Issue <ul style="list-style-type: none"> <li>Moving to an IMR status.</li> <li>IMR still pending.</li> <li>Proposed to state Advair will be considered a benefit exclusion vs. a generic equivalent.</li> </ul> </li> <li>Reimbursement for Out-of-Network services <ul style="list-style-type: none"> <li>Being handled as 2 case: Consumer Complaint and SFH</li> </ul> </li> </ul> </li> </ul> </li> </ul>
3.	Discussion/Vote: Continuing to extend the end date of PA authorizations to 6/30/21 when requested by providers	Monica	1:10 – 1:25	<ul style="list-style-type: none"> <li>In March or April 2020, we made the decision to extend authorizations to expire 12/31/20 when requested by providers.</li> <li>Recently we have been receiving approximately 5 requests each week to extend authorizations and would like to give PA Coordinators the okay to do this. Most requests relate to auths that are 3 months in duration.</li> <li>UMC voted to extend, if requested, authorizations deadlines to 30 June 2021; quorum met.</li> </ul>
4.	CO-57 / Criteria Hierarchy	Monica/Morgan	1:25 – 1:35	<ul style="list-style-type: none"> <li>Discussed focused on if DMGs are required to align their UM review practices using SFHP's criteria hierarchy described in CO-57.</li> <li>The Medi-Cal contract was referenced. <ul style="list-style-type: none"> <li>The concern is does DHCS through the Medi-Cal contract expect DMGs to “mirror” the same UM review practices imposed by SFHP.</li> <li>See Action Item below; the Compliance Team will investigate this question.</li> </ul> </li> </ul>
5.	UMC and Audit Documentation	Kirk	1:35 – 1:40	<ul style="list-style-type: none"> <li>Moving forward; ease of review</li> <li>Recommendation was to include a Consent Calendar in the UMC Agenda/Minutes template.</li> </ul>
6.	Recap / Action Item Review	Kirk	1:40 – 1:35	<ul style="list-style-type: none"> <li>Status of GAFS criteria</li> </ul>

#### 1.19.21 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
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1.	Monica	<ul style="list-style-type: none"> <li>PA TAT Tables: formally requesting IT Team to assist in correcting this issue.</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
2.	Ralph Crowder	<ul style="list-style-type: none"> <li>Appeal MA201217001 – need to follow-up Dr. Kim Murphy regarding blood vs. urinary ketone monitoring.</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
3.	Betty	<ul style="list-style-type: none"> <li>Will review the Med-Cal contract/DHCS to determine if DMGs are required to adopt and follow CO-57's criteria hierarchy.</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
4.	Kirk	<ul style="list-style-type: none"> <li>Create a Consent Calendar section for the agenda/minutes UMC template</li> </ul>	<ul style="list-style-type: none"> <li>Completed; includes an appendix item of the full reportage suite UMC is responsible for.</li> </ul>

#### 12.15.20 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
5.	Tamsen	<ul style="list-style-type: none"> <li>CPAP follow-up</li> <li>Will add to the 2.21 UMC Agenda</li> <li>Working w/ Katy Shaffer to dive deeper into the utilization data.</li> <li>Need to provide a 6-month impact analysis of the PA removal and report to UMC.</li> </ul>	<ul style="list-style-type: none"> <li>Placed on the 2.21 UMC agenda</li> </ul>
6.	Heather/April/Matija	<ul style="list-style-type: none"> <li>Matija - to investigate how the sister plans are handling CGM? A covered benefit?</li> <li>Heather/April - to reach out to the DMGs to ask if they cover CGMs.</li> <li>Need to bring pharmacies into the SFHP network?</li> <li>Is there a single source for CGMs?</li> </ul>	<ul style="list-style-type: none"> <li>See below.</li> <li>The Governor's 2021 budget will cover Medi-Cal coverage expansion for CGM; continuous glucose monitors for Medi-Cal members age 21 and over with Type 1 diabetes; no timeframe specified.</li> <li>Update on sister plans Gold Coast <ul style="list-style-type: none"> <li>Covers CGM with MCG criteria Partnership</li> </ul> </li> </ul>

			<ul style="list-style-type: none"> <li>Covers CGM with tight list of requirements.</li> </ul> <p>CCAH</p> <ul style="list-style-type: none"> <li>Covers CGM on limited basis.</li> </ul> <p>Kern</p> <ul style="list-style-type: none"> <li>Covers CGM on case by case basis using MCG, however they have concerns about limited documentation support for continued use of CGM and improvement. They were interested in knowing if anyone had guidelines on that.</li> </ul>
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#### 11.20.20 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Monica	<ul style="list-style-type: none"> <li>Working with PNO &amp; IT Teams regarding the claim edits issues arising from the issue of UCSF clinical affiliations not currently configured.</li> </ul>	<ul style="list-style-type: none"> <li>Will be raising the issue in January 2021 at the monthly C-4 meeting.</li> </ul>
2.	Tony	<ul style="list-style-type: none"> <li>To include the authorization dashboard in future meetings when the director's dashboard is discussed.</li> <li>The director's dashboard will be moved to Tableau by 1.21.</li> </ul>	<ul style="list-style-type: none"> <li>There will be a delay in transitioning dashboard to be</li> </ul>



			moved to Tableau January 2021.
3.	Matija	<ul style="list-style-type: none"> <li>Vision Therapy – Next Steps <ul style="list-style-type: none"> <li>Reach out to Sister Plans to ask their directors how they handle this type of benefit.</li> </ul> </li> </ul>	<p>Gold Coast</p> <ul style="list-style-type: none"> <li>Doesn't cover vision therapy.</li> </ul> <p>Partnership</p> <ul style="list-style-type: none"> <li>Doesn't cover vision therapy.</li> </ul> <p>CCAH</p> <ul style="list-style-type: none"> <li>No response on vision therapy</li> </ul> <p>Kern</p> <p>ion therapy normally not covered, however there was a request once in the past few years at the code was not covered but was deemed medically necessary under EPSDT so they covered it.</p>

#### 9.15.2020 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Monica / Tamsen (?) / Morgan (?)	<ul style="list-style-type: none"> <li>Roll out to the DMGs the updated critical hierarchy in CO-57.</li> <li>File updated version of PP CO-57 with DHCS as a "file-and-use" status</li> <li>On DHCS approval of the revisions to PP-CO-57, will require updates to: <ul style="list-style-type: none"> <li>PP CO-22</li> <li>Some desk-top-procedures</li> <li>2 Essette assessments</li> <li>LMS criteria course</li> <li>Additional staff training</li> </ul> </li> <li>Communication to DMEs</li> </ul>	<ul style="list-style-type: none"> <li>CO-57 passed @ Nov PCC (11/18). After required signatures are obtained (CEO &amp; CMO), Morgan will request PNO disburse update to DMGs.</li> <li>After DHCS approval (minimum of 60 days) it is estimated about 2-months to complete</li> </ul>

			all internal/external updates.
2.	Monica / Angie	<ul style="list-style-type: none"> <li>Will work with PNO about the GAFS surgeons' proposal for increasing their ownership role in surgery coordination.</li> </ul>	<ul style="list-style-type: none"> <li>1.21 – a draft PP has been prepared; the criteria draft is completed.</li> <li>12.20 – received APL from DHCS.</li> <li>12/20 - DHCS concurrently also is preparing to release a new APL about Transgender Health care; will wait for the APL to see its impact on the draft Gender Affirmation Criteria. In progress when the Gender Affirmation criteria is completed/approved will reach out to the GAFS surgeons.</li> <li>Suggested to have 1:1 meeting with each surgeon vs. a group meeting.</li> </ul>

#### 8.18.2020 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Heather / April	<ul style="list-style-type: none"> <li>Follow-up on ASH's action steps to correct the NOA issue.</li> </ul>	<ul style="list-style-type: none"> <li>12.15 - ASH has agreed to add language (not required by regulations) to make our member denial letters more clear!!! All denial</li> </ul>

			<p>letters will contain the headers Notice of Action - About Your Treatment Request - This is not a Bill.</p> <ul style="list-style-type: none"> <li>There have been multiple appeals and decline to files related to member confusion around ASH denial letters potentially being a bill. This language will reduce member confusion and thereby reduce appeals team work to explain the letters.</li> <li>A mini-audit may be performed in January if there are denials available for review.</li> </ul>
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#### 4.21.2020 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Maxine / Kirk	<ul style="list-style-type: none"> <li>Per Jim the following adjustment/consideration, due to COVID-19, needs to be made when assessing the metrics for the following quarters – conduct a 90, 120, 180 review of the non-attached to a claim referral. This will impact for the following quarters: <ul style="list-style-type: none"> <li>Q4-2019</li> <li>Q1, Q2, Q3, Q4 of 2020</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>February 2021 UMC Meeting – present the annual report, will address Jim's question in the report; will cover Q4-19 to Q3-20.</li> </ul>

#### Parking Lot

7.21.2020	Tamsen Staniford	<ul style="list-style-type: none"> <li>Will work with the Claims Team on the issue of removing auth</li> </ul>	<ul style="list-style-type: none"> <li>This was implemented in Aug 2020, so we can run the</li> </ul>
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		<p>requirements for both J3490 and J8499:</p> <ul style="list-style-type: none"> <li>○ Follow-up on the suggestion of raising the threshold of approving a claim with no auth from \$25 to \$200.</li> <li>○ In the past, there were issues with setting a \$25 limit, need to confirm if those same issues will occur if a \$25 limit is executed.</li> <li>○ Are there provider contracts in place obligating SFHP to pay a percentage of bill charges if the auth requirements are removed? This may not apply if only removing the auth requirements for codes (J3490 and J8499) that are below \$25.</li> <li>○ On obtaining the answers, bring back to UMC August meeting (8.18) and a formal vote will be held to approve the final recommendation for not requiring an authorization for claims below a certain dollar threshold.</li> <li>● When the final recommendation is approved, there will be a 6-month follow-up to determine</li> </ul>	<p>follow up claims impact analysis in February 2021</p>
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		the impact of this change on claims associated with J3490 and J8499.	
6.18.19	Kirk	<ul style="list-style-type: none"> <li>ALOS Readmission Data</li> </ul>	<ul style="list-style-type: none"> <li>12.09.20 – assessing whether this report needs to be continued; was used for a specific NCQA QI report which will not be repeated for the 2023 Renewal Accreditation audit. BUT.... NCQA might require for the 2022 proposed changes.</li> </ul>
6.16.20	Monica	<ul style="list-style-type: none"> <li>Will review the Private Duty Nursing EPSDT criteria at the <b>June 2021</b> UMC meeting</li> </ul>	<ul style="list-style-type: none"> <li>Has been placed on the <b>June 2021</b> UMC agenda</li> </ul>
5.19.20	Kirk	<ul style="list-style-type: none"> <li>Benchmark follow-up</li> <li>Due to the COVID-19 impact on the health industry, and potentially, skewing UM metrics, need to monitor if NCQA will be adjusting the HEDIS percentiles.</li> <li>If NCQA does institute a HEDIS adjustment, need to regroup with UMC to reassess the 75 percentile benchmarks being used.</li> </ul>	<ul style="list-style-type: none"> <li>As of 9.20: NCQA / HEDIS monitoring in progress.</li> </ul>
3.17.20	Monica / Jim	Add to the JOC agenda the issue of members who have never contacted their assigned PCP, leading in some cases to accessing OOMG/OOA providers.	On hold to further notice.
1.21.20	Kirk / Katy Shaffer	<ul style="list-style-type: none"> <li>A “cheat-sheet” for the Utilization Trending Service report/tool.</li> </ul> <p>Create a resource by providing screen shots with explanatory labels.</p>	12.20 – Katy is still refining the model; so, waiting for stabilization before creating a guide.
2.20.18	Monica	Will obtain metrics on Retrospective Utilization Reviews to guide Compliance on the effect of a 90 or a 180-day guideline.	12.20 - closed

<b>Membership and Voting Rights</b>	<p>The UMC membership, with voting rights on all motions, consists of:</p> <ul style="list-style-type: none"> <li>• Chief Medical Officer, MD</li> <li>• Associate Medical Director, MD</li> <li>• Senior Manager, Prior Authorization, RN</li> <li>• UM Nurse Manager, Prior Authorizations, RN</li> <li>• Manager, Concurrent Review and Care Transitions, RN</li> <li>• Program Manager, Utilization Management, PhD</li> <li>• Director, Pharmacy, Pharm.D.</li> <li>• Manager, Pharmacy, RPh.</li> </ul> <p>The UMC membership, with voting rights limited to behavioral health and mental health motions, consists of:</p> <ul style="list-style-type: none"> <li>• Director of Clinical Services – Beacon Health Options (ad hoc) <ul style="list-style-type: none"> <li>◦ Valid State Clinical License required (RN, LCSW, LMFT, PhD or PsyD)</li> </ul> </li> <li>• Medical Director (MD/ Psychiatry) – College Health IPA (Beacon Health Options) (ad hoc)</li> </ul>
<b>Quorum</b>	<ul style="list-style-type: none"> <li>• A quorum of the UMC is five members with at least one representative from Clinical Operations, Pharmacy, and the Medical Director staff.</li> <li>• At least one behavioral health representative must also be in attendance to conduct any business related to behavioral health benefits.</li> </ul>

**April Tarpey (email - Fri 1/15/2021 7:08 AM) – response to action items for 12.15.20**

CGM MONITORING AS OF 1/15/2021

#### **NEMS/NMS**

*NEMS has been covering CGM for patients with uncontrolled diabetes even though it is not a covered benefit for Medi-Cal*

**CCHCA**

*We would verify the benefit and then approve based on criteria/medical necessity.*

**BTP**

*If being requested by a contracted provider to a contracted provider, no auth is required*

**HIL**

No response provided

**KAISER**

*For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices), insulin pumps and supplies to operate the pump are provided*

**JADE**


No response provided

**ASH**

N/A

**BEACON**

N/A

 <b>SAN FRANCISCO HEALTH PLAN™</b>	<b>Utilization Management Committee (UMC)</b> <b>16 February 2021</b>  <b>Meeting Invite / Conference connection through Microsoft Teams</b>	
<b>Meeting called by:</b>	Matija Cale	
<b>Type of meeting:</b>	Mandatory – Monthly Recurring	<b>Recorder: K. M. McDonald</b>
<b>Present:</b>	<u><b>Clinical Operations</b></u> Matija Cale, Monica Baldzikowski; Tamsen Staniford; Kirk McDonald; April Tarpey; Morgan Kerr; Ravid Abraham; Jim Glauber; Tony Tai; Maxine Casey  <u><b>Pharmacy</b></u> Ralph Crowder, Lisa Ghotbi	<u><b>Compliance</b></u> Betty DeLos Reyes Clark; Crystal Garcia  <u><b>Access and Care Experience</b></u>  Jesse Chairez
<b>Not Present:</b>	Fiona Donald; SeDessie Harris; Ralph Custodio; Amy Petersen;	
<b>Quorum (details after the <i>Action Items</i> section below)</b>  <b>February Meeting: Quorum met</b>	<ul style="list-style-type: none"> <li>• Chief Medical Officer, MD (Jim Glauber)</li> <li>• Senior Manager, Prior Authorization, RN</li> <li>• Program Manager, Utilization Management, PhD</li> <li>• Manager, Pharmacy, RPh.</li> <li>• Director, Clinical Operations, RN</li> <li>• Director, Pharmacy, Pharm. D.</li> <li>• UM Nurse Manager, Prior Authorizations, RN</li> </ul> <hr/> Not Present: Manager, Concurrent Review and Care Transitions, RN	
<b>Documents Presented:</b>	Draft_Minutes_UMC_Jan_v2.2.21 UM Director Dashboard_Jan 2021_02 10 21 Jesse_Appeals_Feb_2021_UMC_Data_v2.11.21 Betty_SFH.IMR.CC_UMC Report_2021.02.09 Blood Pressure Monitor Pharmacy Data UMC	



	GAFS_UMCPresentation_2_16_21
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#### Consent Calendar

ITEM #	Document	Review Schedule	STATUS
1.	UM Program Description UM1_ElemA_Factors1,3,5,6_2020_UMProgDescrip_v9.17.20	• Annual (Q1)	Evote by 2.26.21
2.	UM Program Evaluation 1.1.A.1_DHCS_UMProgEval-2020_v1.14.21	• Annual (Q1)	Evote by 2.26.21

#### Agenda

	Topic	Brought By	Time	MINUTES
1.	Standing Items: <ul style="list-style-type: none"> <li>• Approval of minutes</li> <li>• Action Items review</li> <li>• Parking lot review</li> <li>• Medical/Pharmacy Directors' Dashboards (ad hoc discussion – odd months only: Jan, March, May, July, Sept. Nov)</li> </ul>	Matija	1:00 – 1:05	<ul style="list-style-type: none"> <li>• Draft January 2021 Minutes</li> <li>• Director's Dashboard               <ul style="list-style-type: none"> <li>○ The PCP Visit increase might be attributed to the increase in tele-health visits. Currently, not able to distinguish between a primary or specialist visit.                   <ul style="list-style-type: none"> <li>▪ Currently, QNXT indicates a physician as a primary care physician based on a code set; yet the code set contains codes HEDIS does not consider primary care.</li> <li>▪ Discussed whether to adopt HEDIS' primary care code set.</li> </ul> </li> <li>○ Discussed changing the organization goal of <i>Primary Care Utilization</i> to <i>Outpatient Visit Utilization</i>, and distinguishing between: Primary, non-Primary, urgent care, and tele-medicine.                   <ul style="list-style-type: none"> <li>▪</li> </ul> </li> </ul> </li> <li>• Action Items               <ul style="list-style-type: none"> <li>○ Betty discussed her email about DMG adoption of SFHP's criteria hierarchy.                   <ul style="list-style-type: none"> <li>▪ The UMC passed a motion:                       <ul style="list-style-type: none"> <li>• Conduct a review of the DMGs' clinical criteria hierarchy, and then review any deviations from SFHP's hierarchy. The intent is not to "enforce" SFHP's hierarchy on a</li> </ul> </li> </ul> </li> </ul> </li> </ul>

**Commented [MK1]:** 2.24.21 – was recorded in the 2021 decision log.

				<p>delegate, but to monitor the delegates' hierarchy to ensure it is based on sound medical evidence, is regularly reviewed, etc., and documenting the manner in which delegates/providers are involved in the development/adoption of criteria.</p> <ul style="list-style-type: none"> <li>• Inform the DMGs that any of their medical decisions reviewed on appeal are subject to CO-57 criteria hierarchy.</li> <li>• Update CO-57 and the Provider Manual to reflect the delegate clinical criteria hierarchy monitoring process and state SFHP's criteria hierarchy will be applied to appeals.</li> </ul>
2. d	<ul style="list-style-type: none"> <li>• Medical/Pharmacy Appeals: Upheld and Overturned</li> <li>• Independent Medical Review (IMR)</li> <li>• State Fair Hearings (SFH)</li> </ul>	<ul style="list-style-type: none"> <li>• Monica</li> <li>• Ralph Crowder</li> <li>• Kandice/Betty</li> </ul>	<p>1:05 – 1:10</p>	<ul style="list-style-type: none"> <li>• UM – Appeals – 2; no change to policy or process. <ul style="list-style-type: none"> <li>○ Upheld appeals - 2</li> <li>○ Overturned appeals - 0</li> </ul> </li> <li>• Pharmacy – Appeals – 3; no change to policy or process. <ul style="list-style-type: none"> <li>○ Upheld appeals - 2</li> <li>○ Overturned appeals – 1</li> </ul> </li> <li>• Compliance <ul style="list-style-type: none"> <li>○ IMR - 0</li> <li>○ SFH – 1</li> <li>○ Consumer Complaint – 1</li> <li>○ SFH &amp; Consumer Complaint – 1</li> <li>○ Discussion <ul style="list-style-type: none"> <li>▪ The SFH for reimbursement for Out-of-Network services hearing will be held on 3.2.21.</li> <li>▪ The SFH for request for Tenogram and Steroid Injection will be held the week of 2.22.21.</li> </ul> </li> </ul> </li> </ul>
3.	Removal of PA for Blood Pressure Monitors (BPMs)	Monica	<p>1:10 – 1:20</p>	<ul style="list-style-type: none"> <li>• The intent is to remove the PA requirement, but with benefit limits. <ul style="list-style-type: none"> <li>○ Would like to have a UMC decision by April 2021 UMC meeting.</li> <li>○ Pharmacy Team supports the removal of the PA, but with benefit limits.</li> </ul> </li> </ul>

