Santa Clara Family Health Plan
Provider Advisory Council
October 10, 2012
Boardroom

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

Delegated Groups: Tuyen Ngo, MD

SCFHP Attendees: Matthew Woodruff, Jimmy Lin, MD, Mike Lipman, Pat McClelland, Vivian Than, Stacy Renteria, Diane Brown, Tammy Moore, Abby Baldovinos, Sarah Moline, and Melinda Shaw

ITEM	DISCUSSION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Meeting Called To Order	Co-Chair Dr. Thad Padua called meeting to order.	None		
Review of Minutes	Meeting minutes are approved by the Committee after a quorum was present at the meeting.	None		
CEO Report	**Healthy Families/Medi-Cal Transition** Matthew Woodruff, COO reported out on the first phase of the transition of Santa Clara County's Healthy Families members to Medi-Cal, which will be implemented on January 2, 2013 with the next phases implemented in April, August and September. The Health Plan has 5 PCP's that will not be moving forward with the Health Plan in this transition into Medi-Cal, which translates to 2.6% of the Health Plan's new Medi-Cal members will need a new Primary Care Provider on January 2, 2013. Services for these Healthy Families members such as dental and vision will remain intact on the Medi-Cal side. Co-payments and premiums will change; for Healthy Families members currently under 150% of the Federal Poverty Level there will be no premium and for those members currently between 151% and 200% of the Federal Poverty Level they will pay the same premium currently have. Co-payments if any - may be minimal and will only be around those members aged 18 and 19 years old.	None	N/A	N/A

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	Outreach and communications to Healthy Families members and providers will be supplied to the Health Plan before October 31st by MRMIB. DHCS and MRMIB will be doing outreach on November 1st and December 1st directly to Healthy Families members via mail and telephone. The Health Plan anticipates continuity of care issues to come up at the September transition date around out-of-network PCP's who see our members and accept our rates then the Health Plan has to keep the member with the out-of-network PCP for 12 months. The Health Plan does not know how that will work around pharmacy providers. This rule mirrors the SPD membership transition around continuity of care and providers. Reporting requirements around the Healthy Families transition will mirror the SPD reporting requirements. Appeals and grievances will be broken out separately; out-of-area, in-area and out of network, continuity of care, etc. The Committee discussed emergency room co-payments to get members to see their PCPs instead of emergency room visits. CMS struck down that provision in the Governor's budget.			
	CBAS – Wait for the CBAS presentation from Tammy and Diane to discuss the topic. The Health Plan has seven CBAS facilities contracted as of October 1st.	None	N/A	N/A
	Duals Demonstration – The Health Plan has not received a contract yet from the State, the original deadline was suppose to	None	N/A	N/A

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	be September now that has been pushed out to November, which will effect the MOU's timeline for the community based providers, which will now be pushed out 30-45 days out after the Health Plan receives the contract from the State. Hopefully around the holidays the MOU's can be put in place. Payment rates are not coming out with the contract, so that means hopefully after the first of the year we will have the rates on reimbursement. Mike Lipman, VP of Provider Operations discussed the Duals Stakeholders meetings around long-term support services and behavioral health to the Committee, which will lead into the Committee voting on two new members appointments to PAC on item IV of agenda. Dr. Thad Padua stated once the meeting has a quorum the Committee can vote on the CBAS stakeholder appointments.			
Medical Services	<u>CBAS Referral Process</u> – Diane Brown, Medical Management Director introduced Tammy Moore as CBAS and Agnews Case Manager and she has been embedded in the Adult Day services. The presentation will cover the changes from Fee-for-service Medi-Cal to Managed Care. Tammy reviewed her presentation with the Committee. Committee has a copy of the presentation in the PAC binder. Dr. Ngo requested a list of CBAS providers contracted with the Health Plan.	Send Dr. Ngo the CBAS List	Mike Lipman	12/5/12

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	The Committee discussed the referral process and education of what CBAS is with providers within the next few months. Tammy recommended hospital case management would be a good place to start the education process about CBAS. CBAS is primarily for senior adults. **PAC Purpose Statement and New Member appointment for LTSS/IHSS** Dr. Padua asked the Committee to review the read-line version of the Provider Advisory Committee Purpose Statement to update. The Committee also agrees to update the meeting requirements on last item around PAC members missing meetings and replacement after 2 meetings missed. Committee approved current read-lined version of purpose statement and approved the new member appointments of Karen Anton and Paul Taylor to move forward to the upcoming Board Meeting. Dr. Padua requested the approved language changes to go forward to the Bylaws Committee.	Approved read-lined version of PAC Purpose Statement to move forward to Bylaws Committee. Approved nomination of Karen Anton and Paul Taylor to move forward to the Board.	Mike Lipman/Matt Woodruff Mike Lipman/Matt Woodruff	12/5/12 12/5/12
Compliance	**Grievance Report** – Matt reviewed the grievance report with the Committee. The report is located in their PAC binder to follow along. Committee reviewed the report. The Committee discussed grievances related to Medicare/Medi-Cal members, which leads to an authorization issue discussion around PMG members who are Medi-Medi.	None None	N/A N/A	N/A N/A
Pharmacy	**P&T Update** – Sarah Moline, Pharmacy Director reviewed the new glucometer based on the P&T Committee's	At least 2 notifications to Provider	Matt Woodruff/Mike	12/5/12