				<ul style="list-style-type: none"> <li>o Discussed how for continuous glucose monitors cannot required a PA but do need to have guidelines to curtail overutilization.</li> <li>o Discussed the need to work with PNO to ensure access to quality BPM at Medi-Cal prices.</li> <li>• Background <ul style="list-style-type: none"> <li>o The risk analysis <ul style="list-style-type: none"> <li>▪ Utilization from 10.18 to 9.19 <ul style="list-style-type: none"> <li>• SFHP offers 8 home BPM on Medi-Cal formulary at \$0 copay / 1 every 5 years.</li> </ul> </li> <li>▪ Between 10.18 and 9.19, there were 1,105 BPM claims. <ul style="list-style-type: none"> <li>• Majority were for formulary BPMs; 4 were for non-formulary.</li> </ul> </li> <li>▪ Only 5 PA requests, however. <ul style="list-style-type: none"> <li>• 3 approved/2 denied.</li> <li>• All 5 PAs were for formulary BPMs.</li> </ul> </li> </ul> </li> </ul> </li> </ul>
4.	Status of the GAFs Criteria	Tamsen	1:20 – 1:30	<ul style="list-style-type: none"> <li>• Refer to the document - <b><i>GAFS_UMCPresentation_2_16_21</i></b> for details.</li> </ul>
5.	Continuous Glucose Monitors (CGMs)	Matija	1:30 – 1:40	<ul style="list-style-type: none"> <li>• The Governor's budget for 2022 includes support for CGMs as a covered Medi-Cal benefit.</li> <li>• Sister plans currently approve, using MGC criteria, CGMs on a case-by-case basis.</li> <li>• Since 6.20, Clin Ops has received 20-30 requests for CGMs.</li> <li>• With the upcoming transfer of Pharmacy services to the State, potentially transferring 124 CGM users to the medical side.</li> <li>• One issue is the number of LOAs for CGM vendors. <ul style="list-style-type: none"> <li>o PNO is currently working on 2 vendor contracts.</li> <li>o Pharmacy is concerned the vendors are out-of-state and would prefer local pharmacy vendors. <ul style="list-style-type: none"> <li>▪ The issue of how billing through the medical vs. the pharmacy claims process is an issue for the local pharmacy vendors.</li> </ul> </li> </ul> </li> </ul>
6.	New Process for Claims analysis of EPSDT denials	Monica	1:40 – 1:50	<ul style="list-style-type: none"> <li>• Tabled to the April UMC meeting (4.20.21)</li> </ul>

7.	Recap / Action Item Review	Kirk	1:50 – 1:55	<ul style="list-style-type: none"> <li>Action Items to be sent post-meeting</li> <li>NOTE: There will be no meeting in March due to the DHCS audit. The next UMC meeting is scheduled for April 7 2:00PM.</li> </ul>
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#### 2.16.21 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	April	<ul style="list-style-type: none"> <li>Conduct a review of the DMGs' clinical criteria hierarchy, and then review any deviations from SFHP's hierarchy.</li> <li>Inform the DMGs that any of their medical decisions reviewed on appeal are subject to CO-57 criteria hierarchy.</li> </ul>	•
2.	April/Kirk/Morgan	<ul style="list-style-type: none"> <li>Update CO-57 and the Provider Manual to reflect the delegate clinical criteria hierarchy monitoring process and state SFHP's criteria hierarchy will be applied to appeals.</li> </ul>	•
3.	Monica	<ul style="list-style-type: none"> <li>No prior authorization will be required for BPM.</li> <li>Work with the Configuration Team to set BPM benefit limits.</li> <li>Work with the Fraud, Waste Abuse Team (Compliance) regarding ability for Pondera software to monitor BPM claims.</li> <li>Work with PNO regarding access to quality BPMs at Medi-Cal prices.</li> </ul>	•
4.	Matija	<ul style="list-style-type: none"> <li>Will track the Governor's budget to confirm CGMs are a confirmed Medi-Cal benefit. and if coverage date remains 1/1/22.</li> </ul>	•
5.	Tamsen	<ul style="list-style-type: none"> <li>Will follow-up with the Pharmacy/PNO for potential of local pharmacies having/obtaining licenses to supply DME in order to provide DME like CGMs after Medi-CalRx go-live.</li> </ul>	•

#### 1.19.21 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
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6.	Monica	<ul style="list-style-type: none"> <li>PA TAT Tables: formally requesting IT Team to assist in correcting this issue.</li> </ul>	<ul style="list-style-type: none"> <li>Still in progress, Tony submitted a report request.</li> </ul>
7.	Ralph Crowder	<ul style="list-style-type: none"> <li>Appeal MA201217001 – need to follow-up Dr. Kim Murphy regarding blood vs. urinary ketone monitoring.</li> </ul>	<ul style="list-style-type: none"> <li>Closed.</li> <li>No changes.</li> </ul>
8.	Betty	<ul style="list-style-type: none"> <li>Will review the Med-Cal contract/DHCS to determine if DMGs are required to adopt and follow CO-57's criteria hierarchy.</li> </ul>	<ul style="list-style-type: none"> <li>Updated from Tue 2/16/2021 10:17 AM (email); content below in Appendix</li> </ul>
9.	Kirk	<ul style="list-style-type: none"> <li>Create a Consent Calendar section for the agenda/minutes UMC template</li> </ul>	<ul style="list-style-type: none"> <li>Completed; in process of creating an appendix of the full reportage suite UMC is responsible for.</li> </ul>

#### 12.15.20 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
10.	Tamsen	<ul style="list-style-type: none"> <li>CPAP follow-up</li> <li>Working w/ Katy Shaffer to dive deeper into the utilization data.</li> <li>Need to provide a 6-month impact analysis of the PA removal and report to UMC.</li> </ul>	<ul style="list-style-type: none"> <li>Will be on the 3.21 UMC agenda.</li> <li>Preliminary PDR and claims edits findings are showing an increase in claims, but likely due to a claims/auth matching issue that is in the processing being resolved.</li> <li>Pondera alerts are being reconfigured to better monitor over-billing.</li> <li>No changes to the PA requirement are recommended at this time.</li> <li>Will continue to monitor for fraud/waste/abuse</li> </ul>

			and resolution of claims/auth matching issue and report back to June UMC.
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#### 11.20.20 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Monica	<ul style="list-style-type: none"> <li>Working with PNO &amp; IT Teams regarding the claim edits issues arising from the issue of UCSF clinical affiliations not currently configured.</li> </ul>	<ul style="list-style-type: none"> <li>Will be raising the issue in April 2021 at the monthly C-4 meeting.</li> </ul>
2.	Tony	<ul style="list-style-type: none"> <li>To include the authorization dashboard in future meetings when the director's dashboard is discussed.</li> <li>The director's dashboard will be moved to Tableau by 1.21.</li> </ul>	<ul style="list-style-type: none"> <li>Still in progress.</li> </ul>

#### 9.15.2020 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Monica / Tamsen (?) / Morgan (?)	<ul style="list-style-type: none"> <li>Roll out to the DMGs the updated critical hierarchy in CO-57.</li> <li>File updated version of PP CO-57 with DHCS as a "file-and-use" status</li> <li>On DHCS approval of the revisions to PP-CO-57, will require updates to: <ul style="list-style-type: none"> <li>PP CO-22</li> <li>Some desk-top-procedures</li> <li>2 Essette assessments</li> <li>LMS criteria course</li> <li>Additional staff training</li> </ul> </li> <li>Communication to DMEs</li> </ul>	<ul style="list-style-type: none"> <li>CO-57 passed @ Nov PCC (11/18). After required signatures are obtained (CEO &amp; CMO), Morgan will request PNO disburse update to DMGs.</li> <li>After DHCS approval (minimum of 60 days) it is estimated about 2-months to complete</li> </ul>

			all internal/external updates.
2.	Monica / Angie	<ul style="list-style-type: none"> <li>Will work with PNO about the GAFS surgeons' proposal for increasing their ownership role in surgery coordination.</li> </ul>	<ul style="list-style-type: none"> <li>1.21 – a draft PP has been prepared; the criteria draft is completed.</li> <li>12.20 – received APL from DHCS.</li> <li>Suggested to have 1:1 meeting with each surgeon vs. a group meeting.</li> </ul>

#### 8.18.2020 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	April	<ul style="list-style-type: none"> <li>Follow-up on ASH's action steps to correct the NOA issue.</li> </ul>	<ul style="list-style-type: none"> <li>(email - Tue 2/9/2021 6:53 AM): "The language was provided to ASH...When I looked into the issue, I discovered that we also did not have that verbiage in our translated letters. The issue has been corrected and implemented with SFHP and the correct translations have been provided to ASH. There was not a mini audit (in) January, however, ASH has their annual audit this month (February 2021). It will</li> </ul>

			obviously not include these changes, so I will ask UM to please provide an example of these updated letters to confirm they are corrected.
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#### 4.21.2020 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Maxine / Kirk	<ul style="list-style-type: none"> <li>Per Jim the following adjustment/consideration, due to COVID-19, needs to be made when assessing the metrics for the following quarters – conduct a 90, 120, 180 review of the non-attached to a claim referral. This will impact for the following quarters: <ul style="list-style-type: none"> <li>Q1, Q2, Q3</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>March 2021 UMC Meeting – present the annual report, will address Jim's question in the report; will cover Q4-19 to Q3-20.</li> </ul>

#### Parking Lot

7.21.2020	Tamsen Staniford	<ul style="list-style-type: none"> <li>Will work with the Claims Team on the issue of removing auth requirements for both J3490 and J8499: <ul style="list-style-type: none"> <li>Follow-up on the suggestion of raising the threshold of approving a claim with no auth from \$25 to \$200.</li> <li>In the past, there were issues with setting a \$25 limit, need to confirm if those same issues will occur if a \$25 limit is executed.</li> <li>Are there provider contracts in place</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Change has been successful in reducing claims edits to manually work from hundreds to less than 10 a week.</li> <li>Report to ensure no claims over \$25 for either code is working as expected.</li> <li>No additional financial risk or side effects of change have been identified.</li> </ul>
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		<p>obligating SFHP to pay a percentage of bill charges if the auth requirements are removed? This may not apply if only removing the auth requirements for codes (J3490 and J8499) that are below \$25.</p> <ul style="list-style-type: none"> <li>○ On obtaining the answers, bring back to UMC August meeting (8.18) and a formal vote will be held to approve the final recommendation for not requiring an authorization for claims below a certain dollar threshold.</li> <li>• When the final recommendation is approved, there will be a 6-month follow-up to determine the impact of this change on claims associated with J3490 and J8499.</li> </ul>	
6.18.19	Kirk	<ul style="list-style-type: none"> <li>• ALOS Readmission Data</li> </ul>	<ul style="list-style-type: none"> <li>• Closed; will continue to track/monitor this metric</li> </ul>
6.16.20	Monica	<ul style="list-style-type: none"> <li>• Will review the Private Duty Nursing EPSDT criteria at the <b>June 2021</b> UMC meeting</li> </ul>	<ul style="list-style-type: none"> <li>• Has been placed on the <b>June 2021</b> UMC agenda</li> </ul>
5.19.20	Kirk	<ul style="list-style-type: none"> <li>• Benchmark follow-up</li> <li>• Due to the COVID-19 impact on the health industry, and potentially, skewing UM metrics, need to monitor if NCQA will be adjusting the HEDIS percentiles.</li> </ul>	<ul style="list-style-type: none"> <li>• As of 9.20: NCQA / HEDIS monitoring in progress.</li> </ul>

		<ul style="list-style-type: none"> <li>If NCQA does institute a HEDIS adjustment, need to regroup with UMC to reassess the 75 percentile benchmarks being used.</li> </ul>	
3.17.20	Monica / Jim	Add to the JOC agenda the issue of members who have never contacted their assigned PCP, leading in some cases to accessing OOMG/OOA providers.	On hold to further notice.
1.21.20	Kirk / Katy Shaffer	<ul style="list-style-type: none"> <li>A “cheat-sheet” for the Utilization Trending Service report/tool. Create a resource by providing screen shots with explanatory labels.</li> </ul>	2.21 – is considered a low priority given shifts in other high priority projects; will be completed by June UMC.

<b>Membership and Voting Rights</b>	<p>The UMC membership, with voting rights on all motions, consists of:</p> <ul style="list-style-type: none"> <li>Chief Medical Officer, MD</li> <li>Associate Medical Director, MD</li> <li>Senior Manager, Prior Authorization, RN</li> <li>UM Nurse Manager, Prior Authorizations, RN</li> <li>Manager, Concurrent Review and Care Transitions, RN</li> <li>Program Manager, Utilization Management, PhD</li> <li>Director, Pharmacy, Pharm.D.</li> <li>Manager, Pharmacy, RPh.</li> </ul> <p>The UMC membership, with voting rights limited to behavioral health and mental health motions, consists of:</p> <ul style="list-style-type: none"> <li>Director of Clinical Services – Beacon Health Options (ad hoc) <ul style="list-style-type: none"> <li>Valid State Clinical License required (RN, LCSW, LMFT, PhD or PsyD)</li> </ul> </li> <li>Medical Director (MD/ Psychiatry) – College Health IPA (Beacon Health Options) (ad hoc)</li> </ul>
Quorum	<ul style="list-style-type: none"> <li>A quorum of the UMC is five members with at least one representative from Clinical Operations, Pharmacy, and the Medical Director staff.</li> <li>At least one behavioral health representative must also be in attendance to conduct any business related to behavioral health benefits.</li> </ul>

## Appendix

Betty's email from Tue 2/16/2021 10:17 AM (unabridged):

*Here is the response for the action item regarding whether DMGs are required to adopt and follow CO-57's criteria hierarchy:*

*During January's UMC, Monica B. asked whether SFHP could require delegates to adopt and follow the SFHP clinical criteria hierarchy stated in CO-57.*

*The DHCS Contract requires SFHP ensure "[t]here is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated." SFHP also has to have a UM Program that has "[e]stablished criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which Providers are involved in the development and or adoption of specific criteria used by the Contractor." Additionally, SFHP's contracts with the delegates generally require the delegates to follow SFHP's policies and procedures. However, delegates may not agree that their obligation to follow SFHP's policies and procedures means that they must adopt SFHP's criteria hierarchy (e.g., NEMS disagreed in a previous audit). Also, the delegates may currently have licensed, proprietary criteria from a company different from MCG, so it may not be feasible to require delegates to use MCG.*


*Rather than require delegates to adopt the SFHP clinical criteria hierarchy, Compliance recommends that UMC ascertain all delegates' clinical criteria hierarchy and then review any deviations from SFHP's hierarchy. This can be done on a rolling basis – SFHP can ask delegates to disclose their clinical criteria hierarchy at their annual delegate audit. The hierarchy would be reviewed during the audit and then any deviations from SFHP's hierarchy can be brought to the CMO or UMC for review and discussion. We think this will be easier for the delegates to accept compared to a mandate to adopt the SFHP criteria hierarchy. It also provides a way for SFHP to monitor delegates' UM processes and facilitate changes if the CMO or UMC has concerns or disagrees with delegates' hierarchies. This process also adheres to the DHCS contract requirements listed above – SFHP is ensuring that criteria used by its delegates is based on sound medical evidence, is regularly reviewed, etc., and SFHP is also documenting the manner in which delegates/providers are involved in the development/adoption of criteria.*

One area where SFHP might have to enforce its own clinical criteria hierarchy is appeals. Except for Kaiser, VSP, and Beacon, appeals are not delegated. When an authorization request is subject to review on appeal and the different criteria hierarchies result in different outcomes, it makes sense to us that SFHP would apply its own criteria hierarchy rather than the delegates' to make the final determination. If UMC agrees, Compliance recommends that the delegates be clearly informed that any of their decisions that are reviewed on appeal are subject to SFHP's criteria hierarchy.

If these recommendations are acceptable, we also recommend that CO-57 and the Provider Manual be updated to reflect the delegate clinical criteria hierarchy monitoring process. CO-57 and the Provider Manual should also clearly state that SFHP's criteria hierarchy will be applied to appeals. Please let us know if you have any questions about this.

Thank you,

Betty DeLos Reyes Clark, Esq.  
Regulatory Affairs Counsel

 <b>SAN FRANCISCO HEALTH PLAN™</b>	<b>Utilization Management Committee (UMC)</b> <b>7 April 2021</b> <b>2PM – 3PM</b>  <b>Meeting Invite / Conference connection through Microsoft Teams</b>	
<b>Meeting called by:</b>	Matija Cale	
<b>Type of meeting:</b>	Mandatory – Monthly Recurring	<b>Recorder:</b> K. M. McDonald
<b>Present:</b>	<u><b>Clinical Operations</b></u> Matija Cale, Monica Baldzikowski; SeDessie Harris, Tamsen Staniford; Kirk McDonald; April Tarpey; Morgan Kerr; Ravid Abraham; Jim Glauber; Tony Tai; Maxine Casey; Fiona Donald; Jim Glauber  <u><b>Pharmacy</b></u> Ralph Crowder, Lisa Ghotbi	<u><b>Compliance</b></u> Betty DeLos Reyes Clark; Crystal Garcia  <u><b>Access and Care Experience</b></u> Ralph Custodio; Amy Petersen, Jesse Chairez
<b>Not Present:</b>		
<b>Quorum (details after the <i>Action Items</i> section below)</b>  <b>April Meeting:</b>	<ul style="list-style-type: none"> <li>• Chief Medical Officer, MD (Fiona Donald)</li> <li>• Senior Manager, Prior Authorization, RN</li> <li>• Program Manager, Utilization Management, PhD</li> <li>• Manager, Pharmacy, RPh.</li> <li>• Director, Clinical Operations, RN</li> <li>• Director, Pharmacy, Pharm. D.</li> <li>• UM Nurse Manager, Prior Authorizations, RN</li> <li>• Manager, Concurrent Review and Care Transitions, RN</li> </ul> <hr/> Not Present:	
<b>Documents Presented:</b>	FINAL_UMC_April_Agenda_vB-4.7.21 Draft_Minutes_UMC_Feb_v2.16.21 CMO HS Dashboard January 2021_03 02 21 UM Director Dashboard_Feb 2021_03 11 21	

**Commented [MK1]:** Inaugural meeting w/ Fiona as CMO.

	Jesse_April Report UMC_v4.2.21 Betty_SF.H.IMR.CC_UMC Report_2021.04.02 Final_Q2-Q3_2020_SpecialtyReferralReport_v4.6.21
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#### Consent Calendar

ITEM #	Document	Review Schedule	Outcome
1.	UM Program Description UM1_ElemA_Factors1,3,5,6_2020_UMProgDescrip_v9.17.20	<ul style="list-style-type: none"> <li>Annual (Q1)</li> <li>Evote (2.26.21)</li> </ul>	<ul style="list-style-type: none"> <li>Approved by quorum.</li> </ul>
2.	UM Program Evaluation 1.1.A.1_DHCS_UMProgEval-2020_v1.14.21a	<ul style="list-style-type: none"> <li>Annual (Q1)</li> <li>Evote (2.26.21)</li> </ul>	<ul style="list-style-type: none"> <li>Approved by quorum.</li> </ul>
3.	Specialty Referral Report Q2/Q3 – 2020	<ul style="list-style-type: none"> <li>April 2021 UMC Meeting</li> </ul>	<ul style="list-style-type: none"> <li>Reviewed by UMC; will need to provide a metric improvement (details below).</li> </ul>

#### Agenda

	Topic	Brought By	Time	MINUTES
1.	Standing Items: <ul style="list-style-type: none"> <li>Approval of minutes</li> <li>Action Items review</li> <li>Parking lot review</li> <li>Medical/Pharmacy Directors' Dashboards (ad hoc discussion – odd months only: Jan, March, May, July, Sept. Nov)</li> </ul>	Matija	2:00 – 2:05	<ul style="list-style-type: none"> <li>The February 2021 minutes were approved with no modifications.</li> <li>Director's Dashboard               <ul style="list-style-type: none"> <li>The number of inpatient authorizations are declining; perhaps an indicator of the declining impact of COVID related medical issues.</li> <li>PDR metrics                   <ul style="list-style-type: none"> <li>Discussed the continued decline in overturn rates.</li> </ul> </li> <li>An increase in CHN out-of-medical-group (OOMG) specialty referrals; potentially due to the pandemic causing limited access to in-medical group specialty providers and shifting to using OOMG specialty providers.                   <ul style="list-style-type: none"> <li>However, the total number of specialty referrals has not increased.</li> <li>There are no waiting lists for OT, PT, ST by allowing referrals to OOMG providers.</li> </ul> </li> </ul> </li> <li>Action Items               <ul style="list-style-type: none"> <li>See below for updates</li> </ul> </li> </ul>

2. d	<ul style="list-style-type: none"> <li>Medical/Pharmacy Appeals: Upheld and Overturned</li> <li>Independent Medical Review (IMR)</li> <li>State Fair Hearings (SFH)</li> </ul>	<ul style="list-style-type: none"> <li>Monica</li> <li>Ralph Crowder</li> <li>Kandice/Betty</li> </ul>	2:05 – 2:10	<ul style="list-style-type: none"> <li>UM – Appeals - 3 <ul style="list-style-type: none"> <li>Upheld appeals – 3 <ul style="list-style-type: none"> <li>The appeal of the denial of semen analysis. <ul style="list-style-type: none"> <li>The analysis is an infertility diagnostic procedure, and a non-covered benefit.</li> <li>The Member Handbook was updated.</li> </ul> </li> </ul> </li> <li>Overturned appeals - 0</li> </ul> </li> <li>Pharmacy – Appeals - 11 <ul style="list-style-type: none"> <li>Upheld appeals – 6 <ul style="list-style-type: none"> <li>No change to policy or processes.</li> </ul> </li> <li>Overturned appeals – 5 <ul style="list-style-type: none"> <li>The appeal concerning SFHP criteria used for review of enteral nutrition products will be reviewed for potential update.</li> <li>The appeal of the denial of Vemlidy 25mg. The appealing provider submits @60% of all Vemlidy appeals. Proposed to follow-up w/ the provider.</li> </ul> </li> </ul> </li> <li>Compliance <ul style="list-style-type: none"> <li>IMR – 0</li> <li>SFH – 2 <ul style="list-style-type: none"> <li>Will be updating SFHP billing rules/Customer Service policy change: If a member is accessing services from a OOMG rendering provider, the provider must be a Medi-Cal provider.</li> </ul> </li> <li>Consumer Complaint – 1 <ul style="list-style-type: none"> <li>No change to policy or process.</li> </ul> </li> </ul> </li> </ul>
3.	DHCS 2021 Audit	Matija	2:10 – 2:20	<ul style="list-style-type: none"> <li>Debriefing Team <ul style="list-style-type: none"> <li>The final findings are usually provided in July/August.</li> <li>DHCS audit team's closing remarks and preliminary findings are: <ul style="list-style-type: none"> <li>PCS (Physician Certification Statement) forms were missing from the NEMT (non-emergency medical transport) files. <ul style="list-style-type: none"> <li>The sister plans also have the same issue.</li> </ul> </li> </ul> </li> </ul> </li> </ul>

				<ul style="list-style-type: none"> <li>There is no added clinical value to having a PCS submitted and perhaps this would be a follow-up with DHCS to reconsider the need for this requirement.</li> <li>Concern about denying retro requests for EPSDT services.</li> <li>The proposed CO-57 realigned criteria hierarchy is not aligned with FFS. <ul style="list-style-type: none"> <li>Partnership uses the same criteria hierarchy and has received no negative feedback from DHCS.</li> </ul> </li> <li>Will be having a meeting with the MGC Team about including a Home Care module in Essette for in-medical-group/in-network providers.</li> </ul>
4.	Private Duty Nursing Criteria (PP) – Retire?	Monica/Tamsen	2:20 – 2:30	<ul style="list-style-type: none"> <li>MGC criteria includes PDN criteria, potentially making the current PDN unnecessary. <ul style="list-style-type: none"> <li>Currently, Clin Ops is not licensed for the home care module in MCG. <ul style="list-style-type: none"> <li>Will be talking to MCG on 4.8.21 about this.</li> </ul> </li> <li>PP CO-33: III. EPSDT Supplemental Nursing Services</li> <li>PP CO-57: 3. EPSDT Private Duty Nursing (p. 2)</li> <li>SFHP EPSDT Private Duty Nursing Medical Necessity Criteria (Provider facing document).</li> </ul> </li> </ul>
	MRIOA and LGBTQ+ Health Expertise	Tamsen	2:30 – 2:40	<ul style="list-style-type: none"> <li>Discussion of a MRIOA review of Transgender Health care request.</li> </ul>
5.	Specialty Referral Report	Kirk	2:40 – 2:50	<ul style="list-style-type: none"> <li>Walk through the document <i>Specialty Referral Report Q2/Q3 – 2020</i>. <ul style="list-style-type: none"> <li>An improvement suggested was to provide a metric of what percentage of total authorizations are specialty referrals.</li> <li>The potential reasons for no claims being attached to a specialty referral are: <ul style="list-style-type: none"> <li>No claim due to a member switching to a new medical group.</li> </ul> </li> </ul> </li> </ul>



				<ul style="list-style-type: none"> <li>There is a 1-year cap on having to submit a claim; therefore, some providers might yet have to submit a claim.</li> </ul>
6.	Recap / Action Item Review	Kirk	2:50 – 2:55	<ul style="list-style-type: none"> <li>Need to discuss consent calendar, e-vote, and reportage calendar.</li> <li>Report cycle</li> </ul>

#### 4.07.21 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Tony / Sandra	<ul style="list-style-type: none"> <li>Begin including the Pharmacy Dashboard review at UMC.</li> </ul>	<ul style="list-style-type: none"> <li>Completed.</li> <li>4.27.21 – first dashboard provided for the May UMC (5.5.21)&gt;</li> </ul>
2.	Kirk	<ul style="list-style-type: none"> <li>Move the following item to the May UMC Agenda: MRloA and LGBTQ+ Health Expertise</li> </ul>	<ul style="list-style-type: none"> <li>4.28.21</li> <li>Will not be included in the May UMC agenda; will be handled directly with MRloA by email.</li> </ul>
3.	Pharmacy Team	<ul style="list-style-type: none"> <li>The appeal concerning SFHP criteria used for review of enteral nutrition products will be reviewed for potential update.</li> <li>Grievance ID MA210318001</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
4.	Lisa Ghotbi	<ul style="list-style-type: none"> <li>Potential follow-up with the provider who submitted the appeal (Grievance ID MA210326001) for Vemlidy 25mg.</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
5.	Monica	<ul style="list-style-type: none"> <li>Regarding the DHCS requirement to obtain a PCS form for NEMT requests; will poll the sister plans about this requirement.</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
6.	Kirk	<ul style="list-style-type: none"> <li>Specialty Referral report</li> <li>The one improvement suggested was to provide a metric of what percentage of total auths are specialty referral.</li> </ul>	<ul style="list-style-type: none"> <li>Completed</li> <li>Expanded metrics will be included in the Q4-2020 Special Referral Report at the June UMC (consent calendar)</li> </ul>

#### 2.16.21 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	April	<ul style="list-style-type: none"> <li>Conduct a review of the DMGs' clinical criteria hierarchy, and then review any deviations from SFHP's hierarchy.</li> <li>Inform the DMGs that any of their medical decisions reviewed on appeal are subject to CO-57 criteria hierarchy.</li> </ul>	<ul style="list-style-type: none"> <li>4.7.21 <ul style="list-style-type: none"> <li>Details in appendix.</li> <li>Kaiser's response is still pending.</li> </ul> </li> </ul>
2.	April/Kirk/Morgan	<ul style="list-style-type: none"> <li>Update CO-57 and the Provider Manual to reflect the delegate clinical criteria hierarchy monitoring process and state SFHP's criteria hierarchy will be applied to appeals.</li> </ul>	<ul style="list-style-type: none"> <li>4.13.21 <ul style="list-style-type: none"> <li>DHCS approved CO-57 policy w/ hierarchy changes</li> </ul> </li> </ul>
3.	Monica	<ul style="list-style-type: none"> <li>No prior authorization will be required for BPM.</li> <li>Work with the Configuration Team to set BPM benefit limits.</li> <li>Work with the Fraud, Waste Abuse Team (Compliance) regarding ability for Pondera software to monitor BPM claims.</li> <li>Work with PNO regarding access to quality BPMs at Medi-Cal prices.</li> </ul>	<ul style="list-style-type: none"> <li>No update.</li> <li>Will take about a month for the Pondera software to be configured.</li> <li>Monica will follow—up.</li> </ul>
4.	Matija	<ul style="list-style-type: none"> <li>Will track the Governor's budget to confirm CGMs are a confirmed Medi-Cal benefit. and if coverage date remains 1/1/22.</li> </ul>	<ul style="list-style-type: none"> <li>In progress</li> </ul>
5.	Tamsen	<ul style="list-style-type: none"> <li>Will follow-up with the Pharmacy/PNO for potential of local pharmacies having/obtaining licenses to supply DME in order to provide DME like CGMs after Medi-CalRx go-live.</li> </ul>	<ul style="list-style-type: none"> <li>This process will continue once the Medi-Cal Rx transition update from the State in May is announced.</li> </ul>

#### 1.19.21 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Monica	<ul style="list-style-type: none"> <li>PA TAT Tables: formally requesting IT Team to assist in correcting this issue.</li> </ul>	In progress

2.	Betty	<ul style="list-style-type: none"> <li>Will review the Med-Cal contract/DHCS to determine if DMGs are required to adopt and follow CO-57's criteria hierarchy.</li> </ul>	<ul style="list-style-type: none"> <li>Completed</li> </ul>
3.	Kirk	<ul style="list-style-type: none"> <li>Create a Consent Calendar section for the agenda/minutes UMC template</li> </ul>	<ul style="list-style-type: none"> <li>Completed; in process of creating an appendix of the full reportage suite UMC is responsible for.</li> </ul>

#### 12.15.20 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Tamsen	<ul style="list-style-type: none"> <li>CPAP follow-up</li> <li>Working w/ Katy Shaffer to dive deeper into the utilization data.</li> <li>Need to provide a 6-month impact analysis of the PA removal and report to UMC.</li> </ul>	<ul style="list-style-type: none"> <li>Updated will be on the 6.21 UMC agenda.</li> </ul>

#### 11.20.20 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Monica	<ul style="list-style-type: none"> <li>Working with PNO &amp; IT Teams regarding the claim edits issues arising from the issue of UCSF clinical affiliations not currently configured.</li> </ul>	<ul style="list-style-type: none"> <li>Will be raising the issue in January 2021 at the monthly C-4 meeting.</li> </ul>
2.	Tony	<ul style="list-style-type: none"> <li>To include the authorization dashboard in future meetings when the director's dashboard is discussed.</li> <li>The director's dashboard will be moved to Tableau by 1.21.</li> </ul>	<ul style="list-style-type: none"> <li>4.5.21</li> <li>In progress.</li> <li>Expected move to Tableau @June 2021.</li> </ul>

#### 9.15.2020 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Monica / Tamsen (?) / Morgan (?)	<ul style="list-style-type: none"> <li>Roll out to the DMGs the updated critical hierarchy in CO-57.</li> <li>File updated version of PP CO-57 with DHCS as a "file-and-use" status</li> </ul>	<ul style="list-style-type: none"> <li>CO-57 passed @ Nov PCC (11/18). After required signatures are</li> </ul>

		<ul style="list-style-type: none"> <li>On DHCS approval of the revisions to PP-CO-57, will require updates to: <ul style="list-style-type: none"> <li>PP CO-22</li> <li>Some desk-top-procedures</li> <li>2 Essette assessments</li> <li>LMS criteria course</li> <li>Additional staff training</li> </ul> </li> <li>Communication to DMEs</li> </ul>	<p>obtained (CEO &amp; CMO), Morgan will request PNO disburse update to DMGs.</p> <ul style="list-style-type: none"> <li>After DHCS approval (minimum of 60 days) it is estimated about 2-months to complete all internal/external updates.</li> </ul>
2.	Monica / Angie	<ul style="list-style-type: none"> <li>Will work with PNO about the GAFS surgeons' proposal for increasing their ownership role in surgery coordination.</li> </ul>	<ul style="list-style-type: none"> <li>4.4 – currently undergoing another round of reviews by the Clinical Operations Team.</li> <li>On the UMC meeting agenda for May 2020.</li> </ul>

#### 8.18.2020 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	April	<ul style="list-style-type: none"> <li>Follow-up on ASH's action steps to correct the NOA issue.</li> </ul>	<ul style="list-style-type: none"> <li>This will be requested from ASH in their CAP.</li> <li>When the CAP is response is available, will update.</li> </ul>

#### 4.21.2020 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Maxine / Kirk	<ul style="list-style-type: none"> <li>Per Jim the following adjustment/consideration, due to COVID-19, needs to be made when assessing the metrics for the following quarters – conduct a</li> </ul>	<ul style="list-style-type: none"> <li>On the April UMC meeting agenda.</li> <li>Completed.</li> </ul>

		90, 120, 180 review of the non-attached to a claim referral. This will impact for the following quarters: ○ Q1, Q2, Q3	
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#### Parking Lot

7.21.2020	Tamsen Staniford	<ul style="list-style-type: none"> <li>Will work with the Claims Team on the issue of removing auth requirements for both J3490 and J8499: <ul style="list-style-type: none"> <li>Follow-up on the suggestion of raising the threshold of approving a claim with no auth from \$25 to \$200.</li> <li>In the past, there were issues with setting a \$25 limit, need to confirm if those same issues will occur if a \$25 limit is executed.</li> <li>Are there provider contracts in place obligating SFHP to pay a percentage of bill charges if the auth requirements are removed? This may not apply if only removing the auth requirements for codes (J3490 and J8499) that are below \$25.</li> <li>On obtaining the answers, bring back to UMC August meeting (8.18) and a formal vote will be held to approve the final</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Change has been successful in reducing claims edits to manually work from hundreds to less than 10 a week.</li> <li>Report to ensure no claims over \$25 for either code is working as expected.</li> <li>No additional financial risk or side effects of change have been identified.</li> </ul>
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		<p>recommendation for not requiring an authorization for claims below a certain dollar threshold.</p> <ul style="list-style-type: none"> <li>When the final recommendation is approved, there will be a 6-month follow-up to determine the impact of this change on claims associated with J3490 and J8499.</li> </ul>	
6.16.20	Monica	<ul style="list-style-type: none"> <li>Will review the Private Duty Nursing EPSDT criteria at the <b>June 2021</b> UMC meeting</li> </ul>	<ul style="list-style-type: none"> <li>Has been placed on the <b>June 2021</b> UMC agenda</li> </ul>
3.17.20	Monica / Jim	Add to the JOC agenda the issue of members who have never contacted their assigned PCP, leading in some cases to accessing OOMG/OOA providers.	<ul style="list-style-type: none"> <li>On hold to further notice.</li> </ul>
1.21.20	Kirk / Katy Shaffer	<ul style="list-style-type: none"> <li>A "cheat-sheet" for the Utilization Trending Service report/tool.</li> </ul> <p>Create a resource by providing screen shots with explanatory labels.</p>	2.21 – is considered a low priority given shifts in other high priority projects; will be completed by June UMC.

<b>Membership and Voting Rights</b>	<p>The UMC membership, with voting rights on all motions, consists of:</p> <ul style="list-style-type: none"> <li>Chief Medical Officer, MD</li> <li>Associate Medical Director, MD</li> <li>Senior Manager, Prior Authorization, RN</li> <li>UM Nurse Manager, Prior Authorizations, RN</li> <li>Manager, Concurrent Review and Care Transitions, RN</li> <li>Program Manager, Utilization Management, PhD</li> <li>Director, Pharmacy, Pharm.D.</li> <li>Manager, Pharmacy, RPh.</li> </ul> <p>The UMC membership, with voting rights limited to behavioral health and mental health motions, consists of:</p> <ul style="list-style-type: none"> <li>Director of Clinical Services – Beacon Health Options (ad hoc)</li> </ul>
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	<ul style="list-style-type: none"> <li>○ Valid State Clinical License required (RN, LCSW, LMFT, PhD or PsyD)</li> <li>• Medical Director (MD/ Psychiatry) – College Health IPA (Beacon Health Options) (ad hoc)</li> </ul>
Quorum	<ul style="list-style-type: none"> <li>• A quorum of the UMC is five members with at least one representative from Clinical Operations, Pharmacy, and the Medical Director staff.</li> <li>• At least one behavioral health representative must also be in attendance to conduct any business related to behavioral health benefits.</li> </ul>

## Appendix

AuthSubClass January 2021	Total Count
Acute Inpatient	389
Acute Rehab	1
Chemotherapy	22
Diagnostics and Procedures	93
Dialysis	3
Durable Medical Equipment	151
ED to IP	10
Home Health Care	42
Home Hospice	1
Home Infusion	10
Maternity	85
Medical Supplies	135
Office Visits	451
Orthotics & Prosthetics	24
Outpatient Services	65
Pediatric/Neonatal	33
Portal DME/Med Supplies	11
PT, OT, ST	55
Radiation Oncology	15
Radiology	119
Skilled Nursing Facility	17
Surgeries with Anesthesia	42
Transgender Services	59
Transportation	26



<b>AuthSubClass February 2021</b>	<b>Total Count</b>
Acute Inpatient	356
Acute Rehab	6
Carve-Out	2
Chemotherapy	15
Diagnostics and Procedures	108
Dialysis	3
Durable Medical Equipment	139
ED to IP	9
Home Health Care	26
Home Hospice	3
Home Infusion	5
Maternity	68
Medical Supplies	142
Office Visits	471
Orthotics & Prosthetics	16
Outpatient Services	85
Pediatric/Neonatal	31
Portal DME/Med Supplies	8
PT, OT, ST	60
Radiation Oncology	17
Radiology	127
Skilled Nursing Facility	52
Surgeries with Anesthesia	33
Transgender Services	52
Transportation	27

Month	Year	Inpatient Auth Count	Outpatient Auth Count
February	2020	542	1565
March	2020	536	1429
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May	2020	464	1033
June	2020	504	1243
July	2020	523	1199
August	2020	516	1330
September	2020	502	1220
October	2020	584	1348
November	2020	577	1118
December	2020	540	1195
January	2021	545	1314
February	2021	526	1335

#### 2.16.21 Follow-up

April	<ul style="list-style-type: none"><li>• Conduct a review of the DMGs' clinical criteria hierarchy, and then review any deviations from SFHP's hierarchy.</li><li>• Inform the DMGs that any of their medical decisions reviewed on appeal are subject to CO-57 criteria hierarchy.</li></ul>
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#### **DMG Criteria Hierarchy**

##### **HIL:**

1. Medicare Guidelines (if applicable), Local Coverage Determinations (LCD), CMS National Coverage Determinations (NCD)  
-Additional Medicare regulations, manuals and instructions including but not limited to the following may be applied:
  - Medicare Benefit Policy Manual
  - Medicare Claims Processing Manual
  - Medicare Managed Care Manual
  - Coverage decisions by local Medicare Administrative Contractors (MACs)
  - Local Coverage Articles
  - MLN Matters \* National Coverage Analyses (NCAs) \* CMS Drug Compendia
2. Medi-Cal Guidelines (if applicable)
3. Health Plan Guidelines
4. MCG Guidelines or Nationally Recognized Evidenced Based Criteria
5. Hill Physicians Medical Group/IPA Guidelines (not applicable for SCAN members)

##### **BTP:**

1. CMS Criteria, if established, is the primary criteria to be utilized by the delegated Provider Organization for Medicare and Medi-Cal UM determinations.
2. The order of medical criteria to be utilized by the delegated Provider Organization for Medicare UM determinations is as follows:
  - a) National Coverage Determination (NCD) [Medicare Program Integrity Manual, Chapter 13]
  - b) Federal Statute/CMS Coverage Manuals i. Medicare Policy Benefit Manual, ii. Medicare Managed Care Manual, iii. Medicare Claims Processing Manual, and iv. Medicare Learning Network 6 | P a g e
  - c) Local Coverage Determinations (LCD) [Medicare Program Integrity Manual]
  - d) CMS Drug Compendia
  - e) Health Plan Clinical/Medical Policies and Guidelines
  - f) Evidence-Based Medical Necessity Criteria derived from randomized controlled trials (RCTs) or systematic review and meta-analysis of multiple RCTs including other published criteria such as InterQual or Milliman Care Guidelines (MCG)

g) Brown and Toland Physicians Clinical Guidelines and Policies, if no other criteria are available. BTP Clinical Guidelines and Policies are developed with guidance from related specialists and the UM Committee.