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	recommendation last September for a new glucometer based on cost analysis. This will replace the One-Touch as the preferred glucometer of the Health Plan. The new vendor For Care will be providing new glucometers to our diabetic membership for free during the transition period. The supplies will be paid and covered by the Health Plan as listed in the formulary. The savings will be volume based due to the exclusive contract the Health Plan has with Foracare which will give us a 1 million dollar savings. The Committee asked to see the price comparison the P&T Committee looked at to make this recommendation. Ms. Moline did not have that comparison chart but assured the Committee that the P&T Committee look at cost-comparisons. Sarah asked for suggestions for a seamless transition. She explained that the Diabetic Clinic at VMC does not use Foracare and she anticipates some problems around that clinic in this transition. 78% of our diabetic members do use the One-Touch system. There is a 90 day transition period. The Committee discussed the various ways the Health Plan will communicate this change to members and providers. A mandatory consult will be done at the pharmacy level with the members. Does the change in machine require a prescription? Sarah stated yes, and re-fills around supplies also need a new prescription as it is a different NDC. This will be requiring much more communication to the provider than the Committee anticipated. What if the	communication around this new product implementation and subsequent prescriptions for new glucometer, refills and modems for diabetic members. For Communication to Members there will have to be one letter and an outbound telephone campaign during the transition period. Sarah and Mike to work with VMC Diabetic Clinic on transition. Call and or meet with the clinic. Report out on progress at next PAC meeting.	Lipman/Sarah Moline Matt Woodruff/Mike Lipman/Sarah Moline Mike Lipman/Sarah Moline Mike Lipman/Sarah Moline	 12/5/12 12/5/12 12/5/12

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	prescription does not specify the machine name or leave as "generic" and the test strips/supplies will still need a new prescription? Can members take their old glucometer with the letter from the health plan about the transition to their pharmacy and get the new machine? Sarah stated yes, members can do that. Pat McClelland suggested when reaching out to the providers to give them a chance to sign off on the new prescription for their existing members just to have it on file so when the member goes to pharmacy the prescription is taken care of and then it's only a matter of talking the member through the new consultation. So that administratively that can already be taken care of. Sarah agreed with suggestion. Matt asked for feedback on the modem communication and if providers would use it. The Committee agreed that may be an easy option for communication results. Dr. Padua requested more internal discussion and a presentation to get a comprehensive picture of this TeleHealth modem and how it will work. Matt stated that the member will put the modem in their home phone line to transmit their results. Upon the Committee's recommendation the Health Plan will start rolling out this program.	Blast Fax/Blast E-mails to Providers There needs to be a TeleHealth portion to the Dual Demonstration Program. An initial letter in December and another notice in January to Providers.	Mike Lipman/Sarah Moline Matt Woodruff/Mike Lipman	12/5/12 12/5/12

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Authorization Policy Review	**Proposed Authorization Policy** Mike reported out on the current issue around the health plan not receiving authorizations on a timely basis to pay claims from the IPA's. The Health Plan constantly has to call the IPA's about authorization information not received before the claims. The Committee discussed the health plan withhold payment to the IPA's until the problem is remedied; discussion of the IT departments to work it out on scheduled workgroup calls; Committee discussed Connect Claims Portal issues around eligibility. Proposed policy will be all claims sent to the Health Plan will be denied until the authorization is sent to the Health Plan and a cap on retro-authorizations. Cap will be 90 days for retro-authorization. Currently there is no end date on retro-authorization. Dr. Padua stated will this Committee approve a no authorization/no pay claim policy that SCFHP will pay through an appeal? Committee voted NO. Should have a time limit on retro-authorization – what should that timeline be 90 days or 6 months? Committee undecided. Agree to bring this back to discuss. Re-write policy nothing retro-authorized past 90 days.	Bring back a second draft of the policy. Put the proposed policy on paper so Committee members can read it. Committee members refused the verbal first draft of the policy.	Matt Woodruff/Mike Lipman	12/5/2012
	E-Claims Update The Health Plan is actively denying initial claims from	None	N/A	12/5/12

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	contracted providers that do not submit electronic claims. Corrected claims and resubmissions are required to come on paper. Claims from a non-contracted provider are OK to come on paper. There are plenty of options for contracted providers to submit claims through electronically, Connect Website Portal for professional claims, DocuHealthLink for electronic professional and institutional claims, Emdeon and Office Ally are contracted clearinghouses with the Health Plan for both professional and institutional claims, 4-eGuru, MedAid Consulting and Office Ally are contracted to process electronic PM160's to the Health Plan. The Health Plan has both big providers and small providers still not compliant. We are targeting education to these providers.			
Other	Request from Dr. Nguyen wanted verification that Office Ally will send PM160 electronically to the State as well as the Health Plan. Does he still needs to submit the PM160 to County?	Requirement for provider to send electronic PM160's to State and/or County.	Matt Woodruff/ Mike Lipman	12/5/12
Provider Services	<u>CME</u> Mike reported on the next CME on October 18th on Addiction Medicine and Addiction Science. The event flyer is in the PAC binder.	None	N/A	
Adjournment	Meeting adjourned at 2:00 pm			

Signature: Paul A. Estess **Date:** 12-12-12