**CCHCA:**

1. National and Local Coverage Determination (Medicare Determinations)
2. California Department of Health Services (DHCS) Medi-Cal criteria
3. Health Plan internally developed and approved criteria
4. MCG®
5. Specialty guidelines, as published by individual specialty organizations as well as government agencies including but not limited to National Comprehensive Cancer Network (NCCN), AIM guidelines, World Professional Association for Transgender Health (WPATH), etc.


**NEMS:**

NEMS' clinical criteria hierarchy in order includes:

1. Federal/State mandates (Medi-Cal/CMS) criteria
2. Health plan adopted Guidelines (San Francisco Health Plan, Anthem Blue Cross adopted the AIM Radiology Guidelines, Anthem Medical Policy, and Anthem UM Clinical Guidelines)
3. MCG Health
4. NEMS MSO Medical Director or physician designee review of the evidence in consultation with relevant external, independent specialty expertise obtained from NEMS' Independent Review Organization when there are no available criteria.

**JADE:**

1. State and Federal (CMS) Mandates and Guidelines
2. Member Benefits
3. InterQual
4. CCHP medical policy for CCHP member authorization requests
5. Health Plan medical policies and benefits for which we are TPA
6. Hayes Medical Technology Directory
7. National standards reflecting best practice
8. Other sources as appropriate and available.

 <p><b>SAN FRANCISCO HEALTH PLAN</b></p>	<p><b>Utilization Management Committee (UMC)</b>  <b>5 May 2021</b>  <b>2PM – 3PM</b></p> <p><b>Meeting Invite / Conference connection through Microsoft Teams</b></p>	
<b>Meeting called by:</b>	Matija Cale	
<b>Type of meeting:</b>	Mandatory – Monthly Recurring	<b>Recorder:</b> K. M. McDonald
<b>Present:</b>	<p><u><b>Clinical Operations</b></u>  Matija Cale, Monica Baldzikowski; SeDessie Harris, Tamsen Staniford; Kirk McDonald; April Tarpey; Morgan Kerr; Ravid Abraham; Jim Glauber; Tony Tai; Maxine Casey; Fiona Donald; Jim Glauber</p> <p><u><b>Pharmacy</b></u>  Ralph Crowder, Lisa Ghotbi</p>	<p><u><b>Compliance</b></u>  Betty DeLos Reyes Clark; Crystal Garcia</p> <p><u><b>Access and Care Experience</b></u>  Ralph Custodio; Amy Petersen, Jesse Chairez, Grace Carino</p> <p><u><b>Guests</b></u>  Julie Thai, Courtney Spalding</p>
<b>Not Present:</b>		
<p><b>Quorum (details after the <i>Action Items</i> section below)</b></p> <p><b>April Meeting:</b></p>	<ul style="list-style-type: none"> <li>• Chief Medical Officer, MD (Fiona Donald)</li> <li>• Senior Manager, Prior Authorization, RN</li> <li>• Program Manager, Utilization Management, PhD</li> <li>• Manager, Pharmacy, RPh.</li> <li>• Director, Clinical Operations, RN</li> <li>• Director, Pharmacy, Pharm. D.</li> <li>• UM Nurse Manager, Prior Authorizations, RN</li> <li>• Manager, Concurrent Review and Care Transitions, RN</li> </ul> <p>Not Present:</p>	
<b>Documents Presented:</b>	<p>Draft_UMC_May_Agenda_v4.28.21  Draft_UMC_April_Minutes_v4.27.21  UM Director Dashboard_March 2021_04 13 21  CMO HS Dashboard March 2021_04 28 21</p>	

	Pharmacy_Dashboard_Mar 2021_04_26_21 Appeals_Data_Q1_2021_v.5.5.21 MCG 24th Edition Summary of Changes Overview MCG 24th Edition Summary of Changes EssetteAuths_March 2021_4 12 2021
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**Commented [MK1]:** This is the inaugural oversight of the Appeals process by UMC. Documented in the 2021 UM Evaluation Report.

#### Consent Calendar

ITEM #	Document	Review Schedule	Outcome
1.	UM Program Description UM1_ElemA_Factors1,3,5,6_2020_UMProgDescrip_v9.17.20	<ul style="list-style-type: none"> <li>Annual (Q1)</li> <li>Evote (2.26.21)</li> </ul>	<ul style="list-style-type: none"> <li>Approved by quorum.</li> </ul>
2.	UM Program Evaluation 1.1.A.1_DHCS_UMProgEval-2020_v1.14.21a	<ul style="list-style-type: none"> <li>Annual (Q1)</li> <li>Evote (2.26.21)</li> </ul>	<ul style="list-style-type: none"> <li>Approved by quorum.</li> </ul>
3.	Specialty Referral Report Q2/Q3 – 2020	<ul style="list-style-type: none"> <li>April 2021 UMC Meeting</li> </ul>	<ul style="list-style-type: none"> <li>Reviewed by UMC; will need to provide a metric improvement (details below).</li> </ul>

#### Agenda

	Topic	Brought By	Time	MINUTES
1.	Standing Items: <ul style="list-style-type: none"> <li>Approval of minutes</li> <li>Action Items review</li> <li>Parking lot review</li> <li>Medical/Pharmacy Directors' Dashboards (ad hoc discussion – odd months only: Jan, March, May, July, Sept. Nov)</li> </ul>	Matija	2:00 – 2:05	<ul style="list-style-type: none"> <li>April minutes were approved (quorum met).</li> <li>Director's Dashboard <ul style="list-style-type: none"> <li>Specialty referrals have increased; potentially due to the post-pandemic appointment catch up.</li> <li>Subacute days have decreased. <ul style="list-style-type: none"> <li>There is a 1-2 month lag in the data; June's dashboard might have a more accurate metric measure for May.</li> <li>There have been some placement issues related to the COVID lockdown.</li> </ul> </li> <li>Clinical Ops TAT <ul style="list-style-type: none"> <li>The graph shows the PA routine authorizations TAT as trending down.</li> <li>This is not an accurate portrayal because of a data issue with how the TAT are calculated.</li> <li>The PA routine authorizations are being completed by day 4 or 5.</li> </ul> </li> </ul> </li> </ul>

				<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>TAT is calculated hourly, not by the day as the State (DHCS) monitors.</li> </ul> </li> <li>Pharmacy Dashboard           <ul style="list-style-type: none"> <li>Appeal &amp; Overturn Rates of Denied PA               <ul style="list-style-type: none"> <li>Overturned appeals rate remains steady.</li> </ul> </li> <li>PA Average Turn Around Time (minus RFI's)               <ul style="list-style-type: none"> <li>Goal is 6 hours rather than 24 hours.</li> </ul> </li> <li>What is driving an increase in prior authorization requests?               <ul style="list-style-type: none"> <li>The Y axis is scale begins at 475 vs. 0.</li> <li>Certain classes of drugs requested, e.g., Acne medications, can drive up the number of auths.</li> <li>The P&amp;T Committee does review this type of activity.</li> <li>The increase in March potentially due to the increase in accessing routine healthcare post-pandemic.</li> <li>5-6 classes of drugs are reviewed every quarter; the appeals rate is reviewed to determine if a prior authorization requirement needs to be removed.</li> </ul> </li> <li>The table Medication Therapy Management Tasks tracks resources.</li> <li>The table Hepatitis C Compliance increases potentially due to increase in medication costs.</li> </ul> </li> <li>Action Items           <ul style="list-style-type: none"> <li>See below for updates</li> </ul> </li> </ul>
2. d	<ul style="list-style-type: none"> <li>Medical/Pharmacy Appeals: Upheld and Overturned</li> <li>Independent Medical Review (IMR)</li> <li>State Fair Hearings (SFH)</li> </ul>	<ul style="list-style-type: none"> <li>Monica</li> <li>Ralph Crowder</li> <li>Kandice/Betty</li> </ul>	2:05 – 2:25	<ul style="list-style-type: none"> <li>Moving forward will only focus on overturned appeals.           <ul style="list-style-type: none"> <li>Should we still review upheld appeals?               <ul style="list-style-type: none"> <li>Will access the need by looking at the appeal trends, denial rates, and assess if a review of upheld appeals is necessary.</li> </ul> </li> </ul> </li> <li>UM – Appeals - 0           <ul style="list-style-type: none"> <li>Upheld appeals – 0</li> <li>Overturned appeals - 0</li> </ul> </li> <li>Pharmacy – Appeals - 1           <ul style="list-style-type: none"> <li>Upheld appeals – 1</li> <li>Overturned appeals – 0</li> </ul> </li> <li>Compliance</li> </ul>

**Commented [MK2]:** This is the inaugural presentation of the RX Dashboard. Document in the UM 2021 Evaluation.

**Commented [MK3]:** The inaugural presentation of a new type of Action Item table in June 2021.

				<ul style="list-style-type: none"> <li>○ IMR – 0</li> <li>○ SFH – 1</li> <li>○ Consumer Complaint – 3 <ul style="list-style-type: none"> <li>▪ Kybella treatments from an out-of-network (OON) provider.</li> <li>▪ Member seeking reimbursement for OON costs.</li> <li>▪ Due to misinformation and communication with the member, to preserve goodwill, agreed to overturn the denial. However, moving forward, member needs to use in-network providers.</li> </ul> </li> <li>• Discussed a biofeedback complaint. <ul style="list-style-type: none"> <li>○ A delegated medical group (DMG) denied a request for biofeedback based on medical necessity.</li> <li>○ Biofeedback is not a covered benefit.</li> <li>○ Raises the issue – medical necessity vs. non-covered benefits. <ul style="list-style-type: none"> <li>▪ Need to be consistent in medical decision outcomes.</li> <li>▪ Need to first assess if the request meets medical necessity, rather than preferencing whether a benefit is covered or non-covered.</li> </ul> </li> </ul> </li> </ul>
3.	MCG Upgrade - Summary of Changes	Courtney Spalding / Julie Thai	2:45 – 2:55	<ul style="list-style-type: none"> <li>• UMC voted (quorum met) to approve the upgrade to MCG 24<sup>th</sup> Edition.</li> <li>• MCG went live 4.22.21 and all staff, module training has been completed.</li> </ul>
4.	UMC Quarterly Oversight of Appeals Activity	Ralph Custodio / Grace Carino	2:25 – 2:45	<ul style="list-style-type: none"> <li>• Q1-2021 Report <ul style="list-style-type: none"> <li>○ There were 20 appeals for Q1-2021.</li> <li>○ Providers are the main initiators of appeals.</li> <li>○ The turn-around-time target is 98%. <ul style="list-style-type: none"> <li>▪ Acknowledgment Letter = 100% TAT</li> <li>▪ Resolution Letter = 98.5% TAT</li> <li>▪ Expedited Cases = 97.25% TAT</li> </ul> </li> <li>○ The A&amp;G Team's internal audit is focused on compliance with regulatory/accreditation requirements. <ul style="list-style-type: none"> <li>▪ No IRR is conducted.</li> </ul> </li> </ul> </li> </ul>
5.	Recap / Action Item Review	Kirk	---	<ul style="list-style-type: none"> <li>• To be provided via email.</li> </ul>

**Commented [MK4]:** Was documented in the decision log.

**Commented [MK5]:** This is the inaugural Appeal oversight report – Q1-2021.



#### 4.07.21 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Tony / Sandra	<ul style="list-style-type: none"> <li>Begin including the Pharmacy Dashboard review at UMC.</li> </ul>	<ul style="list-style-type: none"> <li>Completed.</li> <li>4.27.21 – first dashboard provided for the May UMC (5.5.21)&gt;</li> </ul>
2.	Kirk	<ul style="list-style-type: none"> <li>Move the following item to the May UMC Agenda: MRloA and LGBTQ+ Health Expertise</li> </ul>	<ul style="list-style-type: none"> <li>Completed <ul style="list-style-type: none"> <li>Will be handled through correspondence.</li> </ul> </li> </ul>
3.	Pharmacy Team	<ul style="list-style-type: none"> <li>The appeal concerning SFHP criteria used for review of enteral nutrition products will be reviewed for potential update.</li> <li>Grievance ID MA210318001</li> </ul>	<ul style="list-style-type: none"> <li>5.5.21 <ul style="list-style-type: none"> <li>Ralph will follow-up and provide update at the June UMC meeting.</li> </ul> </li> </ul>
4.	Lisa Ghotbi	<ul style="list-style-type: none"> <li>Potential follow-up with the provider who submitted the appeal (Grievance ID MA210326001) for Vemlidy 25mg.</li> </ul>	<ul style="list-style-type: none"> <li>5.5.21</li> <li>Ralph will follow-up and provide update at the June UMC meeting</li> </ul>
5.	Monica	<ul style="list-style-type: none"> <li>Regarding the DHCS requirement to obtain a PCS form for NEMT requests; will poll the sister plans about this requirement.</li> </ul>	<ul style="list-style-type: none"> <li>Completed</li> <li>All Sister plans use the PCS form (standard and customized versions).</li> </ul>
6.	Kirk	<ul style="list-style-type: none"> <li>Specialty Referral report</li> <li>The one improvement suggested was to provider a metric of what percentage of total auths are specialty referral.</li> </ul>	<ul style="list-style-type: none"> <li>Completed</li> <li>Expanded metrics will be included in the Q4-2020 Special Referral Report at the June UMC (consent calendar)</li> </ul>

#### 2.16.21 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
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1.	April	<ul style="list-style-type: none"> <li>Conduct a review of the DMGs' clinical criteria hierarchy, and then review any deviations from SFHP's hierarchy.</li> <li>Inform the DMGs that any of their medical decisions reviewed on appeal are subject to CO-57 criteria hierarchy.</li> </ul>	<ul style="list-style-type: none"> <li>5.3.21 – Completed.</li> <li>Kaiser does not use a criteria hierarchy per se, they objectively assess the member's needs and local delivery system to make decision. Since Kaiser handle's its own appeals and grievances, our CO-57 for appeal review does not apply.</li> </ul>
2.	April/Kirk/Morgan	<ul style="list-style-type: none"> <li>Update CO-57 and the Provider Manual to reflect the delegate clinical criteria hierarchy monitoring process and state SFHP's criteria hierarchy will be applied to appeals.</li> </ul>	<ul style="list-style-type: none"> <li>4.13.21</li> <li>DHCS approved CO-57 policy w/ hierarchy changes</li> </ul>
3.	Monica	<ul style="list-style-type: none"> <li>No prior authorization will be required for BPM.</li> <li>Work with the Configuration Team to set BPM benefit limits.</li> <li>Work with the Fraud, Waste Abuse Team (Compliance) regarding ability for Pondera software to monitor BPM claims.</li> <li>Work with PNO regarding access to quality BPMs at Medi-Cal prices.</li> </ul>	<ul style="list-style-type: none"> <li>Will take about a month for the Pondera software to be configured.</li> <li>Tentatively, will be covered by Pharmacy.</li> <li>Continuous Glucose Monitors <ul style="list-style-type: none"> <li>Pharmacy vs. LOA arrangement</li> <li>Will continue to be available through Pharmacy.</li> </ul> </li> </ul>
4.	Matija	<ul style="list-style-type: none"> <li>Will track the Governor's budget to confirm CGMs are a confirmed Medi-Cal benefit. and if coverage date remains 1/1/22.</li> </ul>	<ul style="list-style-type: none"> <li>In progress</li> </ul>
5.	Tamsen	<ul style="list-style-type: none"> <li>Will follow-up with the Pharmacy/PNO for potential of local pharmacies having/obtaining licenses to supply</li> </ul>	<ul style="list-style-type: none"> <li>This process will continue once the Medi-Cal Rx transition update</li> </ul>

		DME in order to provide DME like CGMs after Medi-CalRx go-live.	from the State in May is announced. <ul style="list-style-type: none"> <li>• In progress.</li> </ul>
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#### 1.19.21 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Monica	<ul style="list-style-type: none"> <li>• PA TAT Tables: formally requesting IT Team to assist in correcting this issue.</li> </ul>	<ul style="list-style-type: none"> <li>• In progress</li> </ul>

#### 12.15.20 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Tamsen	<ul style="list-style-type: none"> <li>• CPAP follow-up</li> <li>• Working w/ Katy Shaffer to dive deeper into the utilization data.</li> <li>• Need to provide a 6-month impact analysis of the PA removal and report to UMC.</li> </ul>	<ul style="list-style-type: none"> <li>• Updated will be on the 6.21 UMC agenda.</li> </ul>

#### 11.20.20 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Monica	<ul style="list-style-type: none"> <li>• Working with PNO &amp; IT Teams regarding the claim edits issues arising from the issue of UCSF clinical affiliations not currently configured.</li> </ul>	<ul style="list-style-type: none"> <li>• Completed.</li> </ul>
2.	Tony	<ul style="list-style-type: none"> <li>• To include the authorization dashboard in future meetings when the director's dashboard is discussed.</li> <li>• The director's dashboard will be moved to Tableau by 1.21.</li> </ul>	<ul style="list-style-type: none"> <li>• Completed.</li> </ul>

#### 9.15.2020 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Monica / Angie	<ul style="list-style-type: none"> <li>• Will work with PNO about the GAFS surgeons' proposal for increasing their ownership role in surgery coordination.</li> </ul>	<ul style="list-style-type: none"> <li>• 4.28 – continuing to be reviewed.</li> <li>• Potentially will be on the June UMC agenda.</li> </ul>

#### 8.18.2020 – Action Steps, Status, and Final Decision

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	April	<ul style="list-style-type: none"> <li>Follow-up on ASH's action steps to correct the NOA issue.</li> </ul>	<ul style="list-style-type: none"> <li>5.3.21</li> <li>We are expecting ASH's CAP response on 5/24. Will update once received.</li> </ul>

#### Parking Lot

7.21.2020	Tamsen Staniford	<ul style="list-style-type: none"> <li>Will work with the Claims Team on the issue of removing auth requirements for both J3490 and J8499: <ul style="list-style-type: none"> <li>Follow-up on the suggestion of raising the threshold of approving a claim with no auth from \$25 to \$200.</li> <li>In the past, there were issues with setting a \$25 limit, need to confirm if those same issues will occur if a \$25 limit is executed.</li> <li>Are there provider contracts in place obligating SFHP to pay a percentage of bill charges if the auth requirements are removed? This may not apply if only removing the auth requirements for codes (J3490 and J8499) that are below \$25.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Complete</li> </ul>
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		<ul style="list-style-type: none"> <li>○ On obtaining the answers, bring back to UMC August meeting (8.18) and a formal vote will be held to approve the final recommendation for not requiring an authorization for claims below a certain dollar threshold.</li> <li>• When the final recommendation is approved, there will be a 6-month follow-up to determine the impact of this change on claims associated with J3490 and J8499.</li> </ul>	
6.16.20	Monica	<ul style="list-style-type: none"> <li>• Will review the Private Duty Nursing EPSDT criteria at the <b>June 2021</b> UMC meeting</li> </ul>	<ul style="list-style-type: none"> <li>• Has been placed on the <b>June 2021</b> UMC agenda</li> <li>• Will be followed up --- Working w/ MCG on the PDN criteria access for review and evaluation</li> </ul>
3.17.20	Monica / Jim	Add to the JOC agenda the issue of members who have never contacted their assigned PCP, leading in some cases to accessing OOMG/OOA providers.	<ul style="list-style-type: none"> <li>• On hold to further notice.</li> </ul>
1.21.20	Kirk / Katy Shaffer	<ul style="list-style-type: none"> <li>• A "cheat-sheet" for the Utilization Trending Service report/tool. Create a resource by providing screen shots with explanatory labels.</li> </ul>	2.21 – is considered a low priority given shifts in other high priority projects; will be completed by June UMC.

<b>Membership and Voting Rights</b>	<p>The UMC membership, with voting rights on all motions, consists of:</p> <ul style="list-style-type: none"> <li>• Chief Medical Officer, MD</li> <li>• Associate Medical Director, MD</li> <li>• Senior Manager, Prior Authorization, RN</li> <li>• UM Nurse Manager, Prior Authorizations, RN</li> <li>• Manager, Concurrent Review and Care Transitions, RN</li> <li>• Program Manager, Utilization Management, PhD</li> <li>• Director, Pharmacy, Pharm.D.</li> <li>• Manager, Pharmacy, RPh.</li> </ul> <p>The UMC membership, with voting rights limited to behavioral health and mental health motions, consists of:</p> <ul style="list-style-type: none"> <li>• Director of Clinical Services – Beacon Health Options (ad hoc) <ul style="list-style-type: none"> <li>◦ Valid State Clinical License required (RN, LCSW, LMFT, PhD or PsyD)</li> </ul> </li> <li>• Medical Director (MD/ Psychiatry) – College Health IPA (Beacon Health Options) (ad hoc)</li> </ul>
<b>Quorum</b>	<ul style="list-style-type: none"> <li>• A quorum of the UMC is five members with at least one representative from Clinical Operations, Pharmacy, and the Medical Director staff.</li> <li>• At least one behavioral health representative must also be in attendance to conduct any business related to behavioral health benefits.</li> </ul>

## Appendix

March 2021 AuthSubClass	Total Count
Acute Inpatient	456
Acute Rehab	2
Carve-Out	3
Chemotherapy	22
Diagnostics and Procedures	138
Dialysis	1
Durable Medical Equipment	129
ED to IP	6
Home Health Care	40
Home Hospice	2
Home Infusion	18
Maternity	82
Medical Supplies	133
Office Visits	624
Orthotics & Prosthetics	38
Outpatient Services	93
Pediatric/Neonatal	35
Portal DME/Med Supplies	2
PT, OT, ST	82
Radiation Oncology	21
Radiology	164
Skilled Nursing Facility	44
Surgeries with Anesthesia	46
Transgender Services	80
Transportation	33

<b>March 2020 - March 2021 AuthSubClass</b>	<b>Per 1000</b>
Acute Inpatient	202.567
Acute Rehab	1.774
Carve-Out	0.933
Chemotherapy	10.362
Diagnostics and Procedures	62.404
Dialysis	2.427
Durable Medical Equipment	93.769
Home Health Care	13.489
Home Hospice	0.653
Home Infusion	5.928
Maternity	45.181
Medical Supplies	53.956
Office Visits	266.791
Orthotics & Prosthetics	17.830
Outpatient Services	14.142
Pediatric/Neonatal	18.996
Portal DME/Med Supplies	1.307
PT, OT, ST	24.691
Radiation Oncology	7.561
Radiology	78.553
Skilled Nursing Facility	21.097
Surgeries with Anesthesia	19.417
Transgender Services	23.664
Transportation	12.509



Month	Year	Inpatient Auth Count	Outpatient Auth Count
March	2020	536	1429
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May	2020	464	1033
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July	2020	523	1199
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September	2020	502	1220
October	2020	584	1348
November	2020	577	1118
December	2020	540	1195
January	2021	545	1314
February	2021	526	1335
March	2021	545	1314

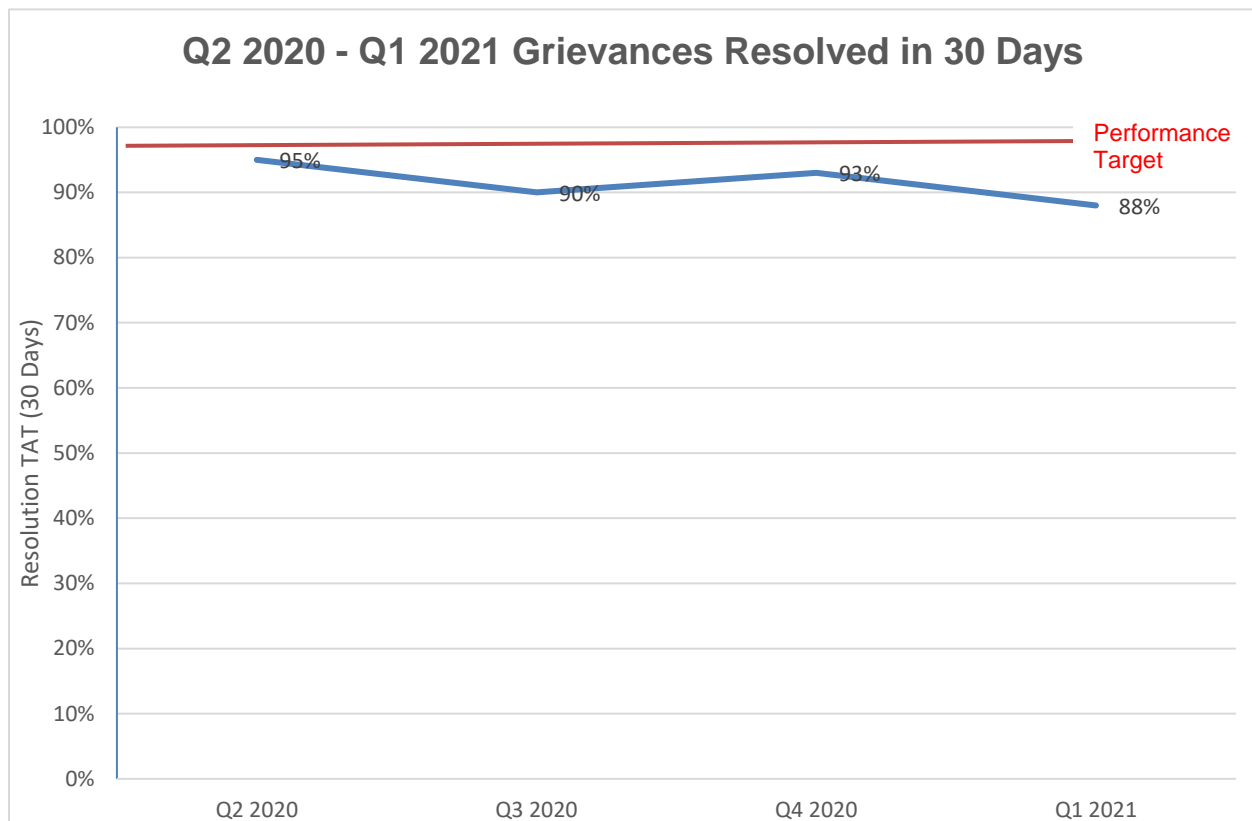
## MEMO

**Date:** June 1, 2021

<b>To</b>	<b>Quality Improvement Committee</b>
<b>From</b>	<b>Grace Cariño, MPH Associate Program Manager, Appeals &amp; Grievances</b>
<b>Regarding</b>	<b>Q1 2021 Grievance Report</b>

- SFHP received a total of 68 grievances in Q1 2021. Overall grievance volume decreased by 7% from 73 total grievances in Q4 2020.
- In Q1 2021, six out of 68 grievances were not closed within the required timeframe of 30 calendar days, as mandated by the Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS).
  - The grievances were not closed within 30 days because additional information was needed for a satisfactory resolution.
- One hundred percent of acknowledgement letters were sent out within five calendar days, as mandated by the Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS).

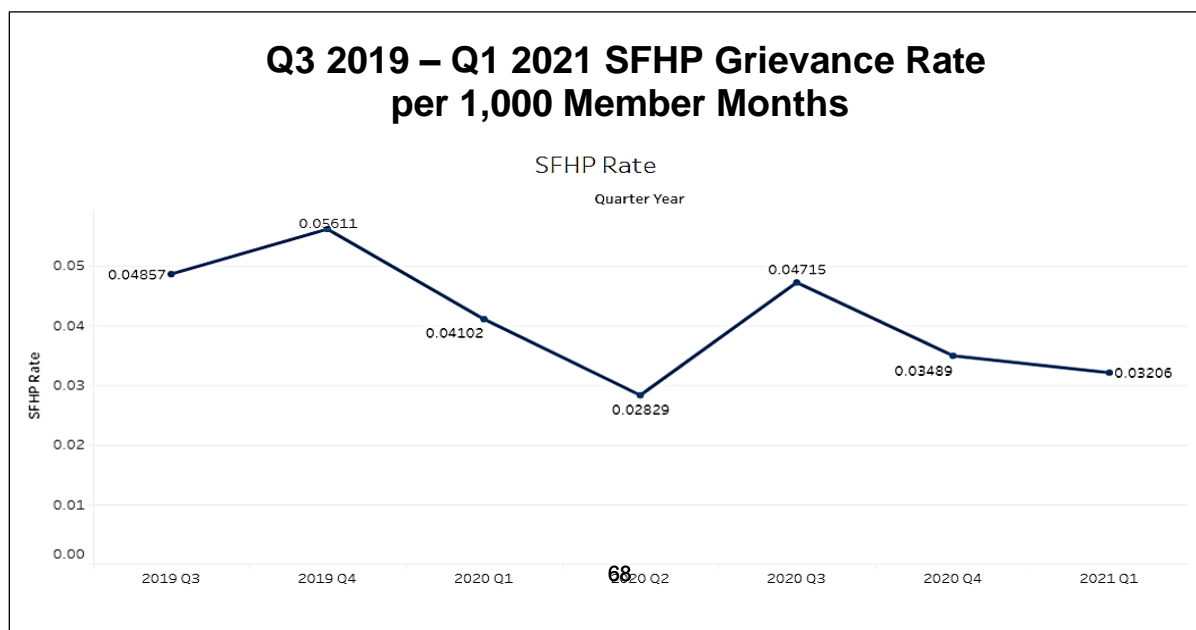
SFHP's performance threshold for closing grievances within the required timeframe of 30 days is 99%. In Q1 2021, the percentage of grievances resolved within 30 calendar days was 88%. SFHP was unable to close three cases within the 30-calendar day timeframe because SFHP did not receive timely grievance investigation responses from providers. SFHP closed these grievances after we received the responses from the providers. Three cases were not closed within the 30-calendar day timeframe because SFHP needed to obtain additional information in order to adequately address the member's concerns. SFHP closed these grievances after we obtained the information needed.



### **SFHP Grievance Rate**

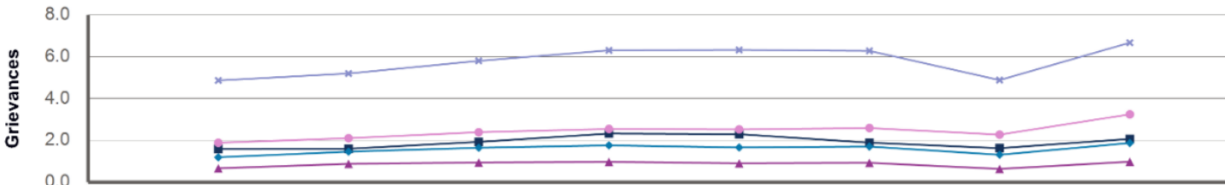
SFHP's grievance rate increased from Q3 2019 to Q4 2019 while the grievance rate significantly decreased in Q1 2020 and Q2 2020 due to the COVID-19 pandemic. SFHP's grievance rate again increased in Q3 2020 then decreased in Q4 2020 and Q1 2021.

SFHP's grievance rate continues to be lower than the DHCS grievance rate. Please see the graph below titled "DHCS Grievance Rates per 1,000 Member Months" for DHCS' grievance rates. Please note DHCS data is two quarters behind.



## DHCS Grievance Rates per 1,000 Member Months

By Population



	2018Q4	2019Q1	2019Q2	2019Q3	2019Q4	2020Q1	2020Q2	2020Q3
Dual	1.6	1.6	1.9	2.3	2.3	1.9	1.6	2.1
MO-ACA	1.9	2.1	2.4	2.5	2.5	2.6	2.3	3.2
MO-OTLIC	0.7	0.9	0.9	1.0	0.9	0.9	0.6	1.0
MO-SPD	4.9	5.2	5.8	6.3	6.3	6.3	4.9	6.7
MO-Other	1.2	1.5	1.7	1.8	1.7	1.7	1.3	1.9
Total	1.6	1.8	2.1	2.2	2.2	2.2	1.8	2.5

\*MO-ACA: Medi-Cal Only Affordable Care Act

\*MO-OTLIC: Medi-Cal Only Optional Targeted Low Income Children

\*MO-SPD: Medi-Cal Only Seniors and Persons with Disabilities

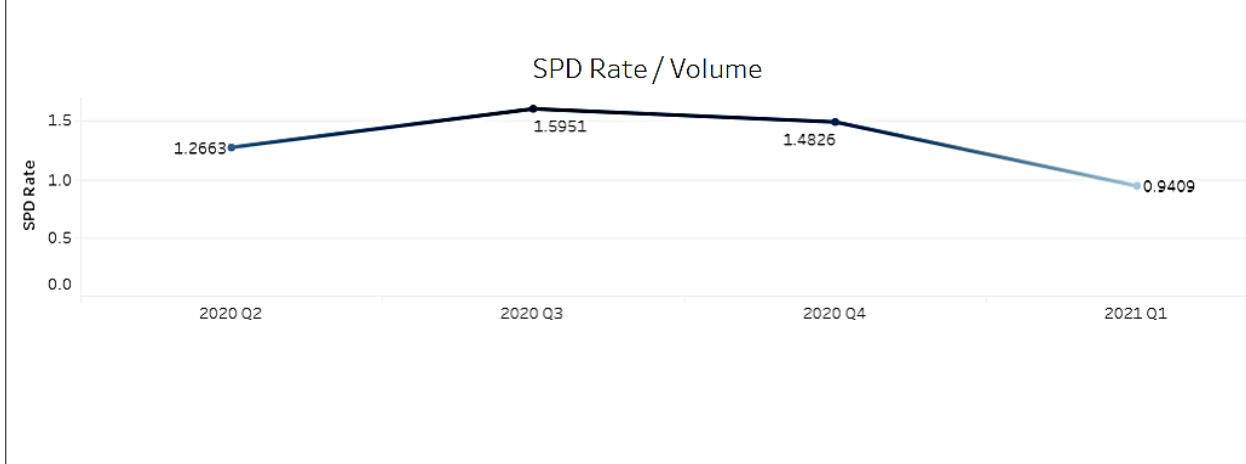
### **Grievances Filed by Seniors and Persons with Disabilities (SPD):**

SFHP monitors grievances filed by members who are part of the SPD population.

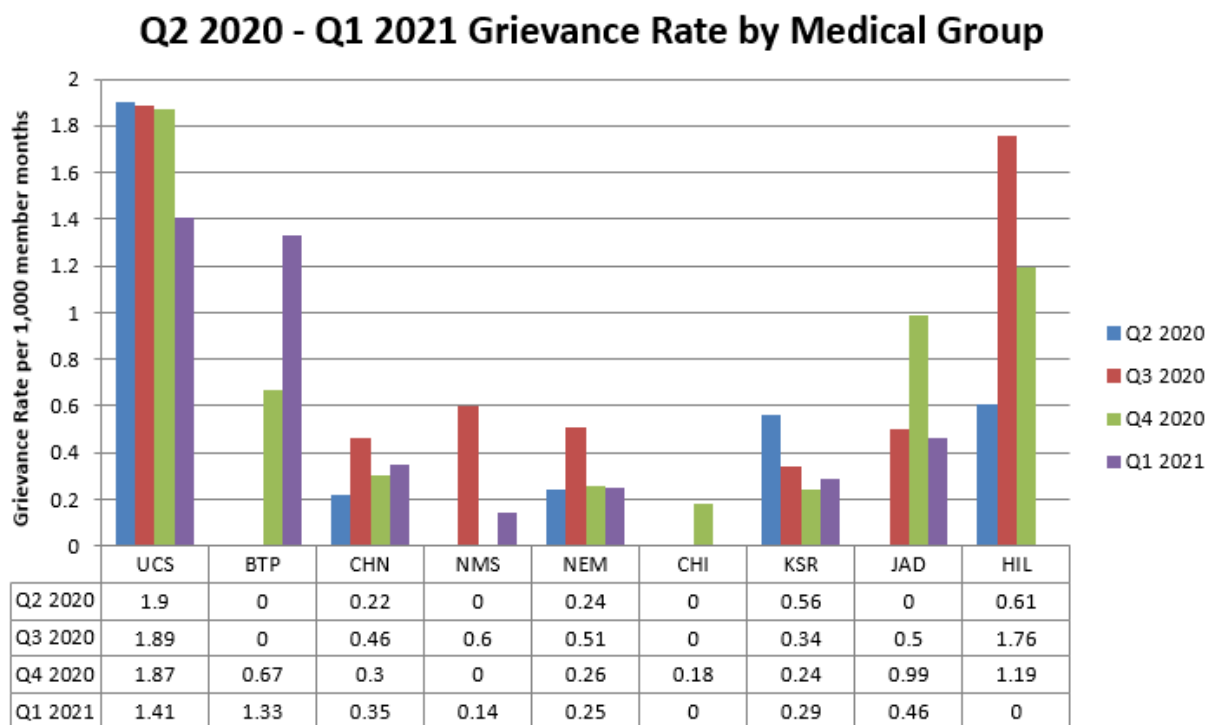
- In Q1 2021, 23 grievances were filed by SPD members. The number of grievances filed by SPDs decreased by 36% compared to Q4 2020 when a total of 36 grievances were filed by SPD members.
- Grievances involving quality of service and quality of care continue to be the most common grievance categories for SPD members. This is similar for grievances filed by non-SPD members.

In comparison, SFHP's SPD grievance rate remains lower than DHCS' SPD grievance rate. Please see the graph above for DHCS' SPD grievance rate.

### **Q2 2020 – Q1 2021 SFHP SPD Grievance Rate**



### **Grievance Rate by Medical Group:**



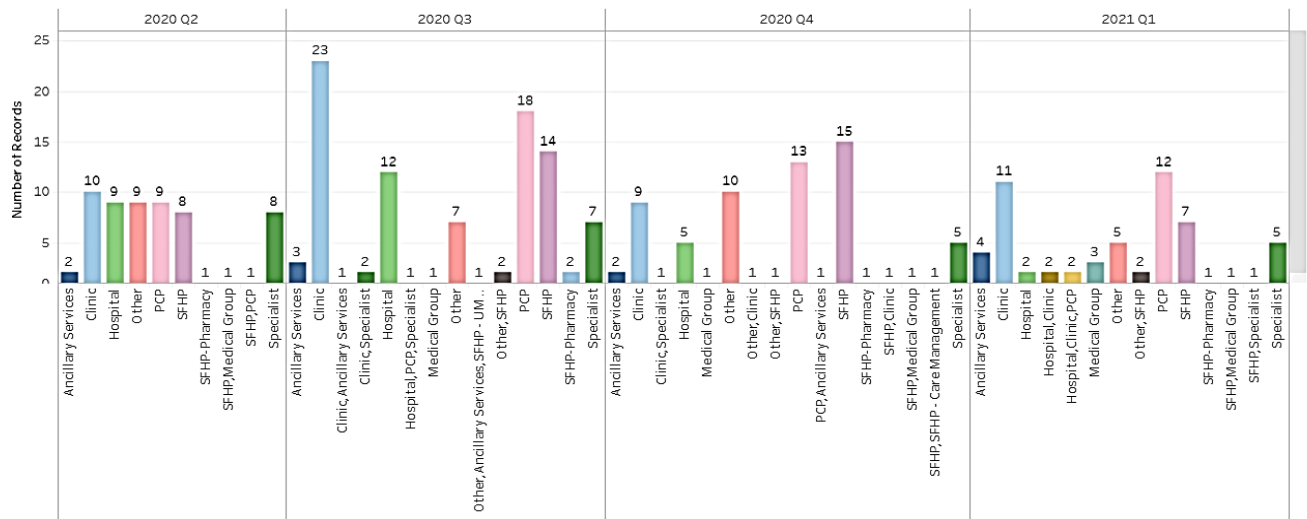
\*Includes clinical and non-clinical grievances only.

In Q1 2021, five of the medical group grievance rates decreased whereas the remaining four increased compared to Q4 2020.

### **Source of the grievances:**

The graph below shows who was involved in the grievance e.g. member's Primary Care Provider (PCP), clinic staff, or specialist. The source of most grievances received in Q1 2021 were those involving services provided by the member's PCP followed by care or services provided by the member's clinic.

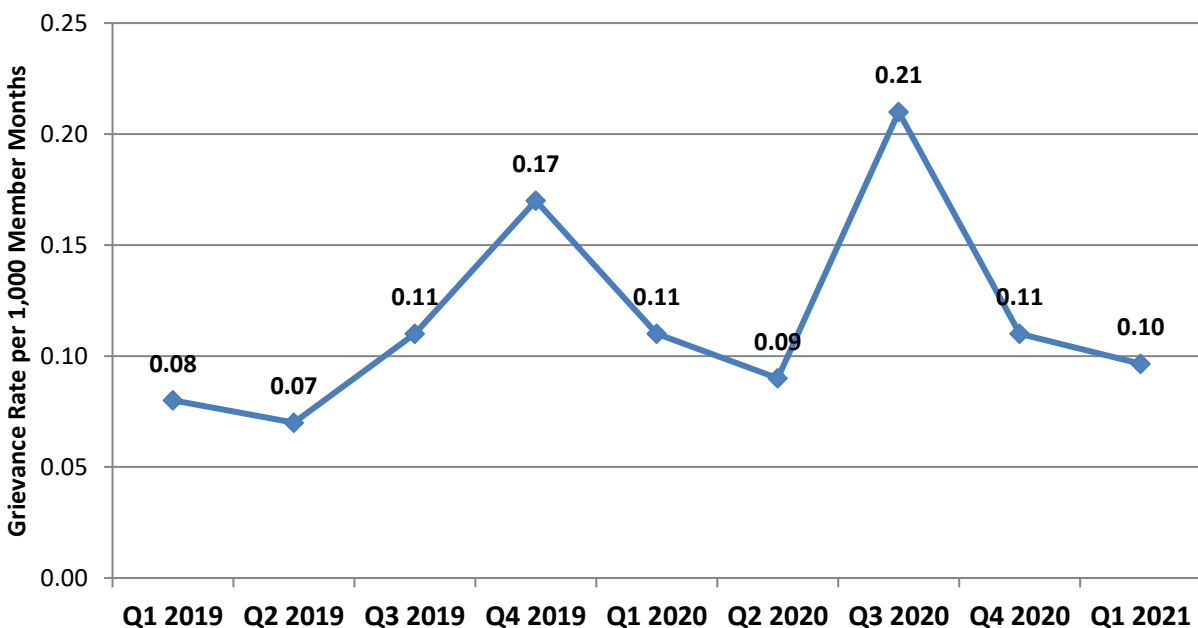
### Q2 2020 – Q1 2021 Grievance Source



### Access to Care Grievances:

From Q1 2019 to Q2 2019, the access grievance rate decreased and then increased in Q3 2019 and Q4 2019. In Q1 and Q2 2020, the rate decreased due to the COVID-19 pandemic. In Q3 2020, the rate increased and then decreased in Q4 2020 and Q1 2021.

### Q1 2019 - Q1 2021 SFHP Access Grievance Rate



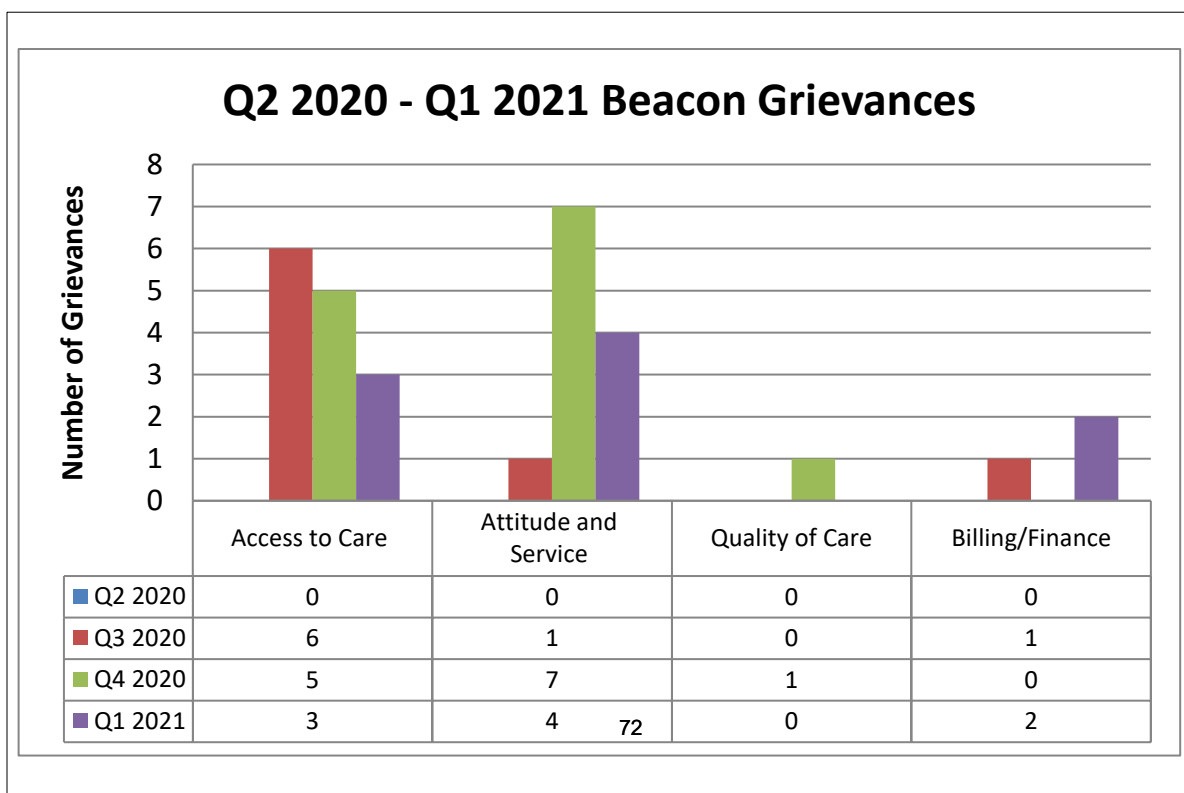
SFHP's Member Experience Dashboard shows all grievances associated with access by medical group from Q3 2019 to Q2 2020. Please note Q3 2020, Q4 2020, and Q1 2021 data were not available at the time of this report.

### Access Grievances per 1,000 Member Months

Medical Group	Metrics				
	Quarter	2019 Q3	2019 Q4	2020 Q1	2020 Q2
CHN-DPH		0.23	0.25	0.25	0.23
CHN-CCC		0.20	0.14	0.07	0.14
CHN-OTHER		0.00	0.00	1.20	1.22
BTP		0.22	1.01	0.00	0.00
CHI		0.00	0.00	0.19	0.00
HIL		0.27	0.55	0.58	1.19
NEM		0.09	0.09	0.08	0.05
UCS		0.57	0.16	0.24	0.57
NMS		0.00	0.18	0.00	0.00

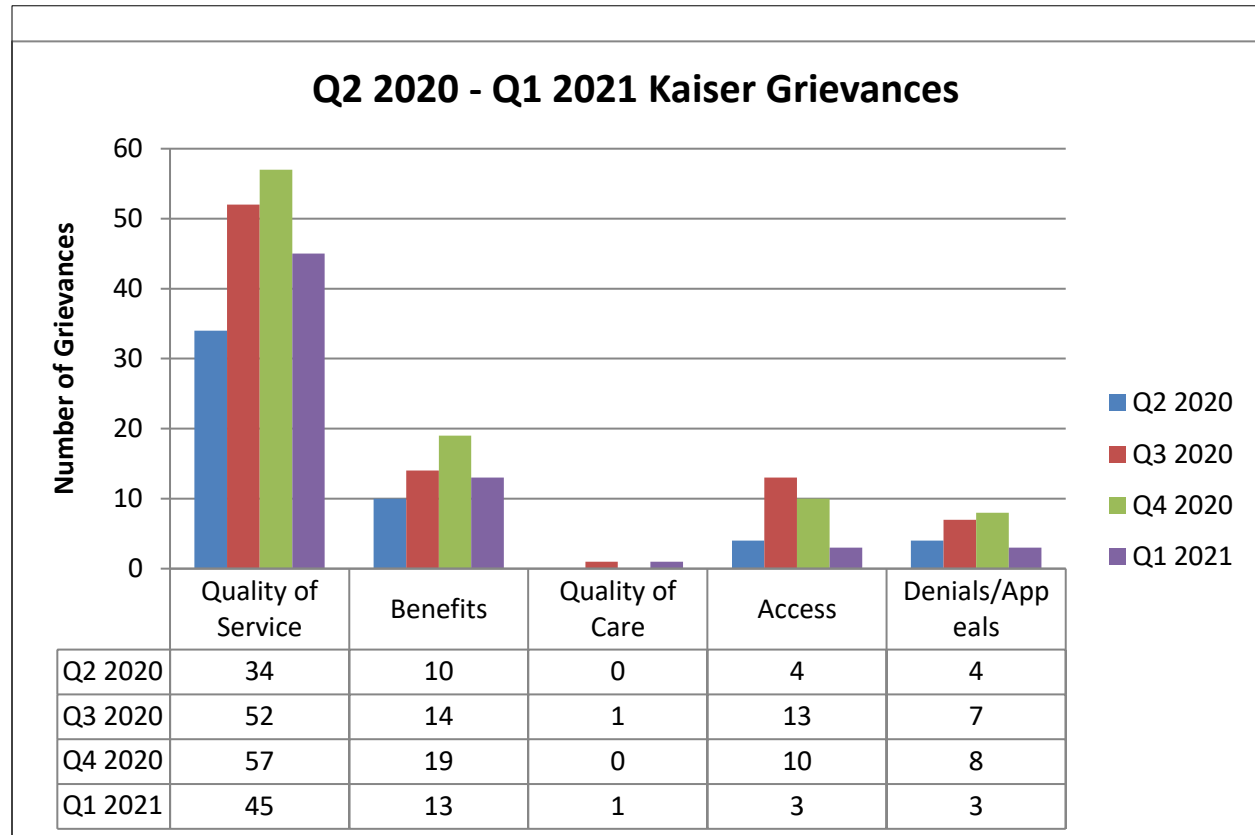
### Beacon:

Beacon Health Options is SFHP's non-specialty mental health provider. Beacon is partially delegated to process grievances. Most grievances received in Q1 2021 involved Attitude and Service.



**Kaiser:**

Kaiser is fully delegated to investigate and resolve grievances. Most grievances received in Q1 2021 were grievances involving Quality of Service and Benefits. This is consistent with previous quarters.



\*Please note SFHP launched a new data visualization to display data. The information in this report may be slightly different from past reports due to the data sources used.



# MEMO

Date: June 1, 2021

To	Quality Improvement Committee
From	Grace Cariño, MPH Associate Program Manager, Appeals & Grievances
Regarding	Q1 2021 UM Medical and Pharmacy Appeals Activity

## Q1-2021 Appeals Activity – Overview

During Q1-2021, there were a total of 20 appeals filed (medical – 5/pharmacy – 15)<sup>i</sup>. In Q1-2021, there were a total of 5,560 authorization<sup>ii</sup> requests (medical – 3,762/pharmacy – 1,798) and a total of 510 denials (medical – 12/ pharmacy – 498).

On a per 1,000 total authorization basis:

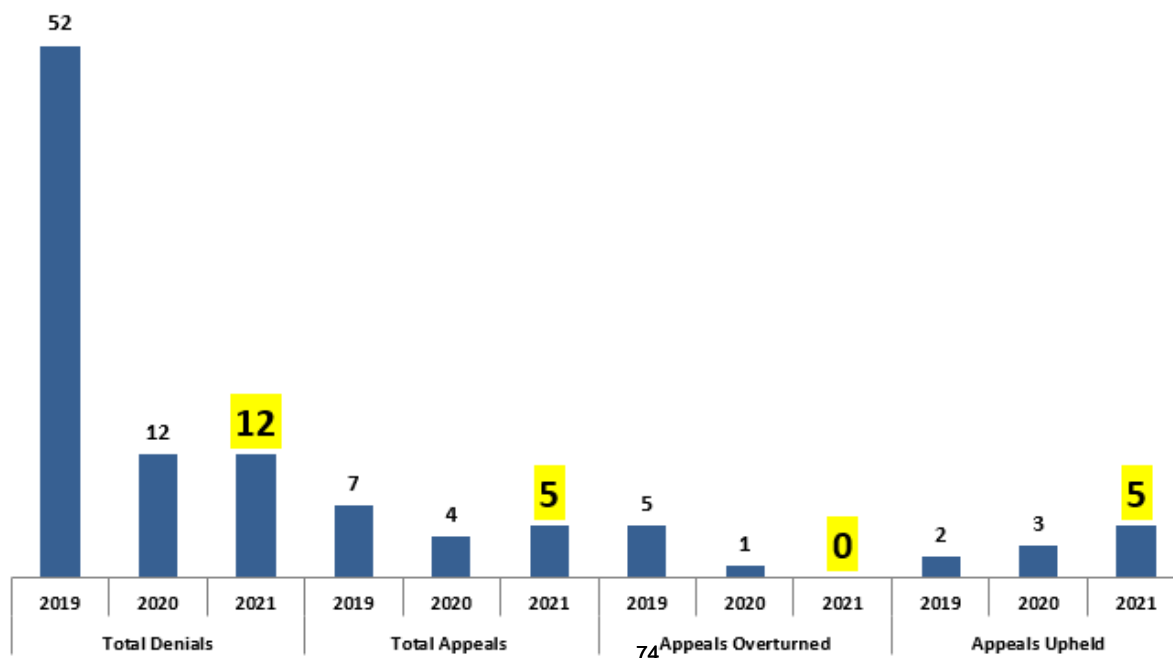
- 3.6 total appeals per 1,000 total authorizations
- 0.9 medical appeals per 1,000 total authorizations
- 2.7 pharmacy appeals per 1,000 total authorizations

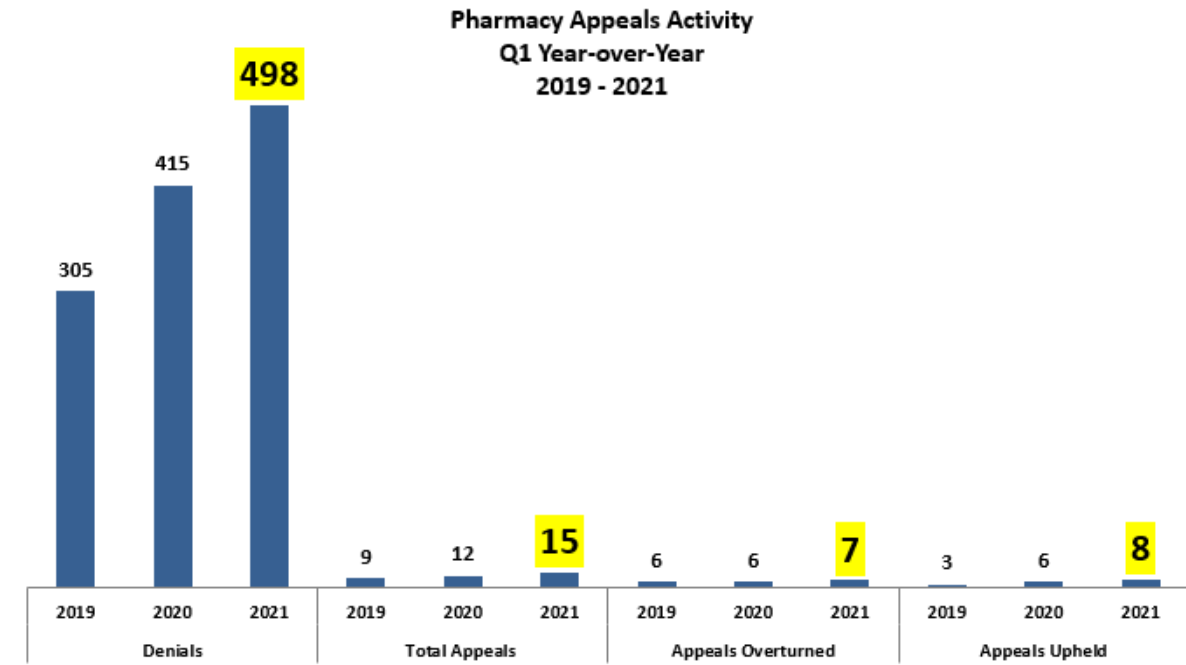
Comparing appeal activity in Q1-2021 to Q4-2020:

- 20 appeals in Q1-2021 vs. 13 appeals in Q4-2020
- 3.6 appeals/1000 in Q1-2021 vs. 2.1 appeals/1000 in Q4-2020

Of the 20 appeals in Q1-2021, 7 appeals were overturned (medical – 0/ pharmacy – 7), which is a 35% overturn rate. This compares to a 31% overturn rate in Q4-2020 (4 overturned out of 13 appeals).

## Medical Appeals Activity Q1 Year-over-Year 2019 – 2021





## Analysis

### Q1-2020 – Q1-2021 Medical Denial Rates

Between Q1-2020 and Q1-2021, the medical denial rates ranged from 0.16% (Q3-2020) to 0.50% (Q2-2020):

	Medical Authorizations	Medical Denials	Medical Denial Rate
Q1-2020	4,072	12	0.29%
Q2-2020	3,970	20	0.50%
Q3-2020	4,319	7	0.16%
Q4-2020	4,373	14	0.32%
Q1-2021	3,762	12	0.32%

### Q1-2020 – Q1-2021 Pharmacy Denial Rates

Between Q1-2020 and Q1-2021, the denial rates ranged from 23.81% (Q2-2020) to 27.70% (Q1-2021):

	Pharmacy Authorizations	Pharmacy Denials	Pharmacy Denial Rate
Q1-2020	1,547	415	26.83%
Q2-2020	1,508	359	23.81%
Q3-2020	1,678	448	26.70%
Q4-2020	1,689	431	25.52%
Q1-2021	1798	498	27.70%

### Q1-2020- Q1-2021 Collective Medical & Pharmacy Appeal Rates per 1000 Denials

Between Q1-2020 and Q1-2021, the collective medical and pharmacy appeal rates per 1000 denials ranged from 29.2 (Q4-2020) to 63.3 (Q2-2020):

	Medical + Pharmacy Denials	Medical + Pharmacy Appeals	Medical + Pharmacy Appeals / 1000 Denials
Q1-2020	427	16	37.5
Q2-2020	379	24	63.3
Q3-2020	455	15	33.0
Q4-2020	445	13	29.2
Q1-2021	510	20	39.2

### Q1-2021 Collective Medical & Pharmacy Appeal Adjudication Turn-Around-Time

100% of the medical and pharmacy appeals were adjudicated within 30-days in Q1-2021:

	Q1-2021		
	Total (Med + Pharm)	Medical	Pharmacy
Number (#) of Appeals	20	5	15
Percentage (%) of Appeals Adjudicated within 30-days	100%	100%	100%
# of Appeals Upheld	13	5	8
# of Appeals Overturned	7	0	7

### Q1-2021 Member and Provider Appeal Activity

Of all appeals filed in Q1-2021, 25% were member initiated and 75% were provider initiated.

Of all appeals filed in Q1-2021, no appeals were expedited.

		Q1-2021		
		Total (Med + Pharm)	Medical	Pharmacy
Member	# of Initiated Appeals	5	3	2
	% of Total Appeals	25%	15%	10%
Provider	# of Initiated Appeals	15	2	13
	% of Total Appeals	75%	10%	65%
Member	# of Expedited Appeals	0	0	0
	% of Initiated Appeals	0%	0%	0%
Provider	# of Expedited Appeals	0	0	0
	% of Initiated Appeals	0%	0%	0%

### Q1-2021 Basis for Overturned Appeals

Of the 7 overturned appeals in Q1-2021, none of the overturned decisions were based on the original clinical information submitted. 100% of the overturned decisions were based on additional clinical information submitted:

	Q4-2020		
	Total (Med + Pharm)	Medical	Pharmacy
# of Overturned Appeals	7	0	7
% of Total Appeals	35%	0%	35%
# of Appeals overturned due to additional clinical information offered	7	0	7
% of Appeals overturned due to additional clinical information offered	100%	0%	100%
# Appeals overturned due to decision based on the same submitted clinical information	0	0	0
% Appeals overturned due to decision based on the same submitted clinical information	0%	0%	0%

### Actions

The Utilization Management Committee's (UMC) standing agenda item is to review and discuss upheld and overturned medical and pharmacy utilization management appeals. The discussion and decision highlights are reflected in the UMC minutes.

<sup>i</sup> 0937ES Essette Grievance Report, Case Receipt Date 1/1/2021 - 3/31/2021 as of 6/2/21 7:45:00 AM.

ii Source for Medical data: Original\_Q1-2021\_AllAuthorizationsData. As of 5.2020, the following data classes are no longer counted in the authorization (auth) total:

- D Class auths - created in error;
- I Class auths - closed cases;
- O Class auths: Authorization Not Required; Duplicate Authorization; Medi-Medi Members; Other Payer; QNXT Failure; Created in Error.
- Additionally, any A Class auths (medical) and pharmacy auths associated with the following statuses were not counted: voids, retrospective, approved by PDRs, closed, pending, received, and early closed.

Source for Pharmacy Data: 202013 Prior Authorization Summaries-San Fran\_v06.2.21.

Measure	Measure Description	Denominator	Baseline	Target	Current Performance	Planned Activities	Update on Activities in Q1 2021
Screening For Clinical Depression	Increase the percentage of clients in Care Management programs successfully screened for clinical depression	41	83.1%	85.0%	88%	<ul style="list-style-type: none"> <li>•Coaching including role-playing activities to reduce the rate of members declining PHQ-9 screening.</li> <li>•Train staff in mental health, particularly on severe mental illness (SMI), in order to ensure that staff is equipped to identify signs and symptoms of clinical depression and address client safety.</li> <li>•Review monthly reports with staff and Clinical Supervisors to coach staff to ensure members are screened and receive appropriate follow up.</li> <li>•Monitor the rate of members declining the PHQ-9 screening via additional report tracking.</li> <li>•Complete bi-monthly staff self-audits; this enables Coordinators to identify and remedy any gaps in the member's care plan including completing the PHQ-9 screening when indicated.</li> <li>•Clinical Supervisors conduct quarterly audits to ensure best practices and regulatory requirements are met.</li> </ul>	<ul style="list-style-type: none"> <li>• Completed all planned activities including offering the following trainings for the Coordinators and RNs this quarter: Health Equity Culturally Responsive Care in the context of COVID-19; Maximizing Resilience: Leveraging Strengths in a Challenging World; Co-Occurring Disorders.</li> </ul>
Follow Up On Clinical Depression	Increase the percentage of clients in Care Management programs who screen positive for depression and receive follow up care	13	85.7%	89.0%	85%	<ul style="list-style-type: none"> <li>•Coaching including role-playing activities to reduce the rate of members declining PHQ-9 screening.</li> <li>•Train staff in mental health, particularly on severe mental illness (SMI), in order to ensure that staff is equipped to identify signs and symptoms of clinical depression and address client safety.</li> <li>•Review monthly reports with staff; Clinical Supervisors to coach staff to ensure members at risk of clinical depression receive appropriate follow up.</li> <li>•Complete bi-monthly staff self-audits; this enables Coordinators to identify and remedy any gaps in the member's care plan including completing the PHQ-9 screening when indicated.</li> <li>•Clinical Supervisors conduct quarterly audits to ensure best practices and regulatory requirements are met.</li> </ul>	<ul style="list-style-type: none"> <li>• Completed all planned activities including offering the following trainings for the Coordinators and RNs this quarter: Health Equity Culturally Responsive Care in the context of COVID-19; Maximizing Resilience: Leveraging Strengths in a Challenging World; Co-Occurring Disorders.</li> </ul>
Care Management Client Perception Of Health	Improve Care Management client's perception of their health based on change in self-reported health status	66	50.5%	55.0%	58%	<ul style="list-style-type: none"> <li>•Clinical Supervisors and Medical Director provide coaching to the Care Management Nurses and Community Coordinators to assess for client barriers and gaps in health education and connection to PCP.</li> <li>•Care Management Nurses complete bi-monthly self-audits; this enables them to identify and remedy any gaps in the member's care plan.</li> <li>•Clinical Supervisors and Medical Director conduct quarterly audits to ensure best practices and regulatory requirements are met including members having chronic condition self-management goals as part of their care plans as indicated..</li> <li>•Utilization of Milliman Care Guidelines (MCG) condition specific assessments and MCG health education materials by Care Management Nurses.</li> </ul>	<ul style="list-style-type: none"> <li>• Medical Director met weekly with the RNs and joined the RNs and Clinical Supervisors 1:1s to provide individual feedback on health coaching/education efforts as needed</li> <li>• Pharmacy team provided the Care Management team with a lecture on Opioid Use Disorder.</li> </ul>
Health Homes CB-CME Case Conference Rate	This measure shows the percent of unique HHP enrolled members that have had at least one case conference during their time in the program.	621	44.0%	51.0%	40%	<ul style="list-style-type: none"> <li>•Provide CB-CMEs with education on importance of case conferences, the definition of case conference, and reminder that this measure is being tracked.</li> <li>•Train new Care Management staff on HHP workflow.</li> <li>•Review of quarterly metrics with team by Clinical Supervisors highlighting both strengths as well as areas for improvement.</li> <li>•Completion of bi-monthly self-audits by staff to identify and remedy any gaps in the member's care plan including completing case conferences.</li> <li>•Completion of quarterly audits by Clinical Supervisors to ensure best practices and regulatory requirements are met.</li> </ul>	<ul style="list-style-type: none"> <li>• Continued to remind CB-CMEs on the importance of regular case conferences to collaborate toward giving Health Homes members the best possible care. Educated CB-CMEs through email and on monthly calls.</li> </ul>

Measure	Measure Description	Denominator	Baseline	Target	Current Performance	Planned Activities	Update on Activities in Q1 2021
Percentage of Members who completed Hepatitis C Treatment	Improve the percentage of members with any past history of Hepatitis C who have completed the Hepatitis C treatment regimen	N/A	37.3%	40.0%	n/a	<ul style="list-style-type: none"> <li>•Develop a member-focused awareness campaign and a provider education outreach campaign for targeted clinics and offices.</li> <li>•Address stigma for Hepatitis C treatment by partnering with providers to ensure access to treatment in their practice.</li> <li>•Provide treatment support through SFHP's Care Transitions and Care Management programs.</li> </ul>	<ul style="list-style-type: none"> <li>• Met with End Hep C campaign to plan educational campaigns.</li> <li>• Care coordinators and pharmacy staff continued to recommend members with active Hepatitis C to be treated.</li> </ul>
Diabetes Prevention Program (DPP) – Do 150 Mins of Physical Activity Per Week	Achieve at least 150 minutes of physical activity per week for 25% of eligible members completing the Diabetes Prevention Program	N/A	100.0%	95.0%	N/A	<ul style="list-style-type: none"> <li>•Offer virtual and in-person classes.</li> <li>•Provide DPP enrollees with home exercise equipment, such as jump ropes or stretch bands.</li> <li>•Develop targeted training for providers to improve program referrals.</li> </ul>	<ul style="list-style-type: none"> <li>• Offered virtual and in-person classes.</li> <li>• Had 8 members who started program after end of 2020. Currently have 6 members that started March 2021. New class started in April 2021 with 5 people. Total of 11 members.</li> <li>• Provided a subset of DPP enrollees with home exercise equipment, such as jump ropes or stretch bands.</li> </ul>
Diabetes Prevention Program (DPP) – Satisfaction	Improve satisfaction with the Diabetes Prevention Program	N/A	91.0%	90.0%	N/A	<ul style="list-style-type: none"> <li>•Offer virtual and in-person classes.</li> <li>•Provide DPP enrollees with home exercise equipment, such as jump ropes or stretch bands.</li> <li>•Develop targeted training for providers to improve program referrals.</li> <li>•Provide training to YMCA staff on health inequities impacting SFHP members. Topics may include food insecurity and LGBTQIA+ identities.</li> </ul>	<ul style="list-style-type: none"> <li>• Offered virtual and in-person classes.</li> <li>• Had 8 members who started program after end of 2020. Currently have 6 members that started March 2021. New class started in April 2021 with 5 people. Total of 11 members.</li> <li>• Provided a subset of DPP enrollees with home exercise equipment, such as jump ropes or stretch bands.</li> </ul>
Diabetes Prevention Program (DPP) - Weight Loss	Achieve at least 5% weight loss for 25% of eligible members completing the Diabetes Prevention Program	N/A	18.8%	25.0%	N/A	<ul style="list-style-type: none"> <li>•Offer virtual and in-person classes.</li> <li>•Provide DPP enrollees with home exercise equipment, such as jump ropes or stretch bands.</li> <li>•Develop targeted training for providers to improve program referrals.</li> </ul>	<ul style="list-style-type: none"> <li>• Offered virtual and in-person classes.</li> <li>• Had 8 members who started program after end of 2020. Currently have 6 members that started March 2021. New class started in April 2021 with 5 people. Total of 11 members.</li> <li>• Provided a subset of DPP enrollees with home exercise equipment, such as jump ropes or stretch bands.</li> </ul>
Medication Therapy Management (MTM)	Increase the percentage of members who are engaged in Care Management and Care Transitions programs and have had an initial medication reconciliation completed by a Pharmacist	0	85.0%	87.0%	0%	<ul style="list-style-type: none"> <li>•Monitor the pharmacist resource requirements needed to support the population of members engaged in Care Management and Care Transitions team.</li> <li>•Assess for efficiencies in workflow and member assessment configurations.</li> <li>•Continue reviewing members in the initial assessment process which recommends an MTM assessment and establishes the denominator population for this measure.</li> </ul>	<ul style="list-style-type: none"> <li>• Created new medication reconciliation tool in member management software for continued integration with SFHP's Care Management and Care Transitions teams</li> <li>• Built a new report to monitor completed medication reconciliations monthly.</li> <li>• Updated pharmacist and pharmacy technician workflow with new medication reconciliation tool.</li> <li>• Presented new medication reconciliation tool to SFHP's Pharmacy, Care Management and Care Transitions teams.</li> </ul>
Opioid Safety - Buprenorphine Prescription	Increase the percentage of members with Opioid Use Disorder with a buprenorphine prescription	1692	12.3%	15.0%	19%	<ul style="list-style-type: none"> <li>•Outreach to methadone clinic providers in order to better support the use of MAT.</li> <li>•Disseminate educational material to members on MAT options.</li> </ul>	No planned activities were completed during Q1 2021.

Measure	Measure Description	Denominator	Baseline	Target	Current Performance	Planned Activities	Update on Activities in Q1 2021
Opioid Safety - Opioid and Benzodiazepine Co-prescribing	Reduce the rate of opioid and benzodiazepine co-prescribing	2892	10.7%	8.0%	7%	•Develop provider information how to taper members off benzodiazepines and alternate treatments for anxiety and insomnia.	Planned activities on hold due to COVID related priorities.
Chlamydia Screening (CHL)	Improve the Chlamydia Screening rate for SFHP members	2073	58.1%	61.1%	60%	<ul style="list-style-type: none"> <li>•Continue to include chlamydia screening as a pay-for-performance measure in the Practice Improvement Program (PIP).</li> <li>•Complete lab data analysis for other data sources to identify data and/or clinical quality issues potentially contributing to the screening rate and make recommendations for improvement.</li> <li>•Include chlamydia screening in member and provider communications.</li> <li>•Budget for and develop educational materials about STDs for teens.</li> <li>•Explore expanding the Well Child member incentive population to the age of 21, and include chlamydia screening in the Adult Wellness member incentive to cover ages 22-24.</li> </ul>	<ul style="list-style-type: none"> <li>• Included Chlamydia Screening education in Adult Wellness member incentives to age group 18-24.</li> </ul>
Well-Child Visits In The First 15 Months Of Life (W30)	Improve the Well-Child Visits for first 15 Months rate for SFHP members	23	46.9%	49.9%	5%	<ul style="list-style-type: none"> <li>• Restructure incentives report to filter for members who have not had a visit in past 9 months to send incentive form 3 months before next birthday. Previous reporting mechanisms timing didn't incentivize visits, new mechanism will incentivize visits that have not yet occurred and allow three months for members to receive incentive within the reporting year.</li> <li>• Determine age groupings for target populations for Health Ed materials to be categorized by appropriate age milestones and will be sent on an annual basis.</li> <li>• Health education materials will be added to incentive form to help inform parents/guardians of importance of visit.</li> <li>• Explore ways to support Provider Network to promote telehealth visit options—provider newsletter, webpage updates, our Health Matters newsletter.</li> <li>• Though this measure is not currently in PIP 2020-2021 program year, participants have optional quality improvement project funding to increase telehealth capacity.</li> </ul>	<ul style="list-style-type: none"> <li>• Determined age groupings for target populations for health education sent out education collateral to this population.</li> <li>• Developed health education materials and added them to the incentive form to help inform parents/guardians of the importance of well-child visits.</li> </ul>
Breast Cancer Screening (BCS)	Improve the Breast Cancer Screening rate for SFHP members	7854	65.9%	68.9%	2%	<ul style="list-style-type: none"> <li>• Provide Health Education materials to Black/African American SFHP members.</li> <li>• Partner with Ameri Corps to offer patient navigation services for Black/African American members due for a breast cancer screening.</li> </ul>	No planned activities were completed during Q1 2021.
Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) Rating of Specialist	Increase the rate of NCQA Rating of Specialist	N/A	57.5%	59.5%	N/A	<ul style="list-style-type: none"> <li>•Increase monitoring of network access and request Corrective Actions when needed.</li> <li>•Identify access-related issues via the Access Compliance Committee and develop plans to address found issues.</li> <li>•Conduct member focus groups.</li> <li>•Promote SFHP's telehealth services to increase access to care.</li> <li>•Implement a cross functional-work group to create a work plan to improve member engagement with the health plan.</li> <li>• Interview health plans high performing in HP-CAHPS to collect best practices for member experience improvement.</li> </ul>	<ul style="list-style-type: none"> <li>• Access survey results shared with regulators and communicated to Access Compliance Committee.</li> <li>• Communicated best practices for member experience improvement through an HP-CAHPS benchmarking report of high performing health plans.</li> </ul>

Measure	Measure Description	Denominator	Baseline	Target	Current Performance	Planned Activities	Update on Activities in Q1 2021
Provider Appointment Availability Survey (PAAS) - Routine Appointment Availability In Specialty Care	Increase the rate of non-behavioral health specialists compliant with routine appointments as measured by Provider Appointment Availability Survey (PAAS)	931	58.8%	60.8%	81%	<ul style="list-style-type: none"> <li>• Include additional specialties in the 2020 survey and develop communication plan for survey fielding</li> <li>• Request Corrective Action Plans of provider groups performing below 80% compliance rate and below 50% response rate.</li> <li>• Provide technical assistance with Corrective Action Plans.</li> <li>• Support provider capacity to offer telehealth visits through Strategic Use of Reserves program.</li> <li>• Publish best practices for telehealth.</li> </ul>	<ul style="list-style-type: none"> <li>• Access survey results shared with regulators and communicated to Access Compliance Committee.</li> </ul>
Cultural and Linguistic Services (CLS)	The organization uses provider data to determine the race/ethnic and languages spoken by 10 percent of individual practitioners in network	N/A	N/A	10.0%	N/A	<ul style="list-style-type: none"> <li>• Explore ways to collect information about languages in which a practitioner is fluent when communicating about medical care</li> <li>-Possible Source: Practitioner survey, credentialing application, provider relations script, CVO, medical association or medical specialty directories</li> <li>• Collect information about language services available through the practice</li> <li>• Explore ways to collect practitioner race/ethnicity data Sources of practitioner language and race/ethnicity information</li> <li>• Publish individual practitioner languages in the provider directory</li> </ul>	<ul style="list-style-type: none"> <li>• Convened meetings to explore the possibilities for collecting language and race/ethnicity data from providers.</li> <li>• Included CLS improvements to the Provider Directory is as part of the a disparities leadership program project plan.</li> </ul>
Primary Care Utilization	Restore overall primary care utilization rate to pre-pandemic levels of Q2 2019 by Q2 2021	N/A	Q3 2020 rate	≥ Q2 2019 rate	N/A	<ul style="list-style-type: none"> <li>• Inform members of the importance of primary care visits through marketing to members.</li> <li>• Continue inclusion of the PCP visit rate in SFHP's pay-for-performance program.</li> <li>• Participate in a Disparities Leadership Program with the aim to increase primary care engagement among SFHP's Black members.</li> <li>• Conduct outreach to members high risk for COVID-19 to facilitate connection to care.</li> <li>• Conduct Early and Periodic Screening, Diagnostic and Treatment calls mandated by DHCS</li> <li>• Provide member financial incentive for adult wellness visit and expand age of target population for well child visit incentive. This targets adults without PCP visits in the last year, and a couple other target populations.</li> <li>• Utilize Prop 56 Value Based Purchasing for several types of preventive and chronic care visits.</li> <li>• Provide grants to SF Community Clinic Consortium for the purchase of Personal Protective Equipment for front line providers. This will make it safer for targeted providers to provide in-person care when indicated.</li> <li>• Implement a cross functional-work group to create a work plan to improve member engagement with the health plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Informed members of the importance of primary care visits through marketing to members in the Spring 2021 Your Health Matters newsletter and the SFHP COVID website.</li> <li>• Outreached to members high risk for COVID-19 to facilitate connection to care. in particular to communicate about receiving the COVID-19 vaccine.</li> <li>• DHCS approved videos created by an SFHP cross functional-work group designed to be member-facing instructional videos to improve member engagement with the health plan.</li> </ul>
Percentage Of Members Utilizing The Non Specialty Mental Health (NSMH) Benefit With More Than Two NSMH Visits	Increase the rate of members with more than two NSMH visits in the past 12 months of members utilizing the NSMH benefit	N/A	39.8%	42.8%	N/A	<ul style="list-style-type: none"> <li>• Promote tele-behavioral health benefit to members through member communications.</li> <li>• Communicate weekend and after-hours appointment access to members.</li> </ul>	<ul style="list-style-type: none"> <li>• Promoted in person and tele-behavioral health benefit to members through member communications including weekend and after-hours appointment access to members through SFHP's COVID website.</li> <li>• Communicated to providers on how to refer to behavioral health services.</li> </ul>
Telehealth Utilization	Increase percentage of primary care visits delivered by telehealth modalities	N/A	N/A	25.0%	32%	<ul style="list-style-type: none"> <li>• Promote tele-health services to members.</li> <li>• Provide incentives for registration of tele-health services and for younger members to receive preventative health visits.</li> <li>• Provide grants to provider network to invest in telehealth infrastructure.</li> <li>• Implement a cross functional-work group to create a work plan to improve member engagement with the health plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Informed members of the importance of primary care visits through marketing to members in the Spring 2021 Your Health Matters newsletter and the SFHP COVID website.</li> <li>• DHCS approved videos created by an SFHP cross functional-work group designed to be member-facing instructional videos to improve member engagement with the health plan</li> </ul>



Policies and Procedures (P&Ps) Updates and Monitoring

Mar-Apr 2021 HE P&P Updates:

Policy	Summary of Updates on Consent
<b>CARE-01: Care Management Programs</b>	<b><u>Policy Update (MRX 10P Deliverable, DHCS approved)</u></b> DEFINITIONS <ul style="list-style-type: none"> <li>- Under CCS definition, replaced “Magellan” with, “Medi-Cal Rx”</li> </ul>
<b>CARE-02: HIFs and HRAs</b>	<b><u>Policy Update (DHCS requested updates)</u></b> <ul style="list-style-type: none"> <li>- Attachment I: HIF for a legible version</li> <li>- Updated current version of Attachment III: New Member HRA form</li> <li>- Added Attachment IV. Customer Service HRA Call Script</li> </ul>
<b>CARE-04: Complex Care Management</b>	<b><u>Policy Update (MRX 10P Deliverable, DHCS approved)</u></b> PROCEDURE <ul style="list-style-type: none"> <li>- Under section III, replaced “Magellan” with “Medi-Cal Rx” and removed reference to January 1, 2021 Medi-Cal Rx transition.</li> </ul>
<b>CO-32: Hospice</b>	<b><u>Policy Update (DHCS requested updates &amp; changes approved)</u></b> PROCEDURE <ul style="list-style-type: none"> <li>- Clarified Continuous Home Care is the hospice level associated with “Periods of Crisis.”</li> <li>- Updated the types of counseling included under hospice: bereavement, dietary, and spiritual.</li> </ul> REFERENCES <ul style="list-style-type: none"> <li>- Added 2 references: 42 CFR § 418.64 - Condition of participation: Core services &amp; 42 CFR § 418.204 - Special coverage requirements.</li> </ul>
<b>HE-05: Non-Monetary Member Incentives</b>	<b><u>Policy Update (Biennial Review)</u></b> <ul style="list-style-type: none"> <li>- Updated template, removed Healthy Kids HMO LOB</li> <li>- Updated reference of “Group Needs Assessment” to “Population Needs Assessment”</li> </ul>
<b>QI-04: Quality Improvement HEDIS and PIP Procedures</b>	<b><u>Policy Update (DHCS approved):</u></b> PROCEDURE & REFERENCES <ul style="list-style-type: none"> <li>- Per DHCS request, moved reference to “NCQA HEDIS Measure” requirement from Procedure section to References section.</li> <li>- Removed DHCS APL 11-021 and 13-005 that were superseded by APL 19-017.</li> </ul>
<b>QI-15: Quality Improvement Program</b>	<b><u>Policy Update (Biennial Review)</u></b> <ul style="list-style-type: none"> <li>- Updated template</li> <li>- Updated QI Work Plan measures from “4” to “6” domains.</li> <li>- Updated relevant P&amp;Ps</li> </ul>

Date: May 27, 2021

<b>To</b>	<b>Quality Improvement Committee</b>
<b>From</b>	<b>Ralph Custodio, RN Quality Review Nurse Appeals &amp; Grievances</b>
<b>Regarding</b>	<b>Quarter 1, 2021 Potential Quality Issue Report</b>

### Case Reviews

<b>Q4 2020 - Case types reviewed</b>		<b>Count</b>
<b>Total cases reviewed for PQI</b>		<b>94</b>
	Appeals	23
	Decline to File Grievances (Clinical)	12
	Grievances (Clinical)	59
	Internal referrals (not including grievances)	0
	External referrals	0
	Provider Preventable Condition (PPC)	0

<b>Outcomes</b>		<b>Count</b>
	Opened for PQI investigation	0
	Formal PQI investigation (PQI letter)	0
	Cases requiring external physician review or peer review	0
	Confirmed Quality Issue	0
	PQI cases resulting in Corrective Action Plan (CAP)	0
	Confirmed Provider Preventable Condition (PPC)	0
	PQI cases closed within 60-day turnaround time	0
	PQI cases closed outside 60-day turnaround time	0

\*Data retrieved from Ramp 937 and 0390ES PQI Case Reports

**PQI Final Determination**  
PRACTITIONER PERFORMANCE AND SYSTEM RANKING

<b>Severity Level (P= Provider Issue S= System Issue)</b>	<b>Definition</b>	<b>Action/Follow-up</b>	<b>Final case status note in Essette</b>
P0/S0	Care appropriate.	No action required.  Resolution notification sent to provider as applicable.	P0/S0 - No confirmed quality issue
P1/S1	Minor opportunity for improvement. No actual adverse outcome to member.	Notification to provider confirming quality issue.  Notification may include Improvement Opportunity recommendation.	P1/S1- Confirmed Minor Quality Issue (CQI)
P2/S2	Moderate improvement opportunity and/or care deemed inappropriate.  Potential/actual minor or moderate adverse outcome to member.	Notification to provider confirming quality issue.  Medical Director/designee may request peer review, offer Improvement Opportunity recommendation, and/or corrective action.  Peer review outcome documented in case notes.	P2/S2–Confirmed Moderate Quality Issue (CQI)
P3/S3	Significant opportunity for improvement and/or care deemed inappropriate.  Potential/actual significant adverse outcome to member.	Notification to provider confirming quality issue.  Medical Director/designee may request peer review, offer Improvement Opportunity recommendation, and/or corrective action.  Peer review outcome documented in case notes. Referral to Physician Advisory Committee (PAC) for review and/or recommendations.	P3/S3– Confirmed Significant Quality Issue (CQI)

**Analysis:** No trends identified during Q1 2021

## **Confirmed Quality Issues**

No Potential Quality Issue (PQI) cases closed during this quarter.

# SFHP and COVID-19 Vaccine

## Goals:

- Support SFDPH goals of equitable vaccine access to impacted communities
- Align communication re: vaccine availability
- Support outreach and scheduling for SFHP members and populations served by our providers
- Address barriers to vaccine access and hesitancy

# What has SFHP done to date?

- ✓ Supported vaccine appointment scheduling for clinics and populations
  - TTS call center
  - Outbound and inbound call capacity
  - Texts/Robocalls/Letters to eligible populations
  - Translation of materials in 10 languages
  - Website Updates
- ✓ Supported coordination and outreach efforts to high risk populations
  - California Children's services, CBAS recipients, Targeted Zip codes, Homebound individuals
- ✓ Work to address disparities/barriers
- ✓ Data tracking

# What our data is telling us so far

Medical Group	No COVID Vax	At Least One
BTP ~1400	64.27 %	35.73 %
CHI ~5700	49.71 %	50.29 %
CLN ~ 16,400	63.48 %	36.52 %
HIL ~1725	71.10 %	28.90 %
JAD ~4300	44.50 %	55.50 %
KSR ~13,300	52.06 %	47.94 %
NEMS ~39,600	49.16 %	51.84 %
NMS ~7300	44.21 %	55.79 %
SFN ~ 43,000	54.90 %	45.10 %
UCS ~13, 800	62.48 %	37.52 %
Total: 147, 890	<b>54.3%</b>	<b>45.9%</b>

# What should SFHP do now?

- All eligible individuals have had letter, text, robocalls
- Options:
  - Targeted outreach by phone through call center
  - Lists to PCPs
  - Engagement of Community Partners
  - Vaccine hesitancy strategies



# Preventive Health Screenings

## Background: Contractual Requirements HEDIS/MCAS

- HEDIS activities for RY 2021/MT2020 complete
- Complete review of HEDIS performance August QIC
- Highlight 2 areas of preventive services: MCAS measures

## USPSTF Guidelines Grade A and B

# MCAS Background

- Managed Care Accountability Set of measures
- Medi-Cal Plans must achieve 50<sup>th</sup> percentile
  - CAP required
  - Plans may be subject to financial penalties

# MCAS Measures RY 2021

• Controlling High Blood Pressure	CBP	50
• Cervical Cancer Screening	CCS	75
• Childhood Immunization Status Combo 10	CIS - Combo 10	95
• Immunizations for Adolescents Combo 2	IMA - Combo 2	95
• Prenatal and Postpartum Care - Prenatal	PPC - Prenatal	66
• Prenatal and Postpartum Care - Postpartum	PPC - Postpartum	95
• <b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents BMI</b>		<b>25</b>
• Follow Up Care for Children Prescribed ADHD Medication-	ADD	NA
• Antidepressant Medication Management-Effective Continuations Phase Tx	AMM	75
• Asthma Medication Ratio - Total	AMR	75
• Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total	APM	50
• <b>Breast Cancer Screening</b>	<b>BCS</b>	<b>33</b>
• Chlamydia Screening	CHL	50
• Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	50

## Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) BMI Percentile Documentation Measure definition for WCC:

- Members 3 to 17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of BMI percentile documentation. This includes the percentile ranking based on the Center for Disease Control and Prevention (CDC) BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same gender and age.

### Telehealth Acceptable:

- Addition of Member Reporting NCQA has added member reporting for biometric values (body mass index, height and weight). Note: Member-reported biometric values (height, weight, BMI percentile) are acceptable if the information is collected by a primary care practitioner while taking a patient's history. The information must be recorded, dated and maintained in the member's health record.

# WCC BMI-Questions

- How can SFHP support documentation of BMI and nutrition counseling?
- Given high rates of immunizations, children appear to be accessing care
  - ?Provider education
  - ?Data systems issue
  - ?Workflow
  - ?Role of Telehealth

# Breast Cancer Screening-BCS

- **BCS Definitions**

Assesses women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years

This year—drop of 9 % in absolute rate to 55.99%

RY202 Medicaid 90<sup>th</sup> is 69.22 % and /50<sup>th</sup> is 58.82

Significant disparities by race: Caucasian/Black/American Indian lowest, Hispanic, Asian, above 50<sup>th</sup> and 90<sup>th</sup> percentiles respectively

Strategies?

Can women auto schedule mammograms?

What barriers exist? Knowledge/access/beliefs?

# Preventive Health Screenings

- **USPSTF Grade A and B**
- ADULT PREVENTIVE HEALTH SCREENING GUIDELINES
- These guidelines for adult health screening and preventive services are derived from the most recent United States Preventive Services Task Force (USPSTF) and other nationally recognized standards of practice from organizations such as: American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American Cancer Society (ACS), and American College of Physicians (ACP), and others
- Age, sex and risk factor specific USPSTF recommendations can be found using the ePSS app found on the USPSTF website. Required interventions are italicized and considered to be an integral component of primary care
- \*The U.S. Preventive Services Task Force (USPSTF) recommends clinicians discuss these preventive services with eligible patients and offer them as a priority. All these Services have received an “A” (strongly recommended) or a “B” (recommended) grade from the Task Force

# Preventive Health Screenings

- USPSTF Grade A and B

How does SFHP support?

->link to USPSTF on Clinical Resources

- [US Preventive Services Task Force](#)
- San Francisco Health Plan (SFHP) approves, adopts, and distributes evidenced-based clinical practice guidelines from recognized sources and promotes them to providers and members in an effort to improve health care quality and reduce unnecessary variation in care. SFHP's clinical practice guidelines are also reviewed and approved by SFHP's Quality Improvement Committee



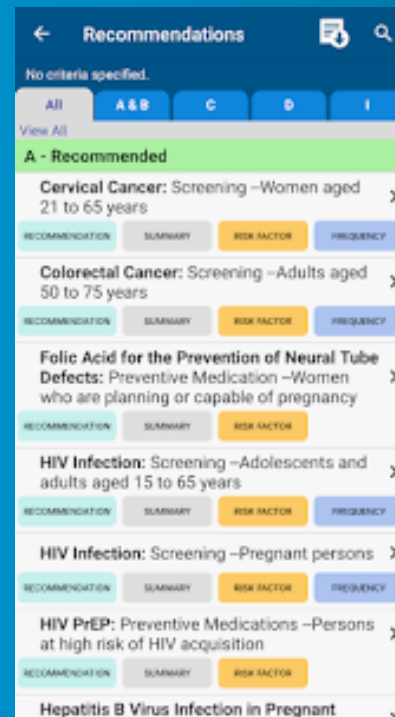
# Preventive Health Screenings: USPSTF Grade A and B Resources

## AHRQ ePSS

### Electronic Preventive Services Selector

The Electronic Preventive Services Selector (ePSS) is an application designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. When using this tool please read the specific recommendation to determine if the preventive service is appropriate for your patient. This tool is not meant to replace clinical judgment and individualized patient care.

- > Search for Recommendations
- > Browse by Topic
- > Browse by Grade
- > Grade Definitions
- > Tools
- > What's New
- > FAQ
- > About



- What are existing resources within clinic systems?
- What information would support?
- Provider Newsletter
- Policy documentation-annual revision
- Highlights:
  - Lung Cancer Screening
  - Screening for Depression, Diabetes

savings in drug insurance premiums or average out-of-pocket costs, however, is absent, as is evidence to assuage the fear that “cutting drug firms’ profits” might discourage efforts to discover and bring to market highly effective new drugs.

If the ACA remains in force, the efforts described above will continue. Their overall effect so far has been small, and I would expect it to remain so into the foreseeable future — affecting only slivers of the population (high-risk, nonpoor, uninsured people and buyers of specific drugs). Major changes affecting large swaths of the population will require legislation that would be unlikely to pass unless it was necessitated by the overturning of the ACA.

In that event, the administration’s most likely core strategy would be an effort to turn back much health policy to the states, with changes in the federal role limited largely to block-grant financing for Medicaid and exchanges. The House Republican

Study Group has outlined an Obamacare replacement incorporating such an approach.<sup>4</sup> States would then pursue their own solutions to challenges such as creating high-risk pools, covering any remaining uninsured people, controlling medical spending, and improving health outcomes. The overall strategy would be to accept that no uniform Republican plan can (or even should) work at the federal level, nor is it politically feasible, so perhaps the states can do better.

Whatever the outcome of the Court case, the one sure feature of health policy under either a second Trump administration or a Biden administration is that for some time to come, its fundamental structure will rest on Medicaid, Medicare, and the ACA exchanges. Employment-based group insurance will remain, as will the Obamacare platform of means-based premiums for means-tested individual insurance coverage. Republicans will oppose a public option, fearing that it will be favored by government bureau-

crats. The great bulk of private insurance provided through employment and often supplied by self-insured employers rather than insurance companies will remain largely unchanged.

Disclosure forms provided by the author are available at NEJM.org.

From the Wharton School, University of Pennsylvania, Philadelphia.

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## Covid-19 and the Mandate to Redefine Preventive Care

Daniel M. Horn, M.D., and Jennifer S. Haas, M.D.

As the U.S. health care system defines the new normal for ambulatory care in the Covid-19 era, it needs a new approach to providing routine preventive care for adults. Concerns about contagion, competing demands, and shortages of personal protective equipment may limit preventive care visits — most commonly the “routine annual exam” and the Medicare Annual Wellness Visit. But given that routine physi-

cal examinations have been shown to have limited clinical value, we believe health care organizations should take this opportunity to advance alternative systems for promoting evidence-based prevention.<sup>1,2</sup> Failure to do so will sustain or worsen the long-standing disparities in health that have been underscored by the pandemic.

Before Covid-19, many primary care clinicians believed that an-

ual exams did not optimally make use of their skills. The visit often became an exercise in checking off regulatory boxes, performing a head-to-toe physical exam for which there is no evidence of benefit, and ordering “routine” lab tests, many of which also lack supporting evidence. Yet many clinicians value these exams as a time for establishing or maintaining relationships with patients and reviewing the results of and

rationale for key preventive screening tests recommended (with a grade A or B) by the U.S. Preventive Services Task Force (USPSTF) — a list that is 25 items long and growing.

There are troubling disparities, however, in use of these evidence-based preventive services according to race, ethnicity, and socioeconomic status.<sup>3</sup> Since use of annual exams is more common among White people than Black people and increases with household income, such exams won't help address disparities in the delivery of preventive services.<sup>4</sup> So we are faced with a long and growing list of evidence-based preventive services to deliver to a broad population but a low-efficiency, low-efficacy mechanism for doing so. And the pandemic has revealed the clear and pressing need for a revamped approach.

We believe the U.S. health care system should embrace this moment as an opportunity to shift the locus of preventive care from face-to-face annual exams to a strategy that focuses on population health: clinical registries that readily identify all preventive services for which a patient is due; annual prevention kits for patients that facilitate widespread deployment of home-based testing, shared decision making, and self-scheduling of preventive screening tests and procedures in more convenient and approachable community settings; and robust community-based strategies involving navigators to overcome health disparities in underserved populations.

The first step in this strategy is developing a robust, real-time clinical preventive care registry that allows tracking of care needs asynchronously from visits. At our

institution, we have deployed a comprehensive registry that tracks all USPSTF grade A and B preventive services and their completion status for our approximately 250,000 primary care patients in eastern Massachusetts, including people who receive care at three community health centers in low-income neighborhoods. The registry is fully integrated into our electronic health records (EHRs) and has robust communication tools for patient outreach. Although many health systems and EHR vendors have established registry functionality, there is a pressing need for “smarter” registries that are interoperable across diverse health care settings, regardless of EHR vendor, and that can analyze utilization patterns, health conditions, and demographics to help link patients to the best prevention approach for them. These registries could also become shared, interactive tools for use by both clinicians and patients to facilitate preventive care.

The second step is to build the infrastructure for an annual “prevention kit” received by every patient. The kit should consist of a language-appropriate, culturally sensitive package that addresses all indicated USPSTF grade A and B preventive services as indicated by the clinical prevention registry. Point-of-care tests should be included to allow preventive care to happen from patients' homes; these could include fecal immunochemical testing, glycated hemoglobin and lipid testing, and perhaps soon, self-sampling of human papilloma virus for cervical cancer screening. QR code links to standardized electronic questionnaires should be included for depression screening, tobacco and alcohol use, and personalized risk assessment for common condi-

tions such as breast cancer and cardiovascular disease. Shared-decision-making materials for lung cancer screening, breast cancer screening intervals, and highly controversial topics such as prostate cancer screening are well studied and easily deployed.<sup>5</sup> Self-scheduling instructions for all recommended procedures and imaging studies should be provided.

After receiving the prevention kit, patients could be invited to schedule a virtual encounter with their primary care provider to review recommendations, engage in shared decision making on nuanced topics such as when to start or stop each type of screening, discuss any findings that may be of concern, and plan necessary interventions. Immunizations and other high-value preventive care that cannot be delivered at home could be addressed during in-person patient visits or at dedicated immunization clinics, rather than during dedicated annual exams.

The third step is to create specific programs to address the known disparities in preventive care within a given population. There is a rich body of literature supporting the effectiveness of community-based patient navigators in closing gaps in cancer-screening rates affecting underserved patients.<sup>3</sup> These navigators facilitate patients' preventive care by using proactive outreach and motivational interviewing and by accompanying patients to procedures such as colonoscopies. Navigators are also well suited to systematically screening for and facilitating access to community-based resources for addressing social determinants of health. In addition, they can connect patients with community-based campaigns to promote prevention,

such as screening vans. Though navigation programs cannot eliminate key social determinants of poor health, such as poverty, educational barriers, food insecurity, and racism, they can help make access to evidence-based preventive services more equitable.

The primary hurdles for implementation of our plan are payment reform and provider and patient acceptance. For a population-based prevention strategy to succeed, the health system needs to offer prospective payment for primary care with accountability **for overall completion of evidence-based preventive care throughout a population and a demonstrable commitment to addressing disparities in preventive care.** Services provided by patient navigators are not billable on any payer's fee schedule and will not generate substantial fee-for-service revenue, since navigators may interact with only a small proportion of a health system's patients. There is no reimbursable Current Procedural Terminology (CPT) code for a preventive care kit or shared-decision-making materials.

Health care centers that disproportionately provide care for disadvantaged populations may face additional barriers to implementing a population-based approach to prevention, since they may have more limited infrastructure and resources, particu-

larly now that the dramatic drop in visit volume during the pandemic has left many safety-net providers in financial crisis. Payment reform should be prioritized to allow these sites to move away from visit-based payments and facilitate innovative community-based prevention programs. Perhaps the Centers for Medicare and Medicaid Services could offer such centers one-time incentive payments to facilitate investment in population health technology.

Gaining clinician and patient acceptance of a new model is a second hurdle. But a potential positive outcome of the current pandemic is that patients may demand a care system that is more comprehensive and accessible, promotes equity, and facilitates their engagement in preventive care from the comfort of their home or community. Providers will face a backlog of patients in need of management of acute and chronic health conditions and will realize that care has to be provided more efficiently and effectively. Both patients and clinicians will have discovered virtual visits' potential for discussion and counseling. If we move to more sophisticated systems that can deliver convenient, personalized home-based testing strategies to patients, engage patients in their own care, and deploy evidence-based pro-

grams to ensure equitable access to preventive services, we believe our population's health will be improved.

A large-scale shift to a population-based prevention strategy is long overdue. The Covid-19 pandemic is delaying life-saving preventive screening for millions of patients, and our health system will struggle to catch up. Perhaps this crisis will be the impetus for change.

Disclosure forms provided by the authors are available at NEJM.org.

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## When All You Have Is Quality of Life — Making Medical Decisions in the Face of Uncertainty

Meghan C. Halley, Ph.D.

“Philip’s labs are high again. We would like to schedule a biopsy for tomorrow morning. Come to the hospital this eve-

ning so we can monitor his blood sugar while he is NPO before the procedure. Afterward, we will need to monitor him

overnight for bleeding. Hopefully it’s not rejection, and you can go home in 3 days. Does that work for you?”

# Questions